Optum Idaho Provider Manual

November 2018 Edition

optumidaho.com

United Behavioral Health operating under the brand Optum

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Resource Guide

Optum Idaho Network Management

Your Optum Idaho Network Management team is here to support you in the provision of quality care to all Idaho Behavioral Health Plan (IBHP) Members. The team consists of seven fulltime employees dedicated to ensuring the Optum Idaho network meets the needs of the IBHP membership statewide. Their primary location of operations is at the Optum Idaho office in the Boise area at:

Optum Idaho
205 East Watertower Street
Meridian, ID 83642

Network Director – responsible for overseeing the development and management of the Optum Idaho network to ensure that the IBHP membership has optimal access to quality care for all IBHP covered services.

Regional Network Manager – responsible for ongoing development and management of the Optum Idaho network in Regions 1 & 2.

Regional Network Manager – responsible for ongoing development and management of the Optum Idaho network in Regions 3, 4 & 5.

Regional Network Manager – responsible for ongoing development and management of the Optum Idaho network in Regions 6 & 7.

Network Associate – responsible for providing administrative support to the Optum Idaho network team Members.

Community Agency Liaisons – responsible for coordinating the interface between the Optum Idaho clinical team and all IDHW partners (including the courts, juvenile justice, department of corrections, as well as child and family services).

This team can be reached during regular business hours by calling the Optum Idaho Provider Services line at **1-855-202-0983.**

Websites

optumidaho.com

Optum Idaho Providers have access to a host of web-based information and resources through our Idaho website **optumidaho.com**, which is designed to reduce their administrative burden and increase their effectiveness. The foundation of this is easily accessible information such as Provider forms, Provider manuals, Level of Care Guidelines, policies and procedures, relevant

news articles, and on-line training, including Continuing Education Units (CEUs) to maintain licensure. We provide secure tools to reduce the administrative tasks, such as online verification of Member eligibility and benefits, treatment authorization request and verification, submission of behavioral health claims online, EDI support so that Providers can easily get their claims processed, status of submitted claims (in accordance with national standards), and the ability to register online to receive electronic payments directly into their bank account.

Resources available on **optumidaho.com** include:

- Optum Idaho Provider Manual
- Optum Idaho Level of Care Guidelines
- Link to Online Verification of Member Eligibility and Benefits
- Link to Online Treatment Authorization Request and Verification
- Link to Online EDI Support
- Link to additional Provider training resources:
  - Relias Learning at ***essentiallearning.com***
  - OptumHealth Education at ***optumhealtheducation.com***
- Access to Standard Screening Tools for primary care physicians

The *optumidaho.com* portal contains direct links to all resources available on the Optum primary Provider portal at *providerexpress.com*.

providerexpress.com

Our industry-leading Provider website includes both public and secure pages. Public pages include general updates and useful information. Secure pages are available only to network Providers and require registration. The password-protected "secure Transactions" gives you access to Member and Provider-specific information.

To Register for Access:

- Select the "First-time User" link in the upper right hand corner of the home page and follow the prompts.

Secure Transactions:

- Check eligibility and authorization or notification of benefits requirements
- Obtain initial authorization or notification requests, if applicable
- Create and maintain My Patients list
- Submit professional claims and view claim status

- Make claim adjustment requests
- Register for Electronic Payments and Statements (EPS), including Electronic Funds Transfer (EFT)
- Update practice information:
  - Add NPI
  - Add Taxonomy Code(s)
  - Update Languages Spoken
  - Update email address
  - Update gender
  - Add Medicaid/Medicare Numbers
  - Update expertise
  - Update ethnicity
  - Manage address locations, including practice, remit, and credentialing
  - Admitting privileges
  - Update phone and fax numbers
  - Availability status
  - Accessibility-practice hours, wheelchair accessibility, public transportation, etc.
- View Achievements in Clinical Excellence (ACE) and ALERT Online Scorecards
- Obtain pre-populated Wellness Assessments
- Link to Clinician version of *liveandworkwell.com* to get patient education resources in English and Spanish (see *liveandworkwell.com* below)

Public Pages

The home page includes "Quick Links" to our most frequently accessed pages as well as recent news and updates:

- Access the latest information about ALERT®
- Obtain ACE program updates
- Download standard forms
- Find staff contacts
- Review clinical guidelines

- Locate current and archived issues of **Network Notes**, the Provider newsletter

liveandworkwell.com

You may use this Member site to:

- Get patient behavioral health education information. Access Member version of site from **optumidaho.com** and click on the Consumer tab, then the link to **liveandworkwell.com**
- Refer patients to appropriate benefit specific online resources:
  - Members may register and log in

Our primary Member website makes it simple for Members to:

- Understand behavioral health benefits
- Identify network clinicians and agencies
- Take self-assessments
- Use Computer Based Self-Help Programs:
  - Depression
  - Anxiety
  - Stress
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - Alcohol & Drugs
- Find articles on a variety of wellness and daily living topics
- Access Parent/Teen/Child integrated medical/behavioral information
- Locate community resources

The *liveandworkwell.com (LAWW)* website provides resources and patient education in English and Spanish. Website content varies according to Member benefit packages so advise Members to link directly to their customized LAWW site by using the hyperlink on the Optum Idaho Consumer page; registration allows access to additional content.

Frequently Used Forms and What You Need to Know

You may submit Service Requests electronically for services requiring prior authorization by going to *Provider Express.*

Algorithms for Effective Reporting and Treatment (ALERT®)

The one-page Wellness Assessment (WA) is a reliable, confidential, consumer-driven instrument

used to help identify targeted risk factors in addition to establishing a baseline for tracking clinical change and outcomes. The WA is routinely administered at the beginning of the first session and then again at session three, four or five. The completed form is faxed to Optum. Detailed instructions and copies of the WA are available at *Provider Express*. Wellness Assessments are also available in Spanish.

- Adult Wellness Assessment – The adult Member seeking treatment completes this form
- Youth Wellness Assessment – The parent or guardian completes this form when the Member you are seeing is a minor

For questions and/or comments about ALERT feel free to send us an email us at **ALERT_CNS_Ref@uhc.com**.

Claims and Customer Service

Claim Entry through Provider Express: You should file Optum claims at **Provider Express**. This secured, HIPAA-compliant transaction feature is designed to streamline the claim submission process. It performs well on all connection speeds and submitting claims on *Provider Express* closely mirrors the process of completing a Form 1500. In order to use this feature you must be a network clinician or group practice and have a registered user ID and password for *Provider Express*. To obtain a user ID, call toll-free **1-866-209-9320**. We strongly encourage you to use this no-cost claims entry feature for claims submission at **Provider Express**, which allows claims to be paid quickly and accurately. For more information about fast and efficient electronic claims submission, please see *Provider Express* **"Improve the Speed of Processing"**, on the Claim Tips page.

EDI/Electronic Claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a Payor (Optum). You may choose any clearinghouse vendor to submit claims through this route. Because Optum has multiple claims payment systems, it is important for you to know where to send claims. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. For Optum claims use Payer ID #87726. Additional information regarding EDI is available on the **Optum Idaho Provider page**.

Clinician Claim Forms: Paper claims can be submitted to Optum using the Form 1500. The claims should include all itemized information such as diagnosis (using the ICD code from the current DSM), units, Member name, Member date of birth, Member identification number, dates of service, type and duration of service (described by Procedure Code), name of clinician (i.e., individual who actually provided the service), credentials, tax ID and NPI numbers. Additional information about outpatient claim submission is available on *Provider Express*, **Outpatient Service Claims**.

Claims and Customer Service issues can be addressed by calling **1-855-202-0983.**

To ensure proper processing of claims, it is important to promptly contact Network Management if you change your Tax ID number. You may make changes to your practice address online. (see

“secure Transactions” section above).

Complaint Process

What is a complaint?

A complaint is an expression of dissatisfaction (other than an appeal) submitted by a Member, a Member’s authorized representative or a Provider (on behalf of a Member, acting as the Member’s authorized representative) that cannot be resolved through a standard inquiry to Optum. In addition, a Provider may file a complaint on his/her own regarding an issue unrelated to a specific Member.

How are complaints classified by Optum?

Concerns regarding the Optum Idaho administration of the plan are classified as Quality of Service Complaints, while concerns about the services received by a Member from a Provider in the Optum network are considered Quality of Care Complaints.

What should I do if I have a complaint?

Those who wish to file a complaint related to Optum may do so by phone (informing staff that the purpose of the call is to register a complaint). Any Optum Idaho employee can accept a complaint and is trained to properly send it to the correct person. Complaints may also be sent by email, by fax, or by mail:

- Phone: Optum Idaho Customer Support Services or Provider Services at **1-855-202-0983** weekdays from 8 a.m. to 6 pm MT
- Email: **optum.idaho.complaints@optum.com**
- Fax: **1-877-220-7330**
- Mail: You may also send your complaint in writing to:

  Optum Idaho
  205 East Watertower Street
  Meridian, ID 83642

How long will it take to process my complaint?

You will receive a letter within five business days after we receive your complaint, to let you know that we received it. If the complaint filed is a general complaint, and not a Quality of Care Concern, you will receive a letter with a resolution within 10 business days after initial receipt of your complaint. The process for Quality Care Concerns is described below.

What does Optum Idaho do when there is a possible Quality of Care issue reported?

A Member, representative or Provider may file a complaint about a potential Quality of Care issue. A Quality of Care issue means the quality of care provided to a Member by a Provider may be unsatisfactory. Quality of Care complaints should be filed the same way as other complaints.

Based on the severity of the complaint, our Complaints Department will determine how to escalate it appropriately. Quality of Care Concerns are resolved within 30 days.

If the complaint is escalated, the Quality Department and Chief Medical Officer will review and investigate the Quality of Care incident reported. The complaint may be forwarded to the Peer Review Committee for additional investigation and corrective action if needed. The actions taken by Optum Idaho to address the complaint may not be released to you; this is dependent on your role in the case. This means that Optum Idaho will advise the person filing the complaint that it has been referred as a Quality of Care complaint, and is being investigated, but details are not normally provided due to privacy issues.

When you file a Complaint you will receive a Complaint Tracking Number unique to your complaint. It is important that you use this tracking number in the event that any follow up is necessary or you have a question about the status of your complaint. You know that you have filed a complaint by receiving a complaint tracking number. You will also receive an acknowledgement of the complaint receipt within 5 days.

Complaints are not Adverse Benefit Determinations, Internal Appeals, nor Provider Disputes; which are all described elsewhere in this manual.

Introduction

Welcome

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 the Idaho specific website optumidaho.com as well as our industry-leading website *providerexpress.com* 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 Optum Idaho Provider Manual. We've included an easy reference Resource Guide 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!

Linda Hibbert
Senior Vice-President
Optum Behavioral Health and Network Strategies

About United Behavioral Health, Optum and Optum Idaho

United Behavioral Health (UBH) was officially formed on February 2, 1997, via the merger of U.S. Behavioral Health, Inc. (USBH) and United Behavioral Systems, Inc. (UBS). Our company is a wholly owned subsidiary of UnitedHealth Group. We have been operating under the brand Optum since 2012.

We are the nation's largest accredited managed behavioral health care organization, providing services to one in six insured Americans. It is supported by the largest behavioral provider network in the United States - more than 130,000 practitioners. And we offer the industry's most comprehensive array of innovative and effective behavioral health care programs including integrated behavioral and medical programs, depression management, employee assistance, work/life management, disability support and pharmacy management programs.

Today, our customers include small businesses, Fortune 100 companies, school districts, health plans, and disability carriers. At the time of this publication, we support 43 million members nationwide.

Optum

Optum is a health services business dedicated to making the health system work better for everyone. We have aligned our businesses and are focused on helping ensure that people receive the right care at the right time from the best practitioners.

Optum supports population health management solutions that address the physical, mental and financial needs of organizations and individuals. We provide health information and services to nearly 60 million Americans – educating them about their symptoms, conditions and treatments; helping them to navigate the system, finance their health care needs and stay on track with their health goals.

We serve people throughout the entire health system allowing us to bring a uniquely broad, yet experienced, perspective. We have the ability and scale to help our clients both envision and implement new approaches that drive meaningful, enduring and positive change.

Optum serves people throughout the entire continuum of healthcare, from promoting wellness and prevention, to servicing those that provide care, to delivering and managing prescription solutions, to being an industry-leader in healthcare research and technology.

Optum Idaho

Effective September 1, 2013, Optum manages outpatient mental health and substance use disorder services, hereby referred to as behavioral health services, to help adults and children enrolled in Idaho Medicaid access the most effective treatment for their needs.

Optum is working closely with the state of Idaho, consumers, family members, providers and community stakeholders to develop, implement and maintain a utilization management program for the Idaho Behavioral Health Plan (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, are focused on measurable outcomes, and are supporting the member's recovery and/or the family's resiliency

Our focus is on improving access to treatment, expanding the array of covered service, enhancing quality of care and improving treatment outcomes. Our goal is to enhance the statewide behavioral health system and make it easier for people to access care.

In addition to adding more behavioral health care providers and new community-based programs, wherever possible, Optum is increasing services available in rural areas to ensure that people throughout Idaho are able to get the care they need close to home.

Optum is committed to recovery, resiliency and person-centered care. This includes assisting and supporting people in learning to manage their behavioral health and wellness challenges. Our practices are anchored in the belief that people with mental illness are able to live, work and participate productively in their communities despite their behavioral health challenges, and are resilient and able to rebound from trauma, stigma and other stresses.

We look forward to an active partnership as we all work together to improve the lives of consumers in Idaho.

Mission and Vision

Our **Mission** is to help people live their lives to the fullest.

Our **Vision** is to be a constructive and transformational force in the health care system.

Core Values

- Integrity
  - Honor commitments
  - Never compromise ethics
- Compassion
  - Walk in the shoes of the people we serve and those with whom we work
- Relationships
  - Build trust through collaboration
- Innovation
  - Invent the future, learn from the past

- Performance
    - Demonstrate excellence in everything we do

Glossary of Terms

These definitions are general definitions applied for purposes of this manual. State law, certain practitioner agreements and individual benefit contracts define some of these terms differently. In such cases, the definitions contained in the applicable law or contract will supersede these definitions. In the definitions below, and throughout this manual, “we”, “us” and “our” refer to Optum Idaho.

Abuse

Unsound business practice resulting in undue remuneration.

Adverse Benefit Determination

A denial, reduction, or termination of coverage, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on the eligibility of a Member or beneficiary to participate in a plan; and a denial resulting from utilization review, the experimental or investigational nature of the service, or the lack of medical necessity or appropriateness of treatment.

Affiliate

Each and every entity or business concern with which we, directly or indirectly, in whole or in part, either: owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Agency

A non-facility based outpatient Provider meeting specific criteria. Examples include, but are not limited to, Federally Qualified Health Centers (FQHC), Community-based Rehabilitative Service Agencies, Substance Use Disorder Agencies and Case Management Agencies. Agencies require clinical oversight by an independently licensed clinician of any staff Members who are not independently licensed.

Agreement

A contract describing the terms and conditions of the contractual relationship between us and a Provider under which behavioral health services are provided to Members.

ALERT®

ALgorithms for **E**ffective **R**eporting and **T**reatment (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 (utilization algorithms) for the authorization and/or clinical review of outpatient services. It also generates Provider profiles that enable quality improvement and clinical staff to take action when trends are identified. In addition ALERT uses a Practice Management Algorithm that complements claims-based fraud, waste and abuse detection.

Algorithm

A set of decision rules we apply to Member-specific data to determine whether there are any targeted clinical issues or risks.

Appeal

A specific request to reverse a Notice of Adverse Benefit Determination or potential restriction of benefit reimbursement.

Authorization

The number of days or non-routine outpatient visits/units for which benefits have been applied as part of the Member benefit plan for payment (formerly known as Certification). Authorizations are not a guarantee of payment. Final determinations will be made based on Member eligibility and the terms and conditions of the Member's benefit plan at the time the service is delivered.

Balance Billing

The practice of a Provider requesting payment from a Member for the difference between the UBH contracted rate and the clinician or facility's usual charge for that service.

Behavioral Health Care

Assessment and treatment of mental health and/or substance use disorders (MH/SUD).

Care Advocate

An Optum employee who is a licensed clinical professional (e.g., nurse, doctor, psychologist, social worker, or professional counselor) who works with Members, health care professionals, physicians, and insurers to maximize benefits available under a Member's benefit plan. The Care Advocate has obtained clinical endorsement, and is specifically licensed with that designation, and has experience in mental health and/or substance use disorder services; primary responsibility is reviewing requests for service authorizations.

Clean Claim

A UB-04 or a Form 1500 claim form, or its successor, submitted by a facility or clinician for MH/SUD health services rendered to a Member which accurately contains all the following information: Member's identifying information (name, date of birth, subscriber ID); facility or clinician information (name, address, tax ID); date(s) and place of service; valid ICD-10 code or its successor code; procedure narrative; valid CPT-4 or revenue code; services and supplies provided;

facility charges; and such other information or attachments that may be mutually agreed upon by the parties in writing.

The primary avenue for clinician claims submissions is electronically through *Provider Express* via the *optumidaho.com* portal.

Coordinated Care Plan

A coordinated care plan is the result of coordinating care from all providers involved in treatment and may take many forms depending on level of involvement. Examples may include person-centered plans, developmental disability plans, court ordered goals, or Family and Community Services plans.

Complaint

An expression of dissatisfaction logged by a Member, a Member's authorized representative or a Provider concerning the administration of the plan and services received. Actions subject to a general complaint include, at a minimum, dissatisfaction with the benefit plan, a Provider, a participant, or the way in which Optum Idaho administers the plan. Possible subjects for complaints include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights. When a complaint is filed, the complainant receives a unique 12 digit tracking number.

Credentialing

The process by which a Provider is accepted into our network and by which that association is maintained on a regular basis.

Crisis (Mental Health)

A mental health crisis is a potentially life threatening situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress due to psychiatric symptoms associated with mental illness or substance use disorder(s). These persons may be considering self-harm or harm to others, disoriented or out of touch with reality or have a compromised ability to function, or are otherwise agitated and unable to self-calm. An immediate response to their circumstances is needed.

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*.

Early Periodic Screening Diagnosis and Treatment (EPSDT) for Children

EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the

Social Security Act (the Act). The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting. EPSDT entitles enrolled infants, children and adolescents to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment or service is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions.

Emergency

A serious situation that arises suddenly and requires immediate care and treatment to avoid jeopardy to life or health. For appointment access standards see “Emergency - Life-threatening”, “Emergency - Non-life-threatening” and “Urgent”.

Emergency—Life Threatening

A situation requiring immediate appointment availability in which there is imminent risk of harm or death to self or others due to a medical or psychiatric condition.

Emergency—Non-life threatening

A situation requiring appointment availability within six hours in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm or death to self or others.

Evidence-Based Practices

Interventions that have been shown through research to be effective in treating specific disorders or populations.

Exclusions

Specific conditions or circumstances listed in the Member’s Benefit Plan for which the policy or plan will not provide coverage reimbursement under any circumstances.

Field Care Coordination Manager

An Optum Idaho Field Care Manager who is an independently licensed clinician who has obtained clinical endorsement, who is specifically licensed with that designation; and with experience in mental health and/or substance use disorder services. Their primary responsibility is managing the Field Care Coordinators and working with Providers, affiliated delivery systems, regional behavioral health boards, regional IDHW staff and others in a designated IDHW region.

Field Care Coordinator

An Optum employee who is a licensed clinical professional (e.g., nurse, doctor, psychologist, social

worker, or professional counselor) who works with Members, health care professionals, physicians, in each of the seven Idaho regions and is responsible for, intensive care coordination cases , routine care coordination cases, discharge coordination cases. Their primary responsibility is working with Providers who are serving Members identified as high need or high risk.

Federally Qualified Health Centers (FQHC)

A federally qualified health center is a type of Provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS), certain tribal organizations, and FQHC Look-a-Likes. An FQHC Look-A-Like is an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.

Fee Maximum

The maximum amount a participating Provider may be paid for a specific health care service provided to a Member under a specific contract. Reimbursement to clinicians is based upon licensure rather than degree.

Fraud

An intentional misrepresentation to gain a benefit.

Health Plan

A health maintenance organization, preferred Provider organization, insured plan, self- funded plan, government agency, or other entity that covers health care services. This term also is used to refer to a plan of benefits.

HIPAA

The Health Insurance Portability and Accountability Act, by which a set of national standards are set for, among other topics, the protection of certain health care information. The standards address the use and disclosure of an individual’s “Protected Health Information” (PHI) by organizations subject to the Privacy Rule (“covered entities”). These standards also include privacy rights for individuals to understand and control how their health information is used. For more information, please visit the Department of Health and Human Services Web site.

Independent Review Organization

An independent entity/individual retained by a private health plan, government agency to review adverse determinations (based on medical necessity) that have been appealed by, or on behalf of, a Member (also sometimes known as External Review Organizations). In the case of the IBHP, the IDHW manages the IRO process for the second level (Fair Hearing) in the Appeal process.

Independently Licensed Clinician

A licensed behavioral health professional whose clinical licensure allows for the independent provision of behavioral health care services without supervision by another licensed professional.

Least Restrictive Level of Care

The Level of Care (LOC) at which the Member can be safely and effectively treated while maintaining maximum independence of living.

Legal Entity

United Behavioral Health (UBH) operating under the brand Optum.

Level of Care (LOC) Guidelines

Objective, evidence-based admission and continuing stay criteria for MH/SUD services. These guidelines are intended to standardize care advocate decisions regarding the most appropriate and available level of care needed to support a Member's path to recovery.

liveandworkwell.com

A Member website which provides resources for wellness information, MH/SUD intervention, and network referrals.

Medical Necessity

A service is medically necessary if:

For Adults:

- The State of Idaho's regulatory definition of medical necessity, located at: **IDAPA 16.03.09.011.16**
- A service is medically necessary if:
  - It is reasonably calculated to prevent, diagnose, or treat conditions in the Member that endanger life, cause pain, or cause functionally significant deformity or malfunction; and
  - There is no equally effective course of treatment available or suitable for the Member requesting the service which is more conservative or substantially less costly
  - Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality

For Children:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services:
  - Medically necessary services for eligible Medicaid participants under the age of

twenty-one (21) are healthcare, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan
    - Services must be considered safe, effective, and meet acceptable standards of medical practice
- Location of definition: **IDAPA 16.03.09.880**

Member

An individual who meets all eligibility requirements and for whom premium payments for specified benefits of the contractual agreement are paid. Also may be referred to as a plan participant, enrollee, or consumer.

Mental Health Center (MHC)

A behavioral health agency that offers mental health services by licensed clinicians whose licensure allows for independent practice. MHC's may utilize such licensed clinicians to provide clinical supervision to unlicensed staff in the provision of services to Members, under the Supervisory Protocols Addendum to the Provider contract. The MHC array of services includes assessment and diagnosis, psychotherapy and pharmacological management. Additional services may include skills training, crisis intervention, case management, psychological testing and neuropsychological testing.

Mental Health Parity

Financial requirements and treatment limitations applied to mental health and substance use disorder benefits may be no more restrictive than those applied to medical/ surgical benefits, per the Mental Health Parity and Addiction Equity Act of 2008. For more information, please see: ***uhc.com/united-for-reform/health-reform-provisions/mental-health-parity***

MH/SUD

Mental Health and/or Substance Use Disorder.

Network Management Department

Consists of Network Managers and Associates who provide services and information to Providers. In addition, they may act as liaisons with other departments such as Care Advocacy and Account Management to contract and retain experienced behavioral health professionals.

Notice of Adverse Benefit Determination

A written notification letter that explains the Adverse Benefit Determination taken, or intended to be taken, regarding denial or limit of authorization of a requested service; termination, suspension, or

reduction of a previously authorized service; the denial, in whole or in part, of a payment for service; or the failure to act upon a request for services in a timely manner.

optumidaho.com

Optum Idaho-specific website providing resources for clinicians and agencies serving the Idaho Behavioral Health Plan membership.

Paraprofessional

A qualified practitioner supervised by an independently licensed clinician.

Payor

The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member who is authorized to access MH/SUD services in accordance with the Agreement.

Program Manager, UM (Utilization Management)

A licensed clinician with a Master's or doctoral degree in psychology, social work, counseling or a related field, or registered psychiatric nurse and a current non-restricted and independent license in a behavioral health field or nursing. Primary responsibilities are to provide clinical supervision, training, oversight and direction to the Care Advocacy teams and ensure that department goals are communicated clearly, and that goals are met or exceeded through team effort. UM Program Manager schedules staff to provide adequate phone service coverage, including on-call after-hours support, monitors utilization and quality trends, audits files for appropriate documentation, conducts clinical case reviews, and is involved in committees and other meetings as necessary. UM Program Manager handles exceptions to policies and procedures, appeals, and problematic cases as needed.

Prospective Review

When future claims (not yet processed) that match suspected abusive patterns submitted by a Provider go under investigation and trigger a request for medical records.

Provider Dispute

A contracted Provider's written notice to Optum Idaho disputing or requesting reconsideration of a claim (or group of claims) that has been denied, adjusted or contested and for which the Member has already received service and for which the Member has no financial liability. Under your Agreement, one level of dispute is available. For more information, see the "Appeals and Provider Dispute Resolution" section of this manual.

Provider Express

Website providing resources for clinicians, agencies and group practices, General information,

manuals, forms and newsletters are available to all Providers. A variety of secure, self-service transactions including authorization inquiry and claim entry are available to network clinicians, agencies and group practices that obtain a registered “User ID”.

Provider Quality Specialists

Optum Idaho Provider Quality Specialists are clinicians who conduct chart reviews to ensure the quality, appropriateness and clinical outcomes of all services provided through the Idaho Behavioral Health Plan, and who follow-up with Providers as appropriate.

Quality Assurance

A formal set of activities to review and affect the quality of services provided. Quality Assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient services. Idaho has regulations for health plans to have quality assurance programs.

Quality Improvement

A continuous process that identifies opportunities for improvement in health care delivery, tests solutions, and routinely monitors solutions for effectiveness.

Relias and OptumHealth Education

Optum Idaho offers free, on-demand resources, training, and CME/CEU licensure courses for our provider community and their staff. These online courses:

- Are designed to fit into a busy schedule
- Won’t require travel time or cost
- Are free of charge within the Optum Network

Relias is an eLearning portal that provides a robust knowledge library of clinical and business courses to all types of clinical and administrative staff. Relias offers a variety of CEU based courses for master’s level clinicians and key learning areas aligned with continued education guidelines for certified healthcare paraprofessionals. Network providers can register for a free Relias account **here**.

Optum Health Education is an eLearning portal that is targeted towards medical professionals (MD, PhD, R.N., P.A.) and offers CME and CEU based courses in behavioral health and related learning areas. Network providers can register for a free account at **Optum Heath Education website**.

Routine Access

A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others.

Telemental Health

The provision of behavioral health services by a behavioral health Provider via a secure two-way, real-time, interactive audio/video telecommunication system. These services may be referred to as Telemental Health or virtual visits.

Urgent Access

A situation in which immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation. Availability should be within 48 hours or less or as mandated by state law.

Waste

Any unnecessary consumption of health care resources.

Wellness Assessment (WA)

A reliable, confidential, Member-driven instrument used to help identify targeted risk factors in addition to establishing a baseline for tracking clinical change and outcomes.

YES Practice Model

Six mandatory practice components that make up an overarching Practice Model. Many practice components will overlap throughout a member's experience in care. The six practice components are: Engagement, Assessment, Care Planning & Implementation, Teaming, Monitoring & Adapting, and Transition. All providers in the Idaho Behavioral Health Plan are required to follow the YES Practice Model.

YES Principles of Care

Eleven principles that are applied to all areas of mental health treatment planning, implementation, and evaluation as outlined in the Jeff D. Settlement, Appendix B. The YES principles of care are the mandatory standards to be used by all stakeholders related to the provision of services and interaction with others and are as follows: Family-centered, Family and Youth Voice and Choice, Strengths-based, Individualized Care, Team-based, Community-based Service Array, Collaboration, Unconditional, Culturally Competent, Early Identification and Intervention, and Outcome-based. All providers in the Idaho Behavioral Health Plan are required to follow the YES principles of care.

Network Requirements

Clinical Network Development and Maintenance

Optum Idaho is responsible for arranging for the provision of a comprehensive spectrum of behavioral health services. In order to fulfill this responsibility, we administer a Provider network which includes but is not limited to licensed qualified professionals, community- based rehabilitative services, case management services and agencies providing mental health and substance use disorder treatment. This network represents an array of clinical and cultural specialties offering a wide variety of services. The diversity of our network allows us to meet the clinical, cultural, linguistic and geographic needs of the Idaho Behavioral Health Plan membership.

Non Discrimination

Optum Idaho does not deny or limit the participation of any Provider in the network, and/or otherwise discriminate against any Provider, based solely on any characteristic protected under state or federal discrimination laws.

Furthermore, Optum has never had a policy of terminating any Provider because the Provider or Provider representative: (1) advocated on behalf of a Member; (2) filed a complaint against Optum; (3) appealed a decision of Optum; or (4) requested a review of a termination decision or challenged a termination decision of Optum. Moreover, consistent with the terms of the Settlement Agreement entered into in Holstein v. Magellan Behavioral Health, Optum has adhered to this practice both before and since the Settlement Agreement was executed. Optum has not, and will not, terminate any Provider from its network based on any of the four grounds enumerated above. Nothing in the Agreement should be read to contradict, or in any way modify, this long-standing policy and practice of Optum.

Agency/Group Credentialing and Re-credentialing

Optum Idaho follows the guidelines of National Committee for Quality Assurance (NCQA) for credentialing and re-credentialing unless otherwise required by law. As part of the credentialing and re-credentialing process, agencies are required to submit documentation supporting their professional and community standing and defining their program offerings. This documentation includes, but is not limited to:

- Current copies of all licenses required by Idaho for the services you offer including Idaho Medicaid credentialing reports
- Current copy of accreditation certificate and/or letter from each accrediting body
- General and professional liability insurance coverage (a minimum of $1 million/$3 million)

- W-9 forms
- Disclosure of Ownership and Control Interest Statement
- Signed malpractice claims statement/history
- Staff roster
- Program description including services provided

In addition, documentation confirming completion of criminal background checks on agency employees, in accordance with Idaho Department of Health & Welfare requirements, may be reviewed during site audits. For more information, visit the **Idaho Criminal History Unit Home Page**.

In the event that your agency is not accredited by an entity recognized by Optum, an On- site Audit will be required prior to credentialing and again prior to re-credentialing (see "Audits of Sites and Records" in the "Quality Improvement" section of this manual for more information).

The Credentialing Plan addresses the requirements for participation, continued participation (maintaining unrestricted license, cooperating with complaints investigation, etc.), and information regarding disciplinary action up to and including termination of participation in the network. The Credentialing Plan is available at **Provider Express**, or you may request that a paper copy be mailed to you by contacting your Network Manager.

Clinician Credentialing and Re-credentialing

Optum Idaho uses the Universal Provider Data Source®, developed by CAQH to obtain the data needed for credentialing and re-credentialing of individual network clinicians. The CAQH web-based credentialing tool streamlines the credentialing process by enabling you to complete your credentialing application online. This free service for healthcare professionals is available 24 hours a day, 365 days a year. The online application allows you to save your work and return later to finish the process. Once completed, CAQH stores the application online and enables you to make updates to your information as needed. By keeping your CAQH information current, future re-credentialing is quick and easy.

Once your application is completed with CAQH, Optum may utilize Aperture, an NCQA certified Credentials Verification Organization (CVO), to review the application packet for completeness and collect any missing or incomplete information.

Clinician Credentialing

Optum Idaho credentials clinicians according to rigorous criteria that reflect professional and community standards, as well as applicable laws and regulations. These criteria include, but are not limited to, satisfaction of the following standards:

- Independent licensure or certification in your state(s) of practice, except as required by applicable state law

- License is in good standing and free from restriction and/or without probationary status
- Board Certification for psychiatrists (Board Eligibility for newly licensed psychiatrists, with requirement to complete Board Certification prior to re-credentialing)
- Current certification through the Federal Drug Enforcement Agency (DEA) for prescribing clinicians in each state in which they practice
- Professional Liability Coverage: a minimum of $1 million occurrence/$1 million aggregate for master's-level and doctoral-level clinicians, and a minimum of $1 million/$3 million for physicians
- Free from any exclusion from government programs
- Disclosure of Ownership and Control Interest Statement

For a more specific list of criteria, please refer to the **Credentialing Plan** on *providerexpress.com*.

You will be asked to sign a release of information granting Optum and its agents access to information pertaining to your professional standing. This is required for primary verification and/or review of records from any professional society, hospital, insurance company, present or past employer, or other entity, institution, or organization that may have information pertaining to your professional standing. Obtaining and reviewing this information is necessary to complete the credentialing process. Failure to provide such a release will preclude completion of your credentialing and prevent your participation in the network.

Optum has specific requirements for identified specialty areas. A comprehensive list of specialty areas is available on the **Specialty Attestation** form, which can be found in the **"Forms"** section on **Provider Express**. If you request recognition of a specialty area, an attestation statement may be required documenting the specific criteria met for the identified specialty. Current competency of a designated specialty may be randomly audited to ensure that network clinicians remain active and up-to-date in their specialty field attestations.

The Credentialing Plan addresses the requirements for participation, continued participation (e.g., maintaining unrestricted license, cooperating with complaints investigation, etc.), and information regarding disciplinary action up to and including termination of participation in the network. The **Credentialing Plan** is available at **Provider Express**, or you may request that a paper copy be mailed to you by contacting Network Management.

Clinician Re-credentialing

In accordance with our commitment to the highest quality of clinical treatment, Optum Idaho re-credentials clinicians every 36 months unless state law or client policies require a different re-credentialing cycle. During re-credentialing, we will access your information through your CAQH application, unless otherwise required by law. In addition, you will be required to provide your current copy of:

- Professional licensure and/or certification
- Federal Drug Enforcement Agency (DEA) certificate (if applicable) for each state in which you practice
- Controlled Dangerous Substances (CDS) certificate (if applicable)
- Professional and general liability insurance
- Curriculum vitae

You may also be asked to:

- Attest to your areas of clinical specialty and appropriate training supporting the identified specialties
- Sign a release of information granting access to information pertaining to your professional standing. This is required for primary verification and/or review of records from any professional society, hospital, insurance company, present or past employer, or other entity, institution, or organization that does or may have information pertaining to your professional standing. Failure to provide such a release will preclude completion of your re-credentialing and prevent your continued participation in the network

You are required to provide a copy of all professional documents whenever they renew or change.

Credentialing and Re-credentialing Rights and Responsibilities

As an applicant to the Optum Idaho network, or as a network Provider in the process of re-credentialing, you are entitled to:

- Be informed of your rights
- Be informed of credentialing or re-credentialing status upon request
- Review information submitted to support your credentialing or re-credentialing application, excluding personal or professional references, internal Optum documents, or other information that is peer-review protected or restricted by law
- Make corrections to erroneous information identified by Optum in review of credentialing or re-credentialing application

In addition to the above rights, you have the responsibility to submit any corrections to your credentialing or re-credentialing application in writing within 10 business days of your notification by Optum.

Written Notification of Status Changes

You are required to notify us in writing within 10 calendar days of any changes to:

- The status of the practice, including changes in practice location, billing address, or telephone or fax number
- Changes agency, or group ownership
- The status of professional licensure and/or certification such as revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, debarment from any government program, monitoring or any other adverse action
- The status of professional liability insurance
- Potential legal standing (any malpractice action or notice of licensing board complaint filing)
- The Tax Identification Number (TIN) used for claims filing
- The programs you offer (services you provide must continue to meet our credentialing criteria)

Registered users of **Provider Express** are strongly encouraged to use the “My Practice Info” function to update this information. Otherwise, clinicians and agencies should submit changes in writing, using fax or mail, to your Optum Idaho Network Management team at **1- 855-202-0983** or **optum_idaho_network@optum.com**.

Practice Locations and Contract Status

Individually Contracted Clinician

Your Agreement is between you and UBH operating under the brand Optum. It is an agreement to see all Members eligible to access this Agreement. Your Agreement with UBH/Optum is not specific to a single location or Tax Identification Number (TIN). It is important to provide us with all practice locations and the TIN(s) under which you may bill to facilitate proper reimbursement.

Agency Contracts

The Agreement is between the agency and UBH. It is an agreement to see all Members eligible to access this Agreement. The Agreement with UBH is specific to a single TIN, but may include multiple practice locations. It is important to provide us with all practice locations and the TIN under which you may bill to facilitate proper reimbursement.

Provider Initiated Unavailable Status

Individual clinicians may request to be made unavailable for new referrals at one or more of your practice locations for up to six months. You are required to notify Optum Idaho Network Management within 10 calendar days of your lack of availability for new referrals. You may make this notification through “secure Transactions” on **Provider Express**, or by contacting Network Management. You will be sent a letter confirming that your request has been processed.

When you have been on unavailable status for five consecutive months, we will send you a letter

reminding you that you will be returned to active status within 30 calendar days. You may contact Network Management to request an extension of your unavailable status. Should you decide that you want to return to active status sooner than expected; you may update your status on **Provider Express** or notify Network Management.

Some common reasons for requesting unavailable status are: extended illness, vacation or leave plans, lack of available appointments. Please note that while on unavailable status your Agreement remains in effect. Agencies that wish to be made unavailable should contact Network Management.

On-Call and After-Hours Coverage

You must provide or arrange for the provision of assistance to Members in emergency situations 24 hours a day, seven days a week. You should inform Members about your hours of operation and how to reach you after-hours in case of an emergency. Each Member's treatment plan must also include a crisis plan that informs the Member what to do in the case of an emergency. In addition, any after-hours message or answering service must provide instructions to the Members regarding what to do in an emergency situation.

When you are not available, coverage for emergencies should be arranged with another participating clinician.

Supervisory Protocols

In accordance with the Agreement, the services you provide must be provided directly by you for all Members unless your agency is the contracting entity and your Optum contract includes the Supervisory Protocols Addendum. Licensed supervising clinicians within the agency may submit claims in their name for treatment services provided by bachelor's level paraprofessional employees within the agency who are under the direct supervision of the licensed clinicians.

Psychological Testing

For information regarding test administration by a psychometrist, psychometrician or psychologist-extender, please refer to the Psychological and Neuropsychological Testing Guidelines at **optumidaho.com**. This guide also addresses other procedures related to testing and report writing. You can also contact the Optum Idaho Care Advocacy Center at **1-855-202-0983** for assistance with such questions.

Termination or Restriction of Network Participation

A Provider's participation with Optum Idaho can end for a variety of reasons. Both parties have the right to terminate the Agreement upon written notice, pursuant to the terms of the Agreement.

If you need clarification on how to terminate your Agreement, you may contact Network Management.

In some cases, you may be eligible to request an appeal of an Optum initiated termination or restriction of your participation. If you are eligible for an appeal, we will notify you of this in writing

within 10 calendar days of the adverse action. The written request for appeal must be received by Optum within 30 calendar days of the date on the letter which notified you of any adverse action decision. Failure to request the appeal within this timeframe constitutes a waiver of all rights to appeal and acceptance of the adverse action.

The appeal process includes a formal hearing before at least three (3) clinicians, appointed by Optum. The Appeal Committee members are not in direct economic competition with you, and have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. You may be represented by a person of your choice at the appeal hearing, including legal counsel. At the conclusion of the hearing you have five business days to submit further documentation for consideration.

The Appeal Committee's decision is by a majority vote of the Members. The decision of this Committee is final, and may uphold, overturn, or modify the recommendation of Optum. Correspondence regarding the decision is sent to the Clinician using First Class mail, postage prepaid and properly addressed, overnight delivery, facsimile or email, within thirty (30) calendar days of the hearing date if submission of further written statements is waived or within thirty (30) calendar days after the Clinician's submission of any final written statements is due to the Appeals Committee. Receipt shall be deemed delivered and received by Provider on the 3rd business day after mailing or actual date of delivery if using overnight delivery, facsimile or email.

Continuation of Services after Termination

Network Clinicians and Agencies who withdraw from the Optum Idaho network are required to notify us, in writing in accordance with your Agreement, 90 calendar days prior to the effective date of termination, unless otherwise stated in your Agreement or required by state law. With the exception of terminations due to quality-related issues, suspected fraud, waste or abuse, change in license status or change in ability to participate in federal programs, clinicians are obligated to continue to provide treatment for all Members under their care. The timeline for continued treatment is up to 90 calendar days from the effective date of the contract termination, or as outlined in your Agreement or until one of the following conditions is met, whichever is shortest:

- The Member is transitioned to another Optum clinician
- The current episode of care has been completed
- The Member's Optum benefit is no longer active

To ensure continuity of care, Optum will notify Members affected by the termination of a clinician or agency at least 30 calendar days prior to the effective date of the termination whenever feasible. Optum will assist these Members in selecting a new clinician, group or agency. You are also expected to clearly inform Members of your impending non- participation status upon the earlier of the Member's next appointment or prior to the effective termination date, in compliance with your Agreement.

Idaho Behavioral Health Plan Benefits, Authorization Requirements and Access to Care

Optum Idaho establishes guidelines and requirements for Providers. Where required by law, more stringent standards may be applied. However, if state law permits the application of less stringent standards, the Optum standards specified herein shall still be applied pursuant to the terms of your Agreement. In accordance with industry standards and Best Practices, Optum may review and modify authorization procedures.

Idaho Behavioral Health Plan Benefits

Optum Idaho administers outpatient behavioral health managed care benefits for Idaho Behavioral Health Plan (IBHP) Members. All IBHP Members shall be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other patients of the Provider. Providers should reference the Level of Care Guidelines for service definitions and for more detail regarding the appropriate provision of these benefits. These documents are located at *optumidaho.com* in the "**For Network Providers**" section.

The following covered services will be available and accessible to all IBHP Members when determined to be medically necessary:

- Adult Skills Training and Development (Partial Care)
- Behavioral Health Assessment by certified paraprofessional for peer support, family support or Community-based Rehabilitative Services
- Behavioral Health Case Management
- Case Consultation
- Case Management - Substance Use Disorder
- Child and Adolescent Needs and Strengths (CANS) Functional Assessment
- Community Crisis Intervention
- Community Transition Support
- Comprehensive Diagnostic Assessment
- Crisis Response
- Drug/Alcohol Testing

- Family Psychoeducation
- Family Psychotherapy
- Family Support by certified Family Support Partner
- Group Counseling - Substance Use Disorder
- Group Psychotherapy
- Health and Behavior Assessment and Intervention
- Individual Assessment - Substance Use
- Individual Counseling - Substance Use Disorder
- Individual Psychotherapy
- Individualized Behavioral Health Treatment Plan
- Intensive Outpatient Program (SUD, MH)
- Language Interpretation Services (sign language or oral interpretation)
- Medication Management
- Neuropsychological Testing
- Peer Support by certified Peer Support Specialist
- Psychiatric Diagnostic Evaluation
- Psychoeducation
- Psychological Testing
- Skills Building/Community-based Rehabilitative Services
- Therapeutic, prophylactic, or diagnostic injection (subcutaneous or intramuscular)

Care Advocacy and High Need Members

Care Advocates

The Optum Idaho Care Advocacy Center (CAC) focuses on activities that impact IBHP Members' stabilization and recovery, and promote active participation in their care. This approach consists of targeted interventions intended to facilitate Member services, identify Members who may be at

risk, and to assist you in the coordination and delivery of care to Members. This approach supports a collaborative relationship between you and the Care Advocate, including Alert Care Advocates and Field Care Coordinators.

The Optum Idaho Care Advocacy Center is open for standard business operations Monday through Friday from 8 a.m. to 6 p.m. MT in the Meridian office location. In addition, Optum offers a Member Access and Crisis Line that is available twenty-four hours a day, seven days a week, including holidays and weekends, to discuss urgent and emergent situations such as potential inpatient admissions, clinical benefit determinations and decisions, or any other questions about the care advocacy process.

Care Advocacy activity may include:

- Emphasizing the integration of medical and behavioral care by promoting communication among all treating Providers involved in Members' care
- Ensuring that Members being discharged from facility-based care have appropriate discharge plans, that they understand them and that they are able to access and afford the recommended services
- Using the information on the Wellness Assessments to identify Members who may be at-risk
- Proactively reaching out to Providers to discuss Members' care when an individual has been identified as being at-risk
- Offering clinical consultations with Optum Idaho medical staff
- Reaching out to Members in some circumstances to educate, evaluate risk, and offer assistance
- Supporting Members to actively participate in treatment and follow-up care
- Referencing web-based and written information for Members and treating clinicians regarding behavioral health conditions, designed to support informed decision- making

Field Care Coordinators

Field Care Coordinators (FCCs) provide additional case consultation for Members with history of hospitalizations, complex treatment issues, and barriers to treatment. They encourage Member engagement in mental health and substance use disorder treatment and consult with Members, Providers, and stakeholders in face to face communication. They also consult on best practices, individualized treatment planning, and recovery and resiliency with our Providers and stakeholders in each Idaho Medicaid Region. FCCs provide presentations to the community on Optum services and initiatives. In addition, they promote recovery and resiliency philosophy among Members and Providers. Finally, they provide follow up after hospitalizations to facilitate linkage to outpatient behavior health services.

Field Care Coordination Program Description and Identification for Referrals: Optum Field

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. As authorized by the Member or Member's legal guardian, coordination of care may include, but is not limited to:

- Assisting Members with accessing appropriate and necessary behavioral health services. When appropriate, assistance may include collaborations with Care Advocates (Care Managers), Providers, primary care physicians, and community agencies and organizations
- Consulting with behavioral health Providers to promote appropriate coordination of care
- Assisting Members with obtaining information needed for their recovery
- Collaborating with health care professionals and natural supports to facilitate effective transition between levels of care, such as from inpatient treatment to outpatient treatment
- Educating and assisting behavioral health Providers and primary care physicians, regarding proper procedures for making appropriate referrals for physical health and behavioral health consultation and treatment
- 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 benefit from the assistance of Field Care Coordination. Among the factors that may contribute to a need for Field Care Coordination are:

- Individuals with a diagnosis of SMI, SPMI or SED who experience complex treatment needs
- Members that have co-morbid conditions that require coordination and management of medical and behavioral Providers by the respective physical health Provider and Optum
- Children and youth served by the IDHW involved with or at risk of being involved with Child Welfare or Juvenile Justice
- Individuals involved with adult corrections and problem-solving courts

Members may also be identified for Field Care Coordination through the following indicators:

- 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

In addition, referrals may come from Optum staff, ALERT staff, Members or their authorized representatives, behavioral health Providers, primary care physicians, stakeholders, or community agencies and organizations. A Field Care Coordinator, typically from the Member's geographical region, is assigned to reach out to Members and /or their Providers, assess their needs and goals, and consult on treatment planning and evidence based practices.

Optum Member Services and Crisis Line

The Optum 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. The Optum Member Services and Crisis Line number **1-855-202-0973** is published and promoted via the Optum website, the Member Handbook, and through Providers. This service 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 applicable law enforcement, emergency room staff, mobile crisis Providers, and community resources as available and clinically indicated. Trained clinical staff work 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 Member Services and Crisis staff generate a comprehensive log on a daily basis describing crisis calls received. This report includes pertinent Member identification information, the nature of the crisis, and the Member's disposition. The log enables the Optum Care Advocate or Field Care Coordinator to contact callers the following day to ascertain their status and determine if further action is needed. This ensures that the caller has received clinical support if they have not already contacted their Provider. When clinically indicated, the Optum Care Advocate will make contact with the Member's Provider.

Providers should speak with their members directly as soon as possible to ensure the Member's crisis has been resolved. Providers' responsiveness to Members whether by phone or in person when there is a crisis should include reviewing and updating the Member's existing crisis plan. The Provider should also assess the Member's ability to implement strategies to prevent a crisis in the future. Providers should arrange follow up professional services and contact the member to ensure no further assistance is needed.

Optum also proactively identifies Members who are at high risk of a crisis or hospitalization. ALERT Care Advocates and Field Care Coordinators reach out to Providers of these Members to coordinate care and develop treatment plans and discuss interventions to minimize the risk of those Members in crisis and seeking crisis services. 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.

Affirmative Incentive Statement

Care Advocacy decision-making is based on the information made available to them at the time of the service request, and only on the appropriateness of care as defined by the **Level of Care Guidelines**, **Psychological and Neuropsychological Testing Guidelines**, the Idaho Behavioral Health Plan, and applicable state and federal laws. The Level of Care and Psychological and Neuropsychological Testing Guidelines are sets of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support Members' recovery, resiliency, and wellbeing. You will find these, along with the **Best Practice Guidelines** at **optumidaho.com** or you can receive a paper copy from Network Management.

Optum expects all treatment provided to Optum Members be outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. Optum does not reward its staff, practitioners or other individuals for issuing denials of coverage or service care. Utilization management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

Eligibility Inquiry

The services a Member receives are subject to the terms and conditions of the IBHP. It is important that you inquire about what services are covered and the Member's enrollment status and obtain required prior authorizations (unless there is a clinical extenuating circumstance that is a barrier to doing so) before providing services. This will help to ensure that you see Members eligible to access this Agreement and the services you provide.

We encourage you to use **Provider Express** "secure Transactions" to conduct eligibility inquiries. This service is only available to Optum-contracted Providers who are registered with *Provider Express*. Select the "First-time User" link in the upper right hand corner of the home page and follow the prompts. You may also inquire about eligibility by calling the Optum Idaho Provider Services phone number **1-855-202-0983**. Be prepared to provide the following information: the Member's name, address, and identification number. In addition, in the event that an authorization is required but is not already in place, Providers may initiate a request for pre-authorization of routine outpatient services online.

In addition to contacting Optum to inquire about eligibility, we encourage you to discuss with the Member the importance of keeping you informed of changes in coverage or eligibility status. Optum will not always have the eligibility information at exactly the same time as the organization that controls the eligibility decisions. The Agreement states that if an individual was not eligible for coverage for services rendered, those services shall not be eligible for payment by Optum. Medicaid Members do not carry any financial burden if services are provided and not covered.

IBHP Outpatient Services

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 the most frequent opportunities for Optum 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 the Chief Medical Officer to reinforce the Optum focus on medical necessity, clinical criteria, evidence-based best practices, and recovery and resiliency.

It is the goal of Optum 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 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. The Optum toll-free Member Access and Crisis Line, Customer Service Line and website (**optumidaho.com**) are also available for those who need additional clarification.

The Optum 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.

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 Idaho has intake policies that facilitate 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 Idaho 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 Idaho will contact the Provider on the Member's behalf and finalize arrangements to help the Member get to the Provider's office or emergency/crisis services

Initial Authorization

At the time of the first appointment, the clinician must complete a comprehensive diagnostic assessment. Authorization is not required to complete the comprehensive diagnostic assessment and any standardized assessments.

In addition to the diagnostic assessment, to guide treatment for children and youth diagnosed with a Serious Emotional Disturbance (SED) and adults recovering from a Severe and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI), the clinician is required to administer a functional assessment tool. The Child and Adolescent Needs and Strengths (CANS) assessment is the functional assessment tool used for children. This instrument will be required after July 1, 2019, but is available for Provider utilization currently, after the Provider's acquisition of certification status to use the tool. Optum does not mandate a specific functional assessment tool for Adults, but one is required to be used.

Providers are expected to administer the Global Appraisal of Individual Need (GAIN-I Core) if the Member is seeking treatment for substance use disorder. When utilized, the results of these assessments must be documented in the medical record:

- For information on the CANS go to: **www.praedfoundation.org**.
- For information on GAIN-I Core go to: **Global Appraisal of Individual Needs**

Before or after the Member's first appointment 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, and 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. However, if the youth is being asked to complete the form themselves, we recommend using the form with youths aged 12 or older.

If the Member refuses or is unable to complete the Optum Wellness Assessment at the time of the initial session, the network Provider is still allowed to submit an Idaho Service Request Form (SRF) to request the Member's needed service(s) if it requires prior authorization. However, the Provider is encouraged to work with the Member to try to complete the Optum Wellness Assessment, as it's strongly preferred as a component of comprehensive care management. In addition, the Treatment Plan should be completed within 10 days of the initial assessment.

Pre-Service Review. A prior authorization review to determine approval of services, in whole or in

part, in advance of the Member obtaining services. The pre-service review process will be conducted in response to a request for care or services in advance of a Member receiving the care or services. Pre-service review may be requested on a non- urgent or urgent (expedited) basis.

Service Request Form (SRF). Benefits that require pre-service review and authorization require that the Provider submit a service request form to Optum prior to provision of the service. Optum has a Provider portal available for submitting SRFs at *Provider Express* or on the Optum Idaho website at: **optumidaho.com**. A pre-service review may be requested on a non-urgent basis or on an expedited basis within 72 hours when required due to the Member's condition.

When continued services are medically necessary, Providers are expected to request additional services in advance of the expiration of the current authorization, with requested dates that do not overlap the existing authorized services. For example, if you have an existing authorization in place for January 1st through March 31st, and you are requesting continued services, the next authorization's requested effective date should be April 1st.

Authorization for additional services must be requested following the same process that was required to request authorization to initiate those services.

Once a request for prior authorization is submitted, Providers may withdraw a request for a variety of administrative reasons, such as the Member is no longer available to participate in the service, the service is no longer necessary, or there is an identified error on the submissions.

Providers may withdraw a request for prior authorization in one of two ways:

1) Electronically through the Service Request Form Portal either on **Provider Express**, or you may access the portal also on **optumidaho.com**. You may withdraw a request up until the time the case status is "Under Review by Optum"

   OR
2) Any time prior to the scheduling of a peer review by calling us at **1-855-202-0983** and pressing "1" to speak to a Care Advocate about canceling a request

Optum will process requests for pre-service authorizations using standard or expedited review processes:

Standard Review. Coverage determinations for non-urgent cases will be made within 14 days, which you're requested service start dates should reflect. Providers will be notified in writing of non-urgent determinations.

Expedited Review. Coverage determinations for urgent/expedited cases will be made within 72 hours of the receipt of a telephonic or written request. Expedited service authorizations are intended for cases where the Provider, attending health care professional, attest that following the standard timeframe could seriously jeopardize the Member's life or health, or ability to attain, maintain or regain maximum function. Providers may request an expedited review by submitting their Service Request via **Provider Express** and then calling Optum Idaho at **1-855-202-0983** and pressing "1" to speak to a Care Advocate about an expedited review. Hours of operation are Monday through Friday, 8 a.m. - 6 p.m. MT.

Retrospective Review. A retrospective review may be requested when extenuating clinical

circumstances prevent the Provider's ability to obtain a required pre-service review and prior authorization, and no claim has yet been filed. When a claim has been filed and Provider seeks reimbursement, please see the Provider dispute process later in this manual. Retrospective reviews are always considered to be non-urgent issues. (See "Retrospective Review Process" below.)

Peer Review. Because Care Advocates may authorize services but may never deny, a clinical review conducted by Peer Reviewer at the doctoral level. The Peer Reviewer conducts the review to determine whether or not a non-coverage determination is warranted.

Peer to Peer Conversation. After receiving an adverse benefit determination, but before an appeal application is completed, Providers may opt to request a Peer-to-Peer conversation to receive details about the determination made. Instructions for scheduling a Peer-to-Peer conversation can be found on the Provider's copy of the Adverse Benefit Determination letter. These conversations may be helpful when deciding, along with the Member, whether an appeal may be indicated. The intent of the Peer-to-Peer conversation is not to reverse the determination, but to clarify the clinical considerations addressed in the review.

Administrative Review. In the event that a request involves a service that may not be a covered benefit, the case is referred to the Clinical Program Manager or designee for an administrative review. The Clinical Program Manager or designee makes all administrative denials based on the benefit coverage outlined in the Member's Certificate of Coverage or Summary Plan Description.

Authorization Requirements Categories

The authorization process for services covered by the IBHP vary depending on the category the requested service falls within. For purposes of authorization, Optum Idaho covered benefits are divided into three categories:

- **No Authorization Required**
  Basic services which require no authorization.

- **Prior Authorization Required**
  Specialized outpatient services, which are authorized to the specific Provider typically for no more than 90 calendar days 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 most services using the Service Request links on Optum Idaho or **Provider Express** in advance of the provision of the service.

- **Threshold Authorizations (No Authorization Required Until Established Threshold is Reached)**
  Select specialized outpatient services that can be performed up to a certain established threshold before a Provider-specific authorization is needed. The units for these services are provided per Member and per calendar year: thresholds will be renewed annually. These services, like all services, should be provided only when medically necessary. When additional services are required, they must be requested in advance of the provision of the services.

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 IDHW.

Required Assessment/Outcome Instruments

The initial evaluation for treatment or comprehensive diagnostic assessment (CDA) is completed by a clinician. No specific instrument is required for the diagnostic assessment; however, the assessment should include:

- Presenting problem
- Behavioral health treatment history, including family history
- Medical history, including family history
- Complete DSM-V diagnosis
- Mental Status Exam
- Risk assessment
- Substance use screening; when a substance use disorder is identified, a GAIN-I Core is completed by an individual certified to use the GAIN who must be under the supervision of an independently licensed clinician
- Assessment of spiritual and culture variables impacting treatment
- For adolescents and children, a developmental history is documented
- When applicable, medication information including prescriptions or refills, medication education and informed consent
- Recommendations

Child and Adolescent Needs and Strengths (CANS)

The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose functional assessment tool developed for children's services to support decision making, including level of care and service planning; to facilitate quality improvement initiatives; and to allow for the monitoring of outcomes of services. The CANS should be administered with youth and family engagement, and results must be reviewed with the youth and family to collaborate in the treatment planning process.

Beginning July 1, 2018, Optum network providers who are Independently Licensed Clinicians (or Masters Level Clinicians working under supervisory protocol) who have received CANS certification may be reimbursed for administering the CANS. Providers seeking to become certified

to administer the CANS can register on the Praed website: **praedfoundation.org**.

The CANS is only reimbursable if administered on the ICANS platform, which is owned and operated by the Division of Behavioral Health. For more information on ICANS, visit: **icans.dhw.idaho.gov**.

If the Member is not going through the Independent Assessor (Liberty Healthcare), the network Provider will administer the initial CANS and the subsequent (90 day) updates to identify adjustments needed to the Member's treatment plan. The CANS may be updated prior to the 90 day minimum in the event that changes in the member's condition warrant an update to the treatment plan. If the Member has a Child and Family Team, clinicians should collaborate with the Person Centered Plan Coordinator to determine who will complete CANS updates and how the updated results and treatment plan will be shared with other members of the child's treatment team. When a CANS update identifies that changes in treatment are necessary, then the member's treatment plan must also be modified. If the child has gone through the Independent Assessment process (See YES System of Care Definitions: Glossary of Terms) the Person Centered Plan must also be modified.

GAIN

When a Member initially presents for substance use disorder treatment or has an initial diagnosis of substance use disorder, the GAIN-I Core is completed by a Provider who is certified to administer the GAIN. If the Provider is not independently licensed, the Provider administering the GAIN must be under the supervision of an independently licensed clinician. If the Provider is independently licensed, the Provider may bill a 90791/90792 and refer to a Provider who is certified to administer the GAIN. As a Category One service, currently no authorization is required. Billing for the GAIN should be done on a Form 1500 using the H0001 code. A maximum of 12 units will be reimbursed for GAIN administration. Members diagnosed with a substance use disorder must have both a Comprehensive Diagnostic Assessment (CDA) and GAIN within the treatment record.

For information on GAIN-I Core go to: **Global Appraisal of Individual Needs**

Wellness Assessment (WA)

The one-page 24 item (25 items for youth) Wellness Assessment (WA) is completed by the Member or guardian at the initial outpatient appointment and returned to Optum via the fax number indicated on the form. The tool may be obtained in both Spanish and English at **Wellness Assessments**. A second WA is completed between session three and five. The Wellness Assessment is further described later in this document.

No Authorization Required

These 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. However, all Out of Network services do require Provider-specific prior authorization. For services that do not require prior authorization, Optum will analyze claims information to identify outlier cases that may benefit from a clinical review.

Mental Health

90791	Comprehensive Diagnostic Assessment (including treatment plan)
90792	Comprehensive Diagnostic Assessment by Prescribing Professional (including treatment plan)
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
90882	Case Consultation
H0030	Crisis Response
H0031	CANS Assessment
H0032	Individualized BH Treatment Plan – Teaming between Clinician and Paraprofessional
H2027	Family Psychoeducation
T2002	Transportation Modifier to be used only with home-based family therapy and individual therapy in the home with the Member present

SERVICE DESCRIPTIONS

Case Consultation

Case Consultation is a scheduled face to face or telephonic meeting between two professionals who are providing direct care services to a member in order to discuss the member's current functioning level, progress in treatment, and adjustments needed to the treatment.

Case Consultation is a service used when providers of treatment interventions consult and share information with other providers in order to improve care and outcomes for a member. As defined for the purpose of reimbursement, Case Consultation is to be conducted between two professionals not in the same agency. These individuals may be treating behavioral health providers or other non-behavioral health professionals involved in the member's life such as medical provider, a teacher or probation officer. In these situations, the Optum Network Provider can be reimbursed for the discussing the clinical attributes of the member's case as necessary. If both parties are network providers from different entities, both parties can be reimbursed for case consultation. Behavioral health clinicians in integrated clinics may bill for consultation time utilized to integrate medical care for the member with the medical professionals within their agency. Case Consultation may be completed without the member or their family member being present.

The professional communication shall occur when the treating professional encounters unusually complex conditions and/or the Member do not progress as expected; and a consult is necessary to obtain additional expertise and adjust treatment.

Case Consultation is a clinical service billed by clinicians allowed to provide psychotherapy services and cannot be claimed by Paraprofessionals. Case managers should continue to use Case Management procedure codes for all case management activities (completed with, or on behalf of the member, either by telephone or in person.)

This service has an expected utilization guideline of 8 hours per member per year for providers. Providers should make a clinical decision and be guided by medical necessity while being aware of the utilization guideline. The provider is not responsible for units used outside of their agency. There is not a hard cap in place to automatically deny claims that exceed the guideline at this time. Optum will analyze claims information to identify outlier cases that may benefit from a clinical review.

Crisis Response

Crisis Response services are telephonic and available 24/7. Crisis Response allows for provider reimbursement when assistance is provided to members who are experiencing a mental health crisis. Crisis Response Services include telephonic contact with the member by skilled crisis response workers. Crisis Response providers must be independently licensed for clinical practice in the State of Idaho or have a Master's degree and be working under supervisory protocol in a group agency.

Beginning April 1, 2019, Providers also must be trained and certified in Non-Violent Crisis Intervention by the Crisis Prevention Institute (CPI) to submit claims for the provision of Crisis Response services. This service provides assessment and crisis de-escalation through counseling, support, active listening, or other telephonic interventions to alleviate the crisis, and offers linkage to services and community providers. If providers do not offer Crisis Response Services they must educate their members about what services are available to support them in crisis such as Optum's 24/7 Crisis Line: (855) 202-0973.

Individualized BH Treatment Plan – Teaming Approach (Skills Building/CBRS)

The teaming approach is the process in which the independently licensed or Master's level clinician under Supervisory Protocol, Skills Building paraprofessional, Member, and family work together to develop an individualized Skills Building/CBRS treatment plan. The purpose of this process is to ensure that the Skills Building paraprofessional is receiving adequate supervision in creating an appropriate treatment plan for the member. This process also allows the supervising clinician to be able to gain a clear, clinical understanding of the case he or she is overseeing.

The paraprofessional must "team" with an independently licensed or Master's level clinician under Supervisory Protocol. This may occur within the same agency and both individuals may bill for teaming.

If a Member is receiving therapy and Skills Building/CBRS at different agencies, the paraprofessional may also "team" with a treating clinician from another agency and both may bill for teaming. Clinical supervision under Supervisory Protocol still applies. Case Consultation may also occur prior to teaming between two clinicians from separate agencies.

Transportation Modifier

When clinically indicated, family or individual therapy may be provided in the Member's home by a licensed clinician when the Member is present.

For those Members being provided family or individual therapy in the home, the Provider may use

the transportation modifier (T2002) to offset the Provider's travel costs with the family and individual billing codes. The Provider is required to document the elements of care and the estimated length of stay for home-based therapy in the Member's clinical chart.

Providers should review the Optum Idaho Professional Reimbursement Schedule for more details related to allowable procedure codes.

Family Psychoeducation

Family Psychoeducation (FPE) is an approach for partnering with Members and families to treat serious mental illnesses and/or serious emotional disturbance. FPE is based on a core set of practice principles as outlined by Substance Abuse and Mental Health Services Administration (SAMHSA) at **samhsa.gov.** These principles form the foundation of the evidence-based practice and guide practitioners in delivering effective FPE services. Family Psychoeducation gives Members and families information about mental illnesses, helps them build social supports, and enhances problem-solving, communication, and coping skills. Since Family Psychoeducation is a unique approach to mental health intervention, specialized sessions (joining sessions and an educational workshop) should be completed before beginning ongoing sessions. These sessions are components of the evidence based protocol as defined in the **SAMHSA Evidence-Based Practice KIT for Family Psychoeducation**.

Optum Idaho covers Family Psychoeducation services for

- Multifamily Group Psychoeducation (2-5 families)
    - Warrants two providers, at least one being an independently licensed clinician or an individual with a master's degree who is able to provide psychotherapy in a group agency under Optum's supervisory protocol. The second may be a minimum of a bachelor's level paraprofessional operating in a group agency under Optum's supervisory protocol.

OR

- Single Family Psychoeducation
    - Requires an independently licensed clinician or an individual with a master's degree who is able to provide psychotherapy in a group agency under Optum's supervisory protocol.

Administrative Operations for Family Psychoeducation

- Submit claims under the covered Member's name regardless of the number of other family or group members participating.
- When more than one family member is a participant in the Idaho Behavioral Health Plan (such as two or three siblings who also are eligible for Medicaid benefits), submit claims for the time spent conducting Family Psychoeducation for one Member only.
- When two professionals facilitate Multifamily groups (2-5 families) submit only one claim

per service facilitator, per family.

- No more than two providers may bill for facilitating a Multiple Family Group Psychoeducation session.

Substance Use

H0001 Individual Assessment and Treatment Plan for Substance Use (including administration of the GAIN)

H0003 Drug/Alcohol Testing

H0004 Individual Drug/Alcohol Counseling

H0005 Group Drug/Alcohol Counseling

Psychological Testing

96101-96103 Psychological Testing
96118-96120 Neuropsychological Testing

Evaluation and Management Services (Prescribing Professionals Only)

99201-99205 Outpatient Office Visit with New Patient
99211-99215 Outpatient Office Visit with Established Patient
90833 Individual Psychotherapy by Prescribing Professional (30 minutes)
90836 Individual Psychotherapy by Prescribing Professional (45 minutes)
96372 Therapeutic, prophylactic, or diagnostic injection

Telehealth

T1014-GT Telehealth Transmission
Q3014-GT Telehealth Originating Site Facility Fee

Language Services

T1013 Language Interpretation Services (sign language or oral interpretation)

Health and Behavioral Assessment and Intervention (HBAI)

96150 Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment

96151 Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment

96152-96154 Health and behavior intervention, each 15 minutes, face-to-face

More Information about Services That Do Not Require a Prior Authorization:
An Optum Idaho network Provider can initiate these above listed services to a Member of the Idaho Behavioral Health Plan without contacting Optum Idaho. After the network Provider provides any of these outpatient services to a Member of the Idaho Behavioral Health Plan, the Provider

must submit the claim to Optum Idaho and the claim is paid after verification through the claims system of the Member's plan enrollment on 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 also expected to submit the Member's Optum Wellness Assessment and administer the GAIN-I Core for those Members receiving SUD treatment, and document the scores in the medical record.

All services provided to IBHP Members (whether a prior authorization is required or not) must be medically necessary.

Health and Behavioral Assessment and Intervention (HBAI):
Full service ambulatory clinics who provide medical services can receive reimbursement for the Health and Behavior Assessment and Intervention (HBAI) Codes. These allow integrated medical clinics to provide brief behavioral interventions to Idaho Medicaid members.

These interventions to not require a Comprehensive Diagnostic Assessment (CDA) or a full treatment plan. However, the interventions are to be documented in the Member's medical record and must be billed with a primary medical diagnosis. The services must be provided by a qualified licensed behavioral health clinician and can provide up to 15 hours (60 units for all codes combined) per calendar year, with a maximum of 4 units per visit.

Interested clinics should contact their Regional Network Manager to learn more about the criteria and how to amend their contract to receive a separate fee schedule that includes these codes.

Prior Authorization Required

H2014	Skills Training and Development, per 15 minutes (Partial Care)
H2015	Community Transition Support Services are under the direction of an independently licensed clinician and provided by an independently licensed clinician, service professional and /or a qualified Peer Support Specialist. As recommended by an Optum Idaho Network Provider, Optum Idaho Discharge Coordinator or Field Care Coordinator.
H2017	Skills Building/Community Based Rehabilitation Services
H0015	Intensive Outpatient - Alcohol and/or Drug Services per diem for IOP Programs that have been specifically credentialed and contracted by Optum.
S9480	Intensive Outpatient - Psychiatric Services, per diem for IOP Programs that have been specifically credentialed and contracted by Optum

SERVICE DESCRIPTIONS

Skills Training and Development (Partial Care)

Skills Training and Development (Partial Care) is treatment for adult Members with Serious and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI), whose functioning is sufficiently disrupted to the extent that it interferes with their productive involvement in daily living.

Skills Training and Development (Partial Care) is a structured ambulatory program of therapeutic interventions offering less than 24-hour daily group-based care delivered by a licensed, qualified professional. These interventions assist Members with stabilizing their behavior and conduct, and preventing relapse or hospitalization through the application of principles of behavior modification for behavior change and structured goal-oriented group socialization for skill acquisition.

Partial care services should:

- Be provided in a structured environment within the MHC setting;
- Be a needed service as indicated through the comprehensive assessment;
- Be identified on the individualized treatment plan; and
- Provide interventions for relieving symptoms and acquiring specific skills

Skills Building/Community Based Rehabilitation Services

Skills Building/CBRS is a home or community- based service that utilizes psychiatric rehabilitation interventions designed to build and reinforce functional skills. Skills Building/CBRS modules and interventions vary in intensity, frequency, and duration in order to support member's ability to manage functional deficits independently. This service is available to children and youth diagnosed with a Serious Emotional Disturbance (SED) and adults recovering from a Severe and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI). Skills Building/CBRS is driven by an individualized Skills Building treatment plan based on a Member's specific needs and strengths identified from a comprehensive diagnostic and functional assessment.

Prior to the provision of Skills Building/CBRS, Optum Idaho requires that a Skills Building/CBRS treatment plan be developed utilizing the teaming approach where the clinician, Skills Building paraprofessional, Member, and family work together to develop their individualized Skills Building plan using the CDA and results of the applied Functional Assessment tool. The Skills Building/CBRS treatment plan must be developed and or updated prior to submitting an Optum Service Request Form. The treatment planning process does not require prior authorization.

Providers are required to utilize an appropriate functional assessment tool to identify the Member specific functional need(s) to be addressed with Skills building/CBRS. The provision of Skills Building/CBRS is premised upon the results of a functional assessment that scores a member's needs in various domains. Providers will use the functional assessment tool results/measurements to develop the skills building treatment plan in order to demonstrate treatment progress or to substantiate the need to modify treatment plans.

Skills building/CBRS treatment plans should include attainable, measurable objectives aimed at assisting the Member in achieving his/her goals related to the specific functional need. Goals for Skills Building/CBRS focus on resolution of functional impairments which will be reflected as functional assessment scores improve. When functional assessment scores do not improve, the interventions should be assessed and changes to treatment considered.

Optum encourages providers to utilize psychiatric rehabilitative interventions based on fundamental principles of skills development in a Member's natural location. Using the teaming approach, Skills Building treatment plans should be reviewed and updated as necessary to reflect changes in the Member's condition, functional needs, goals, progress, preferences, and or change in skill related goal, but this must occur at least every 90 days. Please review the Level of Care Guidelines for additional information.

When requesting a prior authorization, providers should complete the service request form with information that demonstrates the member's current condition and how the member meets the medical necessity criteria established by the Level of Care Guidelines. Providers should use the service specific Skills Building/CBRS service Level of Care Guideline to guide their practice. Providers should also use the Optum Idaho Common Clinical Best Practices, Common Admission Criteria, Continued Service Criteria and Common Discharge Criteria for all levels of care.

Skills Building/CBRS services that are not prior authorized are not covered unless there is an extenuating member-related clinical circumstance, such as recent discharge from an inpatient stay or incarceration. Optum will work with providers to assure that such members are able to receive medically necessary services in a timely manner. Please refer to this **quick reference guide** for additional information.

Intensive Outpatient Programs

Intensive outpatient services are organized activities which may be delivered in any appropriate community setting that meets State certification and Optum credentialing criteria.

Intensive Outpatient Programs (IOP) are structured programs available to adults and adolescents who are recovering from mental health (MH) and/or substance use disorders (SUDs), experiencing moderate behavioral health symptoms that can be addressed and managed in a level of care that is less intensive than partial hospitalization but that require a higher level of care than outpatient services. The program may function as a step-down program from psychiatric hospitalization, partial hospitalization, or residential treatment. It may also be used to prevent or minimize the need for a more intensive level of treatment. IOP is appropriate for Members who live in the community without the restrictions of a 24-hour supervised treatment setting during non-program hours.

IOP Program Type. The type of IOP is dependent upon the Member's primary diagnosis. The clinical emphasis in IOP may be directed at MH considerations, and/or substance SUDs. In the presence of both MH and SUDs concerns, the acute aspects of SUDs treatment should be primary as the initial course for treatment. Programs for adolescents are separately offered from programs for adults.

Prior Authorization and Clinical Review. IOP Providers must submit a written request via the

portal to Optum Idaho for a prior authorization. This request will contain current clinical information regarding the Member and the Member's condition, progress, and goals. In this clinical review, the Optum Care Advocate (CA) will consider if IOP is appropriate for the Member's condition or if he/she should be treated at an alternate level of care. If the request is found to be appropriate based on the clinical information provided and Optum's Level of Care Guidelines (including admission criteria and continued stay criteria), the Optum CA will authorize IOP services for up to 56 calendar days. Should IOP be required beyond 56 days, Providers are to submit a continuing service request to Optum Idaho for clinical review at least 14 days prior to the authorization's expiration. The CA will determine if the IOP level remains appropriate for continued care.

IOP Programming Requirements. IOP occurs at a minimum of three (3) days per week, maintaining at least nine (9) hours of service for adults and at least six (6) hours of service for adolescents. Services are expected to be maintained at this level throughout the Member's participation in the program. However, Providers may request and Optum may authorize services at a less intense level, for less hours per week as the Member moves toward discharge until the Member can be safely and appropriately transitioned back into the community.

IOP consists of a scheduled series of sessions appropriate to the treatment plan of the Member served. The program includes but is not limited to:

- Biopsychosocial assessment addressing member strengths and functional deficits to be addressed in IOP. The assessment must be completed and signed by a licensed professional.
- When appropriate, the Provider must submit a Wellness Assessment and also administer a GAIN-I Core and document the scores in the medical record.
- Treatment planning interventions to enhance motivation and support member's recovery, resiliency, and well-being. Plan must include duration and frequency of treatment and must be reassessed and updated frequently, as Member's condition improves, worsens, or Member does not respond.
- Individual, group, family psychotherapy and education focused on recovery
- Evidence-informed practices, such as group therapy, cognitive behavioral therapy (CBT), motivational interviewing, and multidimensional family therapy
- Psychiatric evaluations and medication management.
- Case coordination. The IOP assumes responsibility for coordinating closely with the member's Providers
- Substance use screening and monitoring
- Transition management and discharge planning. This begins at intake and must be developed with the Member to identify when this level of care is no longer appropriate.
- 24-hour crisis coverage

Initial and ongoing risk assessments are required to be administered and documented throughout the course of treatment.

A physical exam should take place within the first week of treatment to address the Member's whole health and ensure this level of care is appropriate.

Per Diem Rate. With the exception of the psychiatric Provider services and medication management, all services are included in the per diem rate and should be addressed for the member by the IOP provider:

- When a member is admitted to IOP it is not appropriate for other behavioral health providers to provide services to the member, except for psychiatric Provider services or medication management.

IOP services may be provided during evenings and on weekends and/or interventions delivered by a variety of professionals working within a member centered and coordinated treatment plan. Because IOP programs have such a different approach and intensity, they are not typically designed to be used for extended duration; instead they rely on an integrated approach with multiple features of high frequency contact to increase functioning, monitor and maintain stability, and support recovery.

Treatment Plan. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must also be completed and signed by a licensed network provider within 72 hours of initiating IOP. This member centered plan should be developed in collaboration with the Member. All participating clinicians working within the member's treatment plan should have integrated therapy goals that are coordinated across modalities. The treatment plan is to be reviewed and updated in collaboration with the Member, as needed. Discharge criteria and planning for aftercare options must begin upon admission and are included in the treatment plan. The Member's transition out of IOP services should be clinically smooth and safe. Providers must assist the Member in his/her transition to other services as needed.

Educating Members. Providers should inform and educate Members, and their families, receiving IOP services about their diagnosis, signs and symptoms of the treatment problem, risk of non-participation, and treatment options. Available community resources and appropriate aftercare services should also be a part of this information exchange. In this way, Members can build on their strengths and abilities to acquire and improve skills needed to reach their individual goals and aspirations.

Coordination of the Member's Care. The IOP Provider is responsible for coordination of care with the Member's primary care provider (PCP) and other behavioral health providers. This collaboration is an integral part of the IOP service and is vital for improved Member outcomes.

Threshold Authorizations

No prior authorization is needed up to a pre-determined threshold for these services. After this threshold is met, a Provider-specific prior authorization is needed.

Like other services, this category of 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 and are indicated as medically necessary. The claim will be paid based on verification of Member eligibility and Provider contract status with reference to the thresholds noted below:

90837-90838 Extended Office Visits – Threshold is 12 units per Member per calendar year, additional services must be prior authorized via Optum Idaho or *Provider Express*.

H2011 Community Crisis Intervention (at the earliest opportunity) – Provision of crisis services do not require prior authorization. A threshold is 40 units per Member per calendar year. When this threshold is met, additional services must be requested after the crisis event, by submitting a Crisis Service Request Form via Optum Idaho optumidaho.com or **Provider Express**:

- Crisis services should be used at the time of the crisis

Authorization for crisis services is completed on a retrospective basis (after the crisis):

T1017 BH Case Management - Threshold is 240 units (60 hours) per Member, per calendar year. Additional services must be prior authorized by submitting a Case Management service request form in advance of the provision of services via Optum Idaho or *Provider Express*.

H0006 Case Management - Substance Use Disorder - Threshold is 240 units (60 hours) per Member, per calendar year. Additional services must be prior authorized in advance of the provision of services via Optum Idaho or Provider Express.

H0023 Telephonic Case Management (either BH or Substance Use Disorder) – Threshold is included with Case Management units.

H0031 HN BH Assessment, by a qualified para/professional with a cumulative threshold of 10 units that is available per Member, per calendar year; If additional BH Assessment Services are necessary, they must be prior authorized and Providers should contact Optum and speak to a Lead Care Advocate at **1-855-202-0983** and press “1”.

Optum expects that paraprofessionals are appropriately supervised by a qualified clinician in this activity. For further information, please review the Supervisory Protocol in your Optum Network Agreement.

Peer Services

H0038 Peer Support by a qualified Peer Support Specialist – Threshold is 416 units per Member, per calendar year. This service is provided to Members 18 years and older. Additional services must be prior authorized via Optum Idaho or *Provider Express*.

H0046 Family Support Services by a qualified Family Support Partner **-** Threshold is 208 units per calendar year. This service is provided to Members under 18 years of age and their families. Additional services must be prior authorized via Optum Idaho or *Provider Express*.

SERVICE DESCRIPTIONS

Community Crisis Intervention

Crisis interventions may be necessary as they address member situations involving mental health crisis (see Glossary: "Crisis") in trajectories that include intense feelings of personal distress (e.g. anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (i.e. neglect of personal hygiene, unusual behavior) or catastrophic life events (e.g. disruptions in personal relationships, support systems or living arrangement loss of autonomy or parental rights; victimization or natural disasters).

Upon contact with any provider, Members who appear in crisis or who request crisis services should be assessed for psychiatric risk. Member's assessed as having an imminent risk should receive or be linked to appropriate care based on their presentation of risk. In some cases, Community Crisis Intervention may not be the appropriate level of care.

Provider Qualifications:
Optum network providers will assure that any staff members providing Community Crisis Intervention are appropriately supported, supervised, trained and qualified to provide the service. Providers of Community Crisis Intervention will apply best practices when serving members in crisis. Optum supports the application of the SAMHSA Practice Guidelines called "Core Elements in Responding to Mental Health Crisis" for all crisis services.
Community Crisis Intervention does not include provisions for provider transportation of members who are deemed to be in crisis.

Community Crisis Intervention providers are required to provide services that are:

- Offered in a timely way
- Provided in the least restrictive manner
- Provided with adequate time spent with the member
- Creating Strengths Based Plans.
- Considering the member's overall plan of care
- Provided by individuals with appropriate training and who demonstrate competence to evaluate and effectively intervene with the problems being presented
- Directed at clarifying and supporting a member's self-identified crisis
- Provided by staff having a comprehensive understanding of the member's crisis
- Helping individuals having a crisis experience regain a sense of control as a priority
- Congruent with culture, gender, race, age orientation, literacy and communication needs of the member.

- Addressing the member’s rights
- Trauma informed
- Addressing a recurring crisis through an appropriate follow-up plan and referral for clinical services.

Peer Services

Peer Support Specialists use their lived recovery experience from a mental health diagnosis and specific specialist training to assist adult Members with defining their goals for recovery and develop a recovery plan. They also assist Members with developing the skills for proactive role in their own treatment plan and to help Members connect with other Members and with their self-defined community

Peer Support Specialist in collaboration with the member will complete an initial needs assessment that includes:

- An inventory of the member’s self-identified strengths and other resilience factors such as the member’s support network;
- An inquiry as to whether the member has a personal wellness plan, an advance directive, and/or a plan for managing relapse;
- An inventory of the member’s behavioral health, medical and community support services;
- An inventory of what the member identifies as the barriers and risk factors which have undermined the member’s participation in clinical and community support services, or have otherwise prevented the member from achieving his/her broader recovery goals;
- An inquiry about the member’s need or desire to better understand of his/her condition, its treatment, and the role that community support services can play in the member’s recovery.

The Peer Support Specialist in collaboration with the member and any other individuals selected by the member will create an individualized recovery plan that reflects the member’s needs and preferences, and describes the member’s individualized goals, interventions, timeframes and measurable results.

At a minimum, the Certified Peer Specialist will collaborate with the member to formally review the recovery plan every three (3) months. However, revisions to the recovery plan will be made whenever there are significant changes in the member’s condition, needs, or preferences.

Optum expects that paraprofessionals are appropriately supervised by a qualified clinician in this activity. For further information, please review the Supervisory Protocol in your Optum Network Agreement.

Family Support

Family Support Specialists use their lived experience as a caregiver to a child with a mental health diagnosis to assist an entire family in their own recovery. They also assist the entire Family unit with developing the skills for advocacy and the belief that recovery is possible. They assist families to identify and navigate service systems on behalf of their loved one in need of services and to develop a family recovery plan.

Certified Family Support Partner (CFSP) in collaboration with the member will complete an initial needs assessment. As part of the assessment, the CFSP provides the member's family with information about Family Support Services, and verifies that the member's family wants these services. In the event that the member's family declines services, the CFSP provides information about obtaining services should the family's needs change.

The CFSP, in conjunction with the member's family, develops a recovery plan within 15 days of the evaluation that addresses the following:

- The member's recovery and resiliency goals;
- The member and family's strengths;
- The member and family's educational needs;
- The member and family's self-care needs and resources;
- Problems;
- Specific and measurable goals for each problem;
- Interventions that will support the member's family and member in meeting the goals

Optum expects that paraprofessionals are appropriately supervised by a qualified clinician in this activity. For further information, please review the Supervisory Protocol in your Optum Network Agreement.

Clinical Outcomes Model: ALERT

Optum is committed to partnering with our network to achieve optimal therapeutic outcomes for the individuals we mutually serve. This approach focuses on assisting the network to make consumer-directed, outcomes-based, cost-effective and clinically necessary treatment decisions. With that goal in mind, we have developed the ALERT model, which includes an authorization or notification process, when required. By effectively identifying outliers[1] and guiding interventions, the ALERT® Outpatient Management program helps control direct and indirect outpatient costs while ensuring optimal clinical outcomes.

[1] "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>.**

ALERT stands for Algorithms for Effective Reporting and Treatment. The outlier management system uses Member responses to a validated tool, the one-page Wellness Assessment (WA), along with claims data. Both WA and claims information are analyzed through a set of algorithms to determine a Member's behavioral health status and potential risks. In addition, the algorithms identify cases that may benefit from a review. Such reviews may include consideration of **Best Practice Guidelines** or **Level of Care Guidelines**. The ALERT algorithms offer opportunities for earlier intervention on potential treatment complications. Care Advocacy will use a combination of letters and/or calls to inform you about any targeted risk or the requirement to complete a review. This allows us to work together more efficiently focusing on those Members with the greatest potential for benefit from such collaboration.

The Wellness Assessment is completed at multiple points rather than at a single point in treatment. This offers more immediate feedback on changes in health status and functioning which may inform further treatment planning, including level of care changes or coordination with medical professionals.

Psychiatrists and prescribing nurses are not required to submit Wellness Assessments, unless they want to participate in the **Achievements in Excellence (ACE) - Clinicians** outcomes recognition program. Please note that claims-based ALERT algorithms do apply to prescribing clinicians and may require Care Advocacy reviews, as noted above.

Interpretive Services

Federal law and Idaho Medicaid regulations require Medicaid providers to make reasonable modifications in their practices or clinics to ensure participants, who have limited ability to read, speak, write or understand English have full access to Medicaid services. This limitation is referred to as Limited English Proficiency (LEP).

LEP individuals are entitled to language assistance to help facilitate the delivery of Medicaid services. Medicaid providers may utilize methods such as interpretation, translation, or Braille to meet the requirement for effective communication. However, these services must be free of charge to Medicaid participants.

When an Optum Network provider is unable to communicate with a participant due to deafness, hearing impairment, vision impairment or LEP, Optum Idaho will provide reimbursement for the provision of the interpretation, translation, Braille or sign language services.

The language services may be provided in person or via telehealth. It is the responsibility of the provider or its agency to hire or contract with a qualified interpreter or translator to facilitate communication with a participant when they are providing an Optum Idaho reimbursed service. If interpretive services are provided through the use of telehealth, the interpretive services must be delivered in accordance with the Optum Idaho Telehealth Policy.

If the participant is under the age of 18 years, and either the child or the parent/guardian is deaf, hearing or vision impaired, or a person with LEP, then interpretation and/or translation services must be provided to facilitate the care of the participant receiving the Optum Idaho reimbursed service.

Reimbursement for interpretation, translation, or sign language services is not available for:

- Administrative services such as:
    - Scheduling appointments
    - Making reminder calls
    - Canceling appointments
    - Travel time for the interpreter
    - No show appointments

- Assisting participants to understand information not related to the Optum Idaho reimbursed service

- Interpretation services provided by an immediate family member (e.g. parent, spouse, sibling, child)

- Interpretation or translation services provided by any individual not meeting the definition of a qualified interpreter/translator. (Note: The provider delivering the Optum Idaho reimbursed service must ensure that the individual is qualified to communicate directly with the participant).

- Interpretive or translation services when the provider of the Optum Idaho reimbursed service is able to communicate effectively, orally or in writing, with the participant.

- Teaching sign language

- Services not reimbursed by Optum Idaho (e.g. claim is denied)

Documentation

Providers must generate documentation at the time of service sufficient to support the claim for reimbursement of interpretive, translation, or sign language services. Sufficient documentation must include the following elements:

- Name of the participant
- Participant's Medicaid ID#
- If the participant is a child, name and relationship of the family member being interpreted for must be documented.
- Name, title, and signature of the provider of the IBHP service
- Description of the Optum Idaho reimbursed service and the translation service being provided (e.g. documentation translation, interpreting for nurse/physician)
- Name, signature, and title (if applicable) of the individual providing interpretive or translation services
- Date, time, and duration of the interpretive or translation services

General Information

Medicaid providers must not require a participant to provide his or her own interpreter or

translation services and must not rely on adult or child accompanying an individual who is deaf, hard of hearing, or a person with LEP to interpret or to facilitate communication.
Exception to this:

- Emergency situation involving an imminent threat to the safety and welfare of an individual or the public
- Participants specifically request that an accompanying adult family member or friend interpret for them

Both "exceptions" must be determined to be appropriate by the medical provider (e.g. appropriate for the procedure/service being rendered)

Translation services may be provided via telehealth when the method of communication does not jeopardize the care of the client and when services are delivered in accordance with the Optum Idaho Telehealth policy.

Telemental Health

Optum Idaho covers the delivery of the following behavioral health services by a doctoral level or, independently licensed clinician via a secure two-way, real time interactive Telemental Health (TMH) system with both an audio and video component:

- Assessment and diagnosis
- Individual or family psychotherapy; and
- Medication management

The Clinician will determine if Telemental Health is the appropriate modality for the patient at the time of service.

Requirements for Optum Idaho providers using Telemental Health to provide services:

- Independently licensed master's or doctoral level provider
- Prior to delivering Telemental Health services, has signed Optum's Telemental Health Attestation, which is located on Provider Express, and received a confirmed validation back from Optum
- Abides by Optum's Telemental Health Checklist Protocol and the American Telemedicine Association's Practice Guidelines for Video-Based Online Mental Health Services, both of which are located on Provider Express
- Uses the current Optum Idaho fee schedule to determine which Telemental Health services are covered by Optum.

Optum Idaho does not cover the following services:

- Behavioral Health services provided via telehealth in a group setting, e.g. group psychotherapy and/or to members at different locations
- Telephone-based services including telephone counseling, email, texting, chat rooms, voicemail, or facsimile
- Remote medical monitoring devices
- Virtual reality devices
- Technologies that do not comply with HIPAA and other applicable privacy and security requirements (e.g., Skype)
- Store-and-forward transmissions of case information
- Psychotherapy co-led by providers or participants at different sites provided via telehealth

Wellness Assessments (WA)

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 WA includes a range of questions to measure symptom severity and overall well-being, and screens for functional impairment, substance use disorder and medical co-morbidity risks. The following process is for IBHP Members who are receiving routine behavioral health outpatient services:

- You provide the one-page WA to each new IBHP Member, or to the parent/guardian of a child or adolescent patient
- You promptly return each completed WA to Optum as instructed on the form
- A second WA is administered between session three and five. Optum reviews the WA and alerts you if a targeted risk is identified. You will either be notified by letter, or contacted by a Care Advocate to discuss the case and/or assist in coordinating additional services
- A follow-up WA will also be sent by Optum directly to the Member approximately four months after the initial evaluation

The information contained in the Wellness Assessment (WA) is confidential and will not be shared without the Member's consent. A Member may also decline to participate in ALERT. If this occurs, submit a WA to Optum by completing the clinician and Member demographic

sections and filling in the "MRef" (Member Refusal) bubble located in the top demographic section of the WA. In the case of Members who are minors (except for those who are emancipated or able to consent to their own treatment under the laws of your state), the parent or guardian should be asked to complete the form.

The two versions of the Wellness Assessment, Adult and Youth, are also available in Spanish. WA forms can be obtained from **Provider Express** or by calling the Forms Hotline at **1-800-888-2998 ext. 5759**. You may go to *Provider Express* for detailed information about **Wellness Assessments**.

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:
    1. Care provision is determined to be evidence-based and recovery based.
    2. 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.
    3. Care provision is not evidence-based and Provider unwilling to modify treatment plan. Peer Review may be 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.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for Outpatient Behavioral Health Services for Children

If a child has a need for outpatient behavioral health services not covered by the State Plan, the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit can be requested for prior

authorization and approval.
EPSDT prior authorization requests may be ordered by the child's primary care physician for outpatient BH services deemed medically necessary that are not available in the Idaho Behavior Health Plan. The EPSDT Authorization Form that can be found on *optumidaho.com* website is used for this purpose. The primary care physician makes the referral for the specific outpatient behavioral health service needed by the child and the parent/guardian must consent by completing and signing the form. The service Provider and the primary care Provider must also complete and sign their sections of the form. Also, information must be included on the form and as attachments as necessary through relevant documentation to substantiate how the requested outpatient behavioral health services will:

- Maintain, correct, or improve the child's condition, and
- Demonstrate that the service requested is safe, and effective, and
- The service requested meets acceptable standards of medical practice

A request for EPSDT benefits must be accompanied by information that substantiates the child's need for the services as indicated in the bullets above, but also that serve to identify the specific goals that will be achieved if the services are approved should be identified.
Additionally, the amount and duration of the service needed should be included. Finally, the identification of specific treatment goals and objectives that cannot be met if the requested service is not authorized should also be clearly identified.

Optum will require all necessary documents are received to complete a review of the request, and upon receipt, an Optum clinical staff will review the information and request received. This process frequently entails contact with the Providers as well as parent/guardian and can take up to 2 weeks dependent on Optum' s receipt of all the information necessary. A decision will be made on the case and there are two outcomes, an authorization or a denial. Optum will work with the Provider and parent/guardian related to their receipt of an authorization and this will be documented by the receipt of a letter detailing the authorization. If the determination is a denial of the service request, the Provider, and the parent/guardian will receive an Adverse Benefit Determination (ABD) denying the services and providing the Member's right to appeal the EPSDT decision.

Return the Optum EPSDT Prior Authorization Form at:

Email: **optumidaho_epsdt@optum.com**

Fax: **1-855-844-7042**

If you have questions about EPSDT you may contact us at **1-855-202-0983**.

The State Plan benefits that are included in the Idaho Behavioral Health Plan (which Optum administers for IDHW) do not have hard limits. For this reason, service authorization requests are submitted that include that scope amount and duration of the benefit and the requested services are reviewed to determine they the meet the EPSDT Medical Necessity requirements. A secondary and additional request called "EPSDT" would be duplicative:

- The review of the child's need for a benefit service being requested incorporates the

requirements of the EPSDT regulations. EPSDT requirements are addressed in all of the reviews of medical necessity completed for children under the age of 21

Optum only reviews requests for outpatient behavioral health services. If you have an EPSDT request for another type of service you will need to submit your request to Medicaid Directly using their EPSDT Request Form. Please visit the IDHW website and search for EPSDT Form or contact Medicaid directly.

If you would like additional information about the Federal Requirements related to EPSDT you may find that on the **Medicaid.gov website**.

Practice Management

Practice Management, a clinical team, in coordination with other Optum Departments, works with network Providers on the following key elements:

- Managing outliers, through the identification of practice patterns that appear to fall outside typical patterns, including the measurement of improvement over time
- Identifying and resolving potential practice patterns that may constitute Fraud, Waste and/or Abuse (see Fraud, Waste and Abuse section)
- Evaluating compliance with Care Advocacy processes and contractual obligations

Practice Management employs intervention strategies to address practice patterns. Interventions may include, but are not limited to, a direct conversation with the Provider, education, peer-to-peer reviews, and site and/or treatment record audits.

Potential results of a Practice Management intervention may include ongoing monitoring, Corrective Action Plans, non-coverage (adverse) benefit determinations, referrals to Peer Review, Credentialing Committee or Program and Network Integrity (PNI).

For additional information please see the sections on “Anti-Fraud, Waste, and Abuse” and the “Treatment Record Documentation Requirements” in this manual.

MH/SUD Medication Management Services

Psychiatrists and prescribing APRNs (including Nurse Practitioners and/or Psychiatric Nurse Practitioners) are not required to obtain prior authorization for the initial consult, routine medication management sessions and other routine outpatient services, such as the 90791, 90792, 90833, 90834 and evaluation and management codes as applicable.

Pharmacy Benefits

Pharmacy benefits are not managed by the IBHP. For information about formularies, pharmacy benefits and cost management programs, please contact the Idaho Medicaid office at **1-888-528-5861**.

Retrospective Review Process

A retrospective review may be requested when extenuating clinical circumstances (e.g., Member eligibility, coordination of benefits) prevent the Provider's ability to obtain a required pre-service review and prior authorization, and a claim has not been filed. Retrospective review requests must be submitted within 365 calendar days following the date(s) of service. For all retrospective reviews, Optum will issue a determination within 30 calendar days of receipt of the request.

The Retrospective Review request process must be initiated in writing by contacting Optum at the address listed below and must include the following information:

- Member identifying information:
  - Name
  - Identification number
  - Date of birth
  - Address
- Service type
- Dates and units of service requested retrospectively
- Your identifying information:
  - Name
  - Tax identification number
  - Contact information
- Any additional information you would like to have considered as part of the retrospective review, including records relating to the current conditions of treatment, co-existent conditions, or any other relevant clinical information which may justify the medical necessity of the service requested per the Optum Level of Care Guidelines
- Your explanation as to why a prior authorization was not requested in advance of the provision of the service

Where to submit a Retrospective Review:

Mail: Optum Idaho
Attention: Retrospective Review
205 East Watertower Street
Meridian, ID 83642

Fax: **1-888-950-1182**

Email: **optum.idaho.provider.dispute@optum.com**

For questions or assistance, call **1-855-202-0983** and press prompt 4.

A clinical review process will be initiated upon receipt of all information necessary to process a timely filed retrospective review request and will result in a determination that is noticed to the Provider. The Provider's right to dispute this determination then applies.

Psychological Testing

Psychological testing is considered after a standard evaluation (CPT code 90791 or 90792 including clinical interview, direct observation and collateral input, as indicated) has been completed and one of the following circumstances exists:

- There are significant diagnostic questions remaining that can only be clarified through testing
- There are questions about the appropriate treatment course for a patient, or a patient has not responded to standard treatment with no clear explanation, and testing would have a timely effect on the treatment plan
- There is reason to suspect, based on the initial assessment, the presence of cognitive, intellectual and/or neurological deficits or impairment that may affect functioning or interfere with the patient's ability to participate in or benefit from treatment, and testing will verify the presence or absence of such deficits or dysfunction.

This service does not require prior authorization and may be subject to retrospective review to address outliers in utilization. Generally, psychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered.

Access to Outpatient MH/SUD

As part of our Quality Improvement Program, and to ensure that all Members have access to appropriate treatment as needed, we develop, maintain, and monitor a network with adequate numbers and types of clinicians and outpatient programs. We require that the network adhere to specific access standards, which are outlined as follows:

- Respond within 24 hours to a Member request for routine outpatient care
- An initial MH/SUD appointment must be offered within 10 business days of the request
- Urgent appointments must be offered within required timeframes (MH/SUD - 48 hours,
- Non-life-threatening emergencies must be offered within six hours
- An immediate appointment must be offered for any life-threatening emergencies

- An MH/SUD outpatient appointment must be offered within 7 days of an acute inpatient discharge

Optum expects that Members will generally have no more than a 15 minute wait time for their appointment in your office. In addition, any rescheduling of an appointment must occur in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with good professional practice. In cases where a Member is being discharged from acute inpatient care, Optum expects a follow-up outpatient appointment to occur within seven (7) days from the discharge date. This appointment should be included in the facility discharge plan.

If you are unable to take a referral, immediately direct the Member to contact Optum Idaho at **1-855-202-0973** so that he or she can obtain a new referral.

Continuation of Services after Termination

Network Clinicians, Group Practices and Agencies who withdraw from the Optum Idaho network are required to notify us, in writing in accordance with your Agreement, 90 calendar days prior to the effective date of termination, unless otherwise stated in your Agreement or required by state law. With the exception of terminations due to quality-related issues, suspected fraud, waste or abuse, change in license status or change in ability to participate in federal programs, clinicians are obligated to continue to provide treatment for all Members under their care. The timeline for continued treatment is up to 90 calendar days from the effective date of the contract termination, or as outlined in your Agreement or until one of the following conditions is met, whichever is shortest:

- The Member is transitioned to another Optum network clinician
- The current episode of care has been completed
- The Member's Optum benefit is no longer active

To ensure continuity of care, Optum will notify Members affected by the termination of a clinician, group practice or agency at least 30 calendar days prior to the effective date of the termination whenever feasible. Optum will assist these Members in selecting a new clinician, group or agency. You are also expected to clearly inform Members of your impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date, in compliance with your Agreement.

Utilization Management 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 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 national standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs). The IBHP criteria and guidelines are applied to all utilization management decisions. 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, updated at least annually and are available to any interested party such as Providers and Members in writing at their request. The Member Handbook provides a simplified version of all Guidelines used by Optum and the Provider network. These guidelines are reviewed annually through the QAPI Committee structure.

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 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. Effectiveness is measured by the improvement in treatment and the risk of the Member's condition likely deteriorating if treatment 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. Specific measures of effectiveness and progress should be documented in the Member's chart and upon any submission of a pre-service request.

- **Care Should be Accessible:** Ideal clinical outcomes result when access to the most appropriate and available level of care is facilitated upon admission to care 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 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 conditio**n.**

Treatment planning should take into account significant variables such as the Member's current clinical need, age and level of development, functional needs, and identified strengths. It should also include whether the proposed services are covered in the Member's benefit plan and if the proposed forms of treatment are appropriate. The frequency and duration of treatment should be evidence- based and available in or near the Member's community. Community resources such as self-help and peer support groups, consumer-run services, and preventive health programs, can also augment treatment.

A change in a Member's condition should prompt an updated treatment plan and selection of the appropriate level of care. When a Member's condition has improved, the reassessment should determine if a lower level of care may safely and adequately treat the Member's current condition, or if the Member no longer requires treatment. When a Member's condition has not improved or it has worsened, the reassessment should determine the accuracy of the diagnosis. The reassessment may also address whether the treatment plan should be modified or the Member's condition should be treated in another level of care. 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 of medical necessity.

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 at least annually.

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. The utilization management process also ensures 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 some 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, such as psychotherapy. This enables the Provider and the Member to use the treatment modalities most appropriate for the Member as the Member progresses in treatment

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. Some Members may require access to several services concurrently. Nothing in the Optum benefit package limits the Member's access to covered services as long as the services are medically necessary.
These needs are recognized for both children and adults.

Timeliness of Decisions

The timeframe for Optum to respond to outpatient service requests is 14 calendar days from the day the request is received by Optum to the day the adverse determination letter is mailed. 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 an expedited/urgent service request is not approved. All other determinations result in either authorization which are sent to the Provider, or written adverse determinations which are sent to both the Provider and the Member within 14 days.

Providers may cancel a request for a variety of administrative reasons, such as the Member is no longer available to participate in the service, the service is no longer necessary, or there is an identified error on the service request form. In those circumstances, Optum notifies the Member via mail of the decision to cancel that was made by the Provider.

Limitation, Modification or Denial of Payment

Optum limits/modifies payment to only those services authorized and approved for reimbursement (for example, 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 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 reflect new scientific evidence as well as:

- The broad clinical experience of Optum staff
- Multi-disciplinary input from the Optum 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 public sector clinical criteria also recognize and support services essential to recovery and resiliency. In addition, these criteria support case management for the comprehensive range of services and programs found in public sector systems. The Optum 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 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
- All staff members accept complaints, which are logged into the Optum complaint 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 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 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 corporate level clinical committee reviews and approves recommended clinical criteria and guidelines, 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.

Treatment Philosophy

We are committed to creating and maintaining relationships with Optum Idaho network Providers. We believe that optimal treatment is attained when delivered in the setting that is both the least restrictive and the one with the greatest potential for a favorable outcome. We know it is the efforts of our clinical network that give IBHP Members the best opportunity to achieve a level of functioning that supports their quest to live healthier lives. As a result, our priority is creating relationships with network Providers that ensure appropriate, time- effective clinical treatment. Through this partnership we look to foster positive outcomes for IBHP Members receiving behavioral health services.

In accordance with your Agreement, you are required to provide services to all IBHP Members and their families in a manner that is consistent with professional and ethical standards as set forth by national certification and state licensing boards, and applicable IDHW regulations. Resources are available to you which outline the expectations for Optum Idaho network treatment quality.

This manual addresses assessment, treatment and discharge planning, coordination of care, and Member rights and responsibilities (see also the “Treatment Record Documentation Requirements” section of this manual). Additional resources in these areas can be found at **optumidaho.com** as well as on **Provider Express:** Home page > Clinical Resources > Guidelines/Policies. You will find the following guidelines, including but not limited to:

- Optum Idaho Level of Care Guidelines
- Best Practice Guidelines:
  - OH/OHBS-CA
- Psychological/Neuropsychological Testing Guidelines

Optum participates with health plans in measuring performance on NCQA HEDIS® measures and incorporates these standards into our requirements and guidelines.

Communication with Providers

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 criteria as guidelines, and always to follow their professional judgment in authorizing services.

Providers are to complete the Service Request Forms in their entirety when requesting a service

that requires prior authorization. When a Care Advocate is unable to authorize a service request based on the information provided, the Care Advocate may request additional information from the treating Provider. If the services cannot be authorized, the Care Advocate refers the request to the Chief Medical Officer or a Peer Reviewer. The Chief Medical Officer or Peer Reviewer makes the decision using clinical judgment and a review of the case against Optum clinical criteria and guidelines, the availability of community resources, and the Member's individual needs.

If the case is not approved due to not meeting medical necessity, the Provider may request a Peer-to-Peer Review with a Medical Director, the instructions of which are provided with the Adverse Benefit Determination letter. To facilitate the decision-making process, Optum uses the Level of Care Guidelines (LOCGs). We review LOCGs annually.

Insufficient Information

Should a Care Advocate require additional clinical information, the Care Advocate may contact the requesting Provider to explain the additional information needed in order to make a determination about the medical necessity of the treatment requested. Providers are afforded 2 reach out calls over 48 hours to respond to the Care Advocate request for additional information. If the Care Advocate does not get a response within 48 hours of when additional information is requested, then the Care Advocate cannot render an authorization and at that time forwards the case for Peer Review. The Peer Reviewer who is a Doctorate Level and above Professional will review the case information as organically submitted. The Peer Reviewer may render an authorization or a denial determination on the based on insufficient information to make a determination.

Provider Guidance for using Utilization Management Criteria

Utilization Management criteria for the IBHP is available to Providers in this Provider Manual, and in posted Level of Care Guideline Documents for each benefit offered. These materials are referenced and reviewed routinely over the course of time during various Provider trainings. In general Providers may locate and utilize the following guidance offered by Optum:

- Comprehensive information, including the level of care (utilization management) criteria are available for Providers on the Optum website under Guidelines and Policies, and then Level of Care Guidelines

- The Provider Manual is posted at the Optum website above and is also provided in hard copy upon request and includes links to the criteria

Level of Care Guidelines

Our Optum Idaho **Level of Care Guidelines** is intended to promote optimal clinical outcomes and consistency in the authorization of benefits by Care Advocacy staff and Peer Reviewers. They are available at **optumidaho.com** for each benefit offered by the IBHP or you may request a paper copy by contacting Network Management at **1-855-202-0983.**

Best Practice Guidelines

We have adopted **Best Practice Guidelines** from external nationally recognized organizations. The guidelines provide information about evidence-based treatment of common behavioral health

conditions. Two aspects of each Supplemental and Measurable Guideline are measured annually, and the data is then used to identify opportunity for improvement. Links to these guidelines may be found at **optumidaho.com**.

Evidence-Based Practice Resource Library

Optum Idaho has developed a resource list of evidence-based practices (EBPs) to promote the use of scientifically established behavioral health interventions. Training and education in these EBPs will increase the expertise needed to provide effective interventions to youth receiving services. Optum Idaho is not mandating use of specific evidence-based practices, but providing a clearinghouse of resources for providers to access based on their specific need and clinical judgement. The recommendations for external EBP resources are based on research done through SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

For information please visit optumidaho.com > For Network Providers > **Provider Trainings**.

Assisting with Recovery

We encourage you to assist IBHP Members with their recovery by providing information about their condition, its treatment, and self-care resources. Members have the right to information that will inform decision-making, promote participation in treatment, enhance self-management, and support broader recovery goals.

We encourage you to discuss all treatment options and the associated risks and benefits and solicit Members' input about their treatment preferences. Nothing in this manual is intended to interfere with your relationship with Members as patients.

Assessment

Thorough clinical assessments are required, and should be included in the clinical record. The initial diagnostic assessment, also known as the comprehensive diagnostic assessment, includes a biopsychosocial history that provides information on previous medical and behavioral health conditions, interventions, outcomes, and lists current and previous medical and behavioral health Providers. The mental status exam includes an evaluation of suicidal or homicidal risk. A substance use screening should occur for Members over the age of 10 years, noting any substances abused and treatment interventions.

Other areas to be covered in the assessment are developmental history, education, legal issues, and social support. Cultural and spiritual considerations should be covered. A note should also be made of any community resources accessed by the Member. A culmination of these assessment aspects, including negative findings, will yield a DSM diagnosis or ICD equivalent.

For routine outpatient services, a Wellness Assessment is to be part of every new treatment episode. Providers encourage and facilitate their Members to complete this assessment.
This tool contributes to comprehensive treatment planning (see the "Idaho Behavioral Health Plan Benefits, Authorization Requirements and Access to Care" section of this manual).

Service Specific Treatment Planning

The treatment plan stems from the Member's presenting condition and is used to document realistic and measurable treatment goals as well as the evidence-based treatments that will be used to achieve the goals of treatment. Effective treatment planning should also take into account significant variables such as the Member's functional deficits, strengths and weaknesses, as well as age and level of development, the history of treatment, whether the proposed services are covered in the IBHP and are available in the community, and whether community resources such as support groups, consumer-run services, and preventive health programs can augment treatment. Providers should include the Member in the treatment planning.

The Provider should also take into account the Member's preferences as might be directly expressed or documented in an advance directive or crisis plan. Finally, effective treatment planning also includes the formulation of discharge criteria specifically designed around the Member's therapy goals. For some Members, treatment is part of a broader recovery & resiliency effort, so the recovery & resiliency goals which may be documented in a recovery plan should also be considered. Please refer to the Optum Idaho Outpatient Services LOCG for more details related to treatment planning requirements.

A change in the Member's condition should prompt a reassessment of the treatment plan and selection of appropriate services. When his or her condition has improved, the reassessment should determine whether a less restrictive level of care or different services may be adequate to treat the condition, or whether he or she no longer requires treatment based upon the original discharge criteria. 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, and/or the condition is better treated with different services, or if a higher level of care is required.

Effective discharge planning enables the Member's safe and timely transition from one level of care to another and documents the services he or she will receive after discharge. Discharge planning begins at the onset of treatment when the Member and Provider include the discharge criteria and estimated time treatment might take into the overall plan. The initial discharge plan may evolve in response to changes in the Member's condition and his or her preferences. The final discharge plan should document the anticipated discharge date, the proposed post-discharge services, the plan to coordinate discharge with the Provider at the next level of care when indicated, and the plan to reduce the risk of relapse such as by confirming that the Member understands and agrees with the discharge plan. The risk of relapse can also be mitigated by arranging a timely first post-discharge appointment.

As the Member transitions from one level of care to another, Optum expects that the first appointment at the next level of care will be scheduled commensurate with the Member's needs. The first post-discharge appointment following inpatient care should occur no later than seven (7) days from the date of discharge. This timeframe is in accordance with the HEDIS® standard for follow-up treatment after discharge from inpatient care. Compliance with this standard is assessed on an annual basis. At Optum, Care Advocates and Field Care Coordinators monitor discharge planning, and are available to assist with identifying and facilitating access to available treatment services and community resources.

Optum expects that the Provider will collaborate with the Member during treatment, recovery and

discharge planning whenever possible.

To coordinate and manage care between behavioral health and medical professionals, Optum requires that you seek to obtain the Member's consent to exchange appropriate treatment information with medical care professionals (e.g., primary physicians, medical specialists) and/or other behavioral health clinicians (e.g., psychiatrists, therapists). Optum requires that coordination and communication take place at: the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate. Coordination of services improves the quality of care to Members in several ways:

- It allows behavioral health and medical Providers to collaborate
- It allows a primary care physician to know that his or her patient followed through on a behavioral health referral
- It minimizes potential adverse medication interactions for Members who are being treated with psychotropic and non-psychotropic medication
- It allows for better management of treatment and follow-up for Members with coexisting behavioral and medical disorders
- It promotes a safe and effective transition from one level of care to another
- It can reduce the risk of relapse

To facilitate effective communication among all treatment professionals involved in a Member's care, Optum Idaho **requires** network Providers to coordinate services with the Member's primary care physician (PCP) at a minimum, by applying the following standards for care coordination:

- During the diagnostic assessment session, request the Member's written consent to exchange information with all appropriate treatment professionals
- After the initial assessment, provide other treating professionals with the following information within two weeks:
  - Summary of Member's evaluation
  - Diagnosis
  - Treatment plan summary (including any medications prescribed)
  - Primary clinician treating the Member
- 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
- At the completion of treatment, send a copy of the discharge summary to the other

treating professionals

- Attempt to obtain all relevant clinical information that other treating professionals may have pertaining to the Member's mental health or substance use disorder problems

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, as well as accrediting organizations, expect you 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 as part of an overall approach to coordinating care.

Member Rights and Responsibilities

You will find a copy of our "Member Rights and Responsibilities" at the end of this manual. You may request a paper copy by contacting Network Management at **1-855-202-0983** (see "**Resource Guide**" section of this manual). These rights and responsibilities are in keeping with industry standards. All Members benefit from reviewing these standards in the treatment setting. We request that you display the Rights and Responsibilities in your waiting room, or have some other means of documenting that these standards have been communicated to Optum Members.

The Clinical Technology Assessment Committee (CTAC)

The CTAC meets quarterly to review current medical and scientific literature. An Optum Medical Director chairs this multidisciplinary committee that includes at least one external clinician on a standing basis. In addition, this committee consults on an as-needed basis with professionals who are actively working with the technology under review and/or clinical issue(s) that may be impacted by the technology under review. This committee examines the use of new technologies and new applications of existing technologies for the assessment and treatment of behavioral health conditions.

The committee also reviews existing technologies when questions arise as to their application. The committee recommends as proven those treatments for which there is published scientific evidence of efficacy and safety. This evidence includes controlled studies of adequate sample size, published in established peer-reviewed journals, as well as guidance from state and federal agencies.

If you have a technology that you would like to have reviewed by this committee, please contact the Optum Idaho Care Advocacy Center. Make your request to the Medical Director and he or she will notify the committee chair of your interest.

Services of Interpreters

It is typically your responsibility to arrange for the services of interpreters, when indicated, for Members under your care. Interpreter services are covered under the IBHP and the appropriate service codes for billing are included on the Optum Idaho Medicaid fee schedule.

Treatment Record Documentation Requirements

In accordance with your Agreement, you are required to maintain high quality medical, financial and administrative records (including appointment or scheduling books) related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community, and conform to all applicable laws and regulations including, but not limited to, state licensing, Centers for Medicare and Medicaid Services (CMS) and/or national certification board standards.

In order to perform required utilization management, practice management and quality improvement activities, we may request access to such records, including, but not limited to, claims records and treatment record documentation. You are permitted under HIPAA Treatment, Payment or Healthcare Operations to provide requested records as contractually required. In accordance with HIPAA and the definition of Treatment, Payment or Healthcare Operations, you must provide such records upon request.

We may review your records during a scheduled On-Site Audit or may ask you to submit copies of the records to Optum for review. An On-Site Audit and/or Treatment Record Review may occur for a number of reasons, including, but not limited to:

- Reviews of agencies without national accreditation such as The Joint Commission, CARF or other agencies approved by Optum
- Audits of high-volume Providers
- Audits of Providers who offer Skills Building/Community Based Rehabilitation Services (CBRS) for adults and/or youth
- Routine random audits
- Audits related to claims, coding or billing issues
- Audits concerning quality of care issues
- Audits related to a Member complaint regarding the physical environment of an office or agency

The audits may focus on the physical environment (including safety issues), policies and procedures, and/or thoroughness and quality of documentation within treatments records and/or accuracy of billing and coding. We have established a passing performance goal of 85% for both the Treatment Record Review and On-Site Audit. On-Site Audit or Treatment Record Review scores under 85% will require a written Corrective Action Plan (CAP). Scores under 80% require submission of a written CAP and a re-audit within six months of the implementation of the CAP. However, in some cases, a requesting committee may require a CAP and/or re-audit regardless of

the scores on the audit tools.

Billing records should reflect the Member who was treated, the rendering and supervising Providers, and the modality of care. Audits related to claims, coding or billing issues may require corrective action.

The Regional 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. These are comprised of the Regional 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

Treatment Record – Content Standards

Optum requires that all non-electronic treatment records are written legibly in blue or black ink. All treatment records must include the following:

- Each Member receiving treatment will have an individual treatment record
- Each record contains the Member's name, address, phone numbers, employer or school information, emergency contact information, relationship and legal status, and guardianship information (when relevant)
- All entries in the treatment record are dated and include the rendering Provider's name, professional degree and license information (when applicable); each entry includes a signature
- Appropriate consent for treatment form(s) are present in the record

- Documentation of a DSM-V diagnosis consistent with the presenting problem(s), history, mental status examination, and other assessment data:
    - List medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of mental health condition
- The presenting problems and conditions are documented
- A behavioral health history, including previous treatment dates and Providers, therapeutic interventions and responses, previous medication history, and relevant family history information are documented as obtained during the initial diagnostic assessment
- A medical history and/or physical exam (appropriate to the level of care) are documented
- A medical health history, including known medical conditions, any drug allergies, previous treatment dates and Providers, previous medication history, current treating clinicians, current therapeutic interventions and responses, and relevant family history are documented
- Each record indicates what medications have been prescribed, the dosages of each, and dates of initial prescriptions or refills. Informed consent for each medication is present in the record
- When a Member is prescribed medication, the progress notes include evidence of medication monitoring
- A complete mental status exam is documented
- A risk assessment including the presence or absence of suicidal or homicidal risk and any behaviors that could present a danger towards self or others is documented. This includes any previous history of risk behaviors
- The record includes an assessment of any abuse the Member has experienced or perpetrated
- The record includes an assessment of the following elements: trauma the Member has experienced; spiritual and cultural variables impacting treatment; educational status (appropriate to the Member's age); legal issues; and identification of community resources the Member and Member's family are currently accessing
- For adolescents and children, prenatal and perinatal events are documented, along with a complete developmental history (physical, psychological, social, intellectual, and academic). For adolescents only, a sexual behavioral history is documented
- The initial assessment includes an assessment for depression
- For Members 10 and older, a substance use screening, including alcohol, drugs,

prescription and over the counter medications, and nicotine is present

- When a substance use disorder issue is identified, the Global Appraisal of Individual Needs (GAIN) is completed. An intervention to address the substance issue is documented
- On an annual basis, the Member is reassessed. The reassessment includes the Member's current status and a new mental status exam
- Coordination of care between the Provider and other medical or behavioral Providers and institutions is documented in the record
- The treatment plan is geared towards the individual Member's needs and includes treatment goals in the Member's own words
- There is documentation that the Member or legal guardian has agreed to the treatment plan. Member and, when applicable, family involvement in treatment is documented
- The treatment plan is consistent with the diagnosis, member strengths and functional needs as well as includes objective and measurable short and long term goals with time frames for goal attainment. The plan also includes an initial discharge plan
- Treatment plan updates occur when goals are achieved or new problems are identified
- Progress notes document the start and stop time for each session
- Progress notes document who is in attendance at each session
- Progress notes document the billing code that was submitted for the session
- Progress notes identify the type of intervention used during the session
- Progress notes reflect reassessments, including on-going risk assessments
- Progress notes document progress or lack of progress towards treatment goals
- Progress notes include identification of Member strengths and weaknesses and how those impact treatment
- Progress notes document the use of any preventive services and referrals to other Providers or services
- When lab work is ordered, the documentation includes evidence that the Provider reviewed the lab results and educated the Member about the lab results
- When the Member is discharged, a discharge summary is completed that includes the reason for discharge, the extent to which treatment goals were met, and any recommended follow up activities

- The dates of follow up appointments are documented

- Is a Member misses an appointment, there is documentation indicating why the appointment was missed (if this is known) and what efforts were made to reengage the Member in treatment

- The record includes documentation supporting medical necessity for services that are rendered. This includes identification of functional deficits the Member is experiencing and how the services that are rendered will address these deficits. The treatment that is provided should be at the lowest level of care necessary to prevent decompensation and the need for a higher level of care

- The record includes documentation of any education provided to the Member related to treatment options, participation in treatment, coping with behavioral health issues, prognosis and outcomes of treatment, and risks of not participating in treatment

- If the Member has limited English proficiency, there is documentation indicating that interpreter services were offered and if the Member accepted or declined the services

During the chart review process, reviewers will make an assessment of the improvement of the Member's level of functioning and overall symptom reduction.

Guidelines for Storing Member Records

Below are additional guidelines for completing and maintaining treatment records for Members:

- Practice sites and agencies must have an organized system of filing information in treatment records

- Treatment records including electronic health records must be stored in a secure area and the site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable laws and regulations, including HIPAA

- The site must have a process in place to ensure that records are available to qualified professionals if the treating clinician is absent

- Treatment records are required to be maintained for a minimum period of seven years from the date of service, or in accordance with applicable state or federal laws or regulations, whichever is longer. Termination of the Agreement has no bearing on this requirement

- Financial records concerning covered services rendered are required to be maintained from the date of service for ten (10) years, or the period required by applicable state or federal law, whichever is longer. Termination of the Agreement has no bearing on this requirement

Member Access to Medical/Behavioral Health Records

A Member, upon written request and with proper identification, may access his/her records that are

in the possession of Optum. Before a Member is granted access to his/her records, the record will first be reviewed to ensure that it contains only information about the Member. Confidential information about other family Members that is in the record will be redacted.

Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing Rules is a federal law enacted to ensure privacy and security of a consumer's Protected Health Information (PHI). PHI is basically defined as individually identifiable health information that is transmitted or maintained in any form or medium.

Our operations are compliant with the required HIPAA privacy practices as well as other applicable state and federal laws. Below are some of the highlights of our privacy practices.

Uses and Disclosures of PHI

We have established policies relating to requests for and disclosure of PHI in accordance with HIPAA and other applicable federal and state laws. These policies ensure that only the minimum amount of information necessary is used and/or disclosed to accomplish the purpose of the disclosure or request.

Release of Information

It is our policy to release information only to the individual, or to other parties designated in writing by the individual, unless otherwise required or allowed by law. For each party that the individual designates permission to access his or her PHI, he or she must sign and date a legally compliant Release of Information (ROI) specifying what information may be disclosed, to whom, for what purpose(s) and during what period of time. An individual's authorization for ROI is not required when PHI is being exchanged with a network clinician, facility or other entity for the purposes of Treatment, Payment, or Health Care Operations as enumerated in HIPAA (and consistent with applicable state and other Federal law).[1]

Identification and Authentication

We require that anyone requesting access to PHI be appropriately identified and authenticated. Members and personal representatives, for example, are required to provide the member identification number and other information (such as the member's date of birth). You or your administrative staff are identified and authenticated in a number of ways and may be asked for your federal tax identification number or physical address, and patient/member information as part of this verification process.

[1] "Treatment, Payment, or Health Care Operations" as defined by HIPAA include: 1) Treatment – Coordination or management of health care and related services; 2) Payment purposes – The activities of a health plan to obtain premiums or fulfill responsibility for coverage and provision of benefits under the health plan; and 3) Health Care Operations – The activities of a health plan such as quality review, business management, customer service, and claims processing.

Internal Protection of Verbal, Written and Electronic PHI

Optum works with UnitedHealth Group, our parent organization, to ensure that all physical and logical safeguards are in place to protect against the unauthorized use, disclosure, modification, and destruction of PHI across all media (e.g., paper records and electronic files). All employees of Optum receive privacy and security training and are familiar with the privacy practices relevant to their job duties and responsibilities.

National Provider Identifier

The purpose of a National Provider Identifier (NPI) is to improve the efficiency and effectiveness of the electronic transmission of health information. We require the billing clinician to include NPI information on all electronic claims. In addition to all electronically submitted claims, Idaho mandates that the NPI be used on all claims (whether paper or electronic submission is used). For more information about obtaining an NPI, you may contact the **Centers for Medicare and Medicaid**. For additional information about claims processing, visit Provider Express: Home page > Admin Resources > **Claim Tips**.

Quality Improvement

Participation in the Optum Idaho Quality Assurance and Performance Improvement Program

We are committed to the highest quality of care provided in a manner consistent with the dignity and rights of Members and to meeting or exceeding customer expectations. Our Quality Assurance and Performance Improvement (QAPI) Program monitors: accessibility; quality of care; appropriateness, effectiveness and timeliness of treatment; and Member satisfaction. The QAPI Program is comprehensive and incorporates the review and evaluation of all aspects of the behavioral health managed care delivery systems. If you have any feedback regarding QAPI projects and processes or are interested in participating in any QAPI committees, please contact Optum Idaho Network Management at **1-855-202-0983**.

Compliance with the QAPI Program is required in accordance with your Agreement, including cooperation with Optum and IDHW in their efforts to adhere to all applicable laws, regulations and accreditation standards.

The key components of the QAPI Program required of you as a participating Provider include, but are not limited to:

- Ensuring that care is appropriately coordinated and managed between you and the Member's primary medical physician and other treating clinicians and/or agencies
- Cooperation with On-site Audits and requests for treatment records
- Cooperation with the Member complaint process (e.g., supplying information necessary to assess and respond to a complaint)
- Cooperation with the Achievements in Clinical Excellence (ACE) program (formerly called Campaign for Excellence (CFE)) (Please refer to the **"Achievements in Clinical Excellence (ACE) Clinicians"** section of this manual for more information)
- Responding to inquiries by our Quality Improvement staff
- Participation in Quality Improvement initiatives related to enhancing clinical care or service for Members
- Submission of information related to an Optum review of potential quality of care concerns and critical incidents
- Helping to ensure Members receive care that is consistent with national performance measures including rapid follow-up upon discharge from an inpatient level of care

Upon request, Optum makes information available about the QAPI Program, including a description of the QAPI Program and a report on our progress in meeting goals. Some of the activities that may involve you are described in more detail below.

Critical Incidents

Critical incidents are defined as a serious, unexpected occurrence involving a Member that is believed to represent a possible quality of care issue on the part of the practitioner/agency providing services, which has, or may have, deleterious effects on the Member, including death or serious disability, that occurs during the course of or subsequent to a Member receiving behavioral health treatment. Reportable Critical Incident categories include but are not limited to:

1. **A completed suicide by a Member** who was engaged in treatment services at any level of care at the time of the death or within the previous 60 calendar days.
2. **A serious suicide attempt by a Member** who was engaged in treatment services at any level of care that required an overnight admission to a hospital medical unit.
3. **An unexpected death of a Member** that occurred while the Member was engaged in treatment services at any level of care or within 12 months of a Member having received treatment services.
4. **A serious injury of a Member** that required an overnight admission to a hospital medical unit that occurred on an agency's premises or in the community at the time that the Member was receiving treatment services at any level of care, including home-based services.
5. **A report of a serious physical assault of a Member** that occurred on an agency's premises or in the community at the time that the Member was receiving treatment services at any level of care, including home-based services.
6. **A report of a sexual assault of a Member** that occurred on an agency's premises or in the community at the time that the Member was receiving treatment services at any level of care, including home-based services.
7. **A report of a serious physical assault by a Member** that occurred on an agency's premises or in the community at the time that the Member was receiving treatment services at any level of care, including home-based services.
8. **A report of sexual assault by a Member** that occurred on an agency's premises or in the community at the time that the Member was receiving treatment services at any level of care, including home-based services.
9. **A homicide that is attributed to a Member** who was engaged in treatment services at any level of care at the time of the homicide or within the previous 60 calendar days.
10. **A report of an abduction of a Member** that occurred on an agency's premises or in the community at the time that the Member was receiving treatment services at any level of care, including home-based services.
11. An instance of **care ordered or provided for a Member by someone impersonating a physician, nurse or other health care professional.**
12. **High profile incidents** identified by the IDHW as warranting investigation.

If you are aware of a critical incident involving a Member that meets any of the above categories, you must notify Optum by calling the Provider Services Line at **1-855-202-0983** and asking to speak with a Customer Service Representative to report the incident.

We have established processes and procedures to investigate and address critical incidents. This includes a Peer Review Committee chaired by Optum Idaho Chief Medical Officer and incorporates appropriate representation from the various behavioral health disciplines. You are required to cooperate with critical incident investigations.

For further details on the Critical Incident reporting process, consult the **Critical Incident Quick Reference Guide** at optumidaho.com > For Network Providers > Guidelines & Policies.

Member Satisfaction Surveys

We regularly conduct a Member Satisfaction Survey of a representative sample of Members receiving behavioral health services within the Optum Idaho network. The results of the survey are reviewed. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Provider Satisfaction Survey

We regularly conduct a Provider satisfaction survey of Providers delivering behavioral health services to IBHP Members. This survey obtains data on Provider satisfaction with Optum services including Care Advocacy, Network Services and Claims Administration.

The results of the survey are analyzed for tracking and trending. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Performance Improvement Program

Our Performance Improvement Programs (PIP) are selected and developed based on the demographic, cultural, clinical, and risk characteristics of Members. You may be enlisted to participate in the design and implementation of a PIP. We encourage all clinicians and agencies to review the content and process of Optum PIPs. These programs are described at **optumidaho.com** as they are developed. If you would like a paper copy of these programs please contact Network Management.

Practice Guidelines

Optum has adopted clinical guidelines from nationally recognized behavioral health organizations and groups. The adopted **Best Practice Guidelines** are available through **optumidaho.com**. Your feedback is encouraged on all guidelines and any suggestions on new guidelines to be considered for adoption are welcome. If you would like a paper copy of these guidelines please contact Network Management.

Complaint Investigation and Resolution

You are required to cooperate with Optum in the complaint investigation and resolution process. If we request written records for the purpose of investigating a Member complaint, you must submit these to Optum within 14 business days, or sooner as requested. Complaints filed by Members should not interfere with the professional relationship between you and the Member.

QI staff, in conjunction with Network Management staff, monitors complaints filed against all clinicians and agencies, and solicits information from them in order to properly address Member complaints. In general, resolution of most complaints is communicated to the Member when the complaint is received from, or on behalf of, the Member. Quality of Care complaints do not include Member notification of resolution.

We require the development and implementation of appropriate Corrective Action Plans (CAP) for legitimate problems discovered in the course of investigating complaints. Such action may include, but is not limited to, having Optum:

- Require you to submit and adhere to a CAP
- Monitor you for a specified period, followed by a determination about whether substandard performance or noncompliance with Optum requirements is continuing
- Require you to use peer consultation for specific types of care
- Require you to obtain specific additional training or continuing education
- Limit your scope of practice in treating Members
- Hold referrals of any Members to your care by changing your availability status to "unavailable" and/or reassigning Members to the care of another participating clinician or agency
- Terminate your participation status with Optum

Cooperation with an unavailable status associated with complaint, Quality of Care or critical incident investigations may include:

- Informing Members of unavailable status at the time of an initial request for services, and identifying other network clinicians or agencies to provide services or referring the Member to Optum for additional referrals
- Informing current Members of status and their option to transfer to another network clinician or agency
- Assisting with stable transfers to another network clinician or agency at the Member's request

Audits of Sites and Records

On-site and record-only audits may occur with any contracted Provider. The on-site audit involves a review of policies and procedures, including policies related to hiring and supervision of staff, discussion of services that are offered and a tour of the agency or office site.

Optum Idaho representatives conduct site visits at agencies such as mental health clinics, SUD treatment centers and clinician offices. This includes audits of Providers who offer community-based rehabilitation services (CBRS) for adults and/or youth. On-site audits are routinely completed with agencies without national accreditation. In addition, audits are completed to address specific quality of care issues or in response to Member complaints about the quality of the office or agency environment.

Agencies that hold national accreditation through organizations such as: The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), DNV Healthcare, Accreditation Commission for Health Care (ACHC), or Healthcare Facilities Accreditation Program (HFAP), receive credit for meeting those standards of care for the identified accredited services or programs without additional review prior to the initial credentialing process.

Agencies that are not accredited will be required to participate in an on-site audit prior to credentialing and a re-credentialing audit prior to their specified re-credentialing timeframe. Any agency, regardless of their accreditation status, may be subject to an on-site audit for any Member complaints or suspected quality of care concerns brought to the attention of Optum.

During on-site and record-only audits for all types of Providers, chart documentation is reviewed, including (but not limited to) the assessment, diagnosis, treatment plan, progress notes, monitoring risk issues, coordination of care activities, and discharge planning. This process also verifies that services were provided to Members. You are expected to maintain adequate medical records on all Members and document in the record all services that are provided. Prior to the audit, you will be notified of the specific types of charts that will be reviewed. Failure to adequately document services that are rendered and/or dates of services may lead to a request for a Corrective Action Plan (CAP). (Please see the “Treatment Record Documentation Requirements” section of this manual for more information). The audit tools are based on NCQA, the Joint Commission and Optum standards. These forms are used during audits and are available at **optumidaho.com**.

Member Education

We offer a variety of Health and Wellness Tip sheets for Members. These are educational materials, written in common, everyday language. Topics include, but are not limited to general therapy issues, self-help, mood and anxiety disorders, and substance use disorders. They address child, adult and elderly populations. You are encouraged to distribute these to Members as appropriate. Health and Wellness Tips are available at **optumidaho.com** via the “Quick Links” to **liveandworkwell.com** or you can request paper copies by contacting Network Management at **1-855-202-0983**. If you have Members who would like to participate in the QAPI program, please call us at **1- 855-202-0983**.

Achievements in Clinical Excellence (ACE) Clinicians

ACE for solo Clinicians and Group Practices

ACE Clinicians recognizes in-network individual and group practices based on effectiveness and efficiency metrics after the threshold for volume of member Wellness Assessments has been met. Data for inclusion in ACE Clinicians program with a Platinum designation is run annually and clinicians are notified when they achieve Platinum recognition or when there is a change in recognition status.

Criteria for Inclusion in Achievements in Clinical Excellence

Network Clinicians and Group Providers must have a minimum of 10 cases for the measurement period (two years) in which the initial ALERT Wellness Assessment for each of those 10 cases measured in the clinical range for global distress. In addition, each of those 10 cases must have submitted at least one follow-up Wellness Assessment attributable to each of those cases.

Access and Tracking ACE Scorecards

Network Clinicians and Group Providers who achieve Platinum status are eligible for a number of rewards including performance-based contracting and recognition on Clinician directories. For more information please see our "**ACE Clinicians**" page on **Provider Express**.

Please note: Due to state regulatory requirements, Providers in the following six states may not be publicly recognized within our online provider directories: **California**, **Colorado**, **Maryland**, **Missouri**, **New York** and **Texas**.

If your practice resides in one of the excluded states, it's very important that you continue submitting ALERT Wellness Assessments. Even though your practice may reside in one of the excluded states, your data will still be evaluated and may still qualify you or your Group for performance-based contracting increases. Also, once we receive national recognition and NCQA accreditation for our ACE metrics, we will have your data on hand in order to recognize you publicly for your achievement.

Clinicians and Group Providers will be able to view their scores by logging into *Provider Express*: > Providers Report > Achievements in Clinical Excellence on their dashboard. ACE metrics will be calculated annually and shared with you in the 4th Quarter. Providers have a 60-day period to review their data prior to public recognition on *liveandworkwell.com*.

Network Clinicians and Group Providers may request a review of their data by submitting an ACE Review Request Form. In order to ensure a timely review, please submit your review request within 30 days of being notified of your ACE score.

Automatic Enrollment

ACE will automatically evaluate qualified Clinicians and Group Providers. However, due to state regulatory requirements, some states may be excluded from ACE. Clinicians and Group Providers in the excluded states are ineligible to receive Clinician directory recognition.

Since measurement relies upon data that is collected over a two year period, it is still very important that Clinicians and Group Providers in excluded states continue to submit ALERT Wellness Assessments. Regulatory changes may occur allowing us to recognize excellent performance through the ACE program.

Compensation and Claims Processing

Compensation

The network rate for eligible outpatient visits is reimbursed to you at the lesser of (1) your customary charge, or (2) the Optum Idaho fee maximum.

Financial records concerning covered services rendered are required to be maintained from the date of service for the greater of 10 years, or the period required by applicable state or federal law, whichever is longer. Any termination of the Agreement has no bearing on this legal obligation.

Balance Billing For Covered Services Is Prohibited

Under the terms of the Agreement, you may not balance bill members for covered services provided during eligible visits, which means you may not charge members the difference between your billed usual and customary charges and the aggregate amount reimbursed by Optum.

Claims Submission

The provider shall submit claims using current (CMS) Form 1500 (its equivalent or successor) with applicable coding including, but not limited to, ICD-10 (or its successor), CPT, and HCPCS coding.

The provider shall include in a claim the member number, provider's Federal Tax I.D. number, National Provider Identifier (NPI) and/or other identifiers requested by Optum.

In addition, you are responsible for billing of all members in accordance with the nationally recognized CMS Correct Coding Initiative (CCI) standards. Please visit the **CMS website** for additional information on CCI billing standards.

Claims are reimbursed based on the Optum Idaho Medicaid network fee schedule for services covered by the IBHP.

Claim Entry through Provider Express: You should file Optum claims at **Provider Express**. This secured, HIPAA-compliant transaction feature is designed to streamline the claim submission process. It performs well on all connection speeds and submitting claims on *Provider Express* closely mirrors the process of completing a Form 1500. In order to use this feature you must be a network clinician or group practice and have a registered user ID and password for *Provider Express*. Select the "First-time User" link in the upper right hand corner of the home page and follow the prompts.

We strongly encourage you to use this no-cost claims entry feature for claims submission at **Provider Express**, which allows claims to be paid quickly and accurately. For more information about fast and efficient electronic claims submission, please see *Provider Express* "**Improve the Speed of Processing—Tips for Claims Filing**."

EDI/Electronic Claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a Payor (Optum). You may choose any clearinghouse vendor to submit claims through this route. Because Optum has multiple claims payment systems, it is important for you to know where to send claims. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. For Optum claims use Payer ID #87726. Additional information regarding EDI is available on *Provider Express* "**Claim Tips**."

Clinician Claim Forms: Paper claims can be submitted to Optum using the Form 1500. The claims should include all itemized information such as diagnosis (from current version of DSM), length of session, member name, member date of birth, member identification number, dates of service, type and duration of service, name of clinician (i.e., individual who actually provided the service), credentials, tax ID and NPI numbers.

Paper Claims submitted via U. S. Postal Service should be mailed to:

Optum
P. O. Box 30760
Salt Lake City, UT 84130-0760

Anti - Fraud, Waste and Abuse (FWA): Optum has an Anti-Fraud, Waste and Abuse Program in place. You are required to remain in compliance with Optum's FWA Program. Please review the following Anti-Fraud, Waste and Abuse section of this manual.

Online Claims Help

Contact information for Claims and Customer Service issues can be found in the "**Contact Us**" section of *Provider Express*.

To ensure proper processing of claims, it is important to promptly contact Network Management if you change your Tax ID number. You may make changes to your practice address online at *Provider Express*.

Customer Service Claims Help

Optum Idaho has a dedicated customer service department with staff available five days a week during regular business hours to assist our network with questions related to general information, eligibility verification or the status of a claim payment.

The Optum Idaho customer service phone number is: **1-855-202-0983.**

Coordination of Benefits (COB)

Some members are eligible for coverage of allowable expenses under one or more additional health benefit plans. In these circumstances, payment for allowable expenses shall be coordinated with the other plan(s). It is your responsibility to inquire and collect information concerning all

applicable health plans available to a member and communicate such information to Optum.

If Optum is a secondary plan, you will be paid up to the Optum contracted rate. You may not bill members for the difference between your billed usual and customary charge and the amount paid by the primary plan(s) and Optum.

In general, if the member has dual coverage, submit to Medicare first as Medicaid is always ‘the Payor of last resort’; when the service is not covered by Medicare, the provider should submit directly to Optum first. If the member is covered by another form of insurance, submit to Optum Idaho with evidence of how or whether any portion was covered by the other insurer.

Processing and Payment of Claims

All information necessary to process claims must be received by Optum Idaho no more than 90 calendar days from the date of service. Claims received after this time period may be rejected for payment at the discretion of Optum and/or the Payor. You may not bill the member for claim submissions that fall outside these established timelines. Any corrections or additions to a claim should be made within 90 days of receipt of the initial claim.

Claims should be submitted as directed by Optum. We strongly recommend that you keep copies of all claims for your own records. You permit Optum, on behalf of the Payor, to bill and process forms for third-party claims or for third-party Payors, and execute any documents reasonably required or appropriate for this purpose. In the event of insolvency of the IBHP or Optum, your sole redress is against the assets of Optum or IDHW, not the member. You must agree to continue to provide services to members through the period for which premiums have been paid. Any termination of the Agreement has no bearing on this requirement.

Claims that contain all of the required information and match the authorization, if applicable, will be paid to the following standard (for the entire network as a whole) per Optum Idaho contract requirements: pay 90% of clean claims within 30 days and 99% of clean claims within 90 days after receipt. This may exclude claims that require Coordination of Benefits (COB) determinations. Benefits are payable provided coverage is in force at the time expenses are incurred, and are subject to all limitations, provisions and exclusions of the plan. You will be paid for covered services by Optum and will not under any circumstances seek payment through Optum for plans for which Optum is not the Payor or administrator.

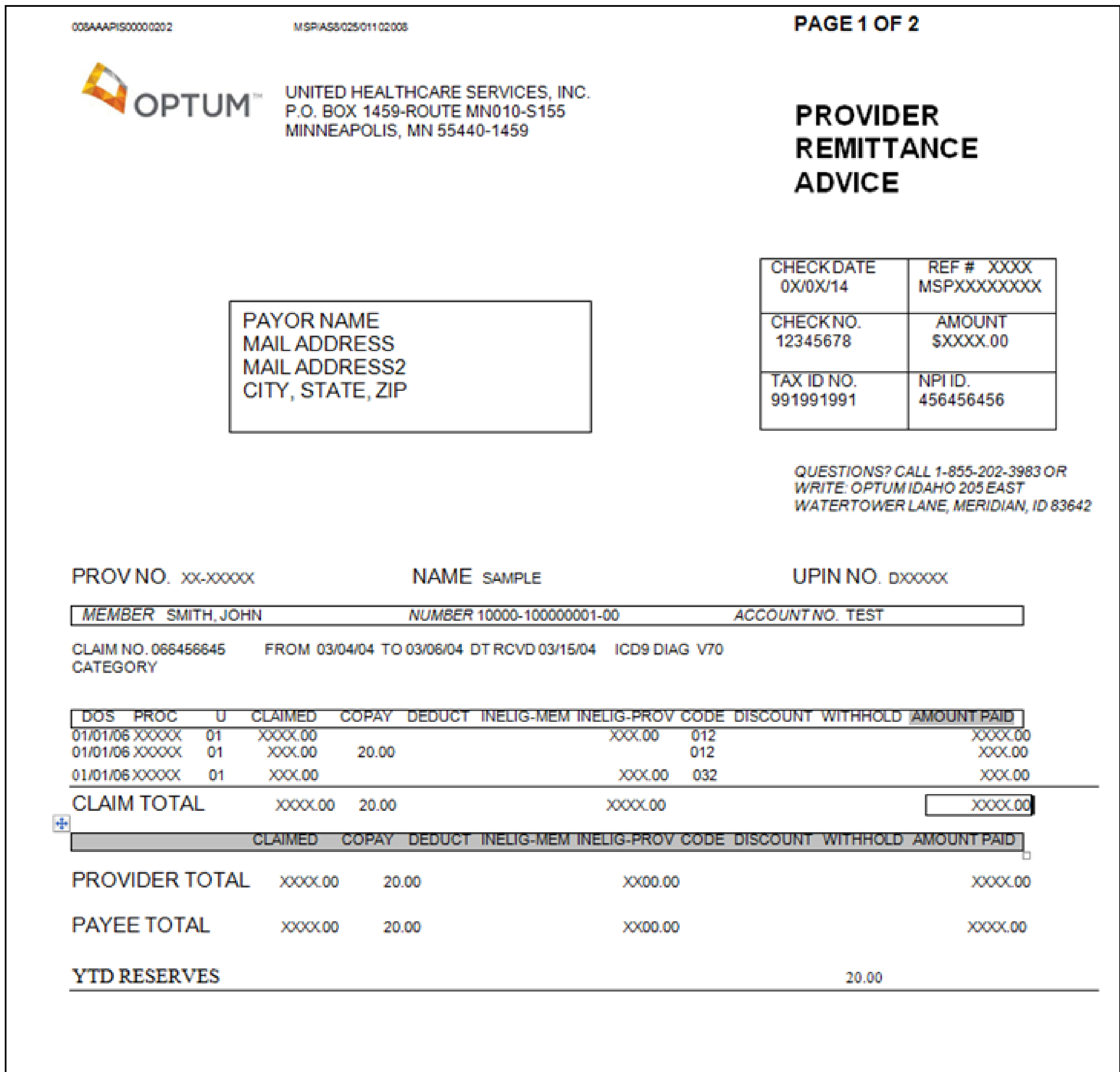
Optum may make corrective adjustments to any previous payments for services and may audit claims submissions and payments to ensure compliance with applicable policies, standards, procedures, including without limitation, the Manual, the Credentialing Plan, the Agreement, and state and federal law. Optum may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law.

Optum Idaho will use a check write process two times per week to ensure network providers experience timely receipt of reimbursement for services rendered. Checks are issued with a Provider Remittance Advice (PRA).

The Provider Remittance Advice contains the following elements; (an example mock-up is shown below):

- Member name
- Member number
- Claim number
- Rendering provider number
- Supervising provider number
- Check number
- Account number
- Check date
- Date of service
- Procedure code
- Amount billed
- Amount paid
- Provider Tax ID number
- Payee ID number
- Billing provider name
- Code descriptions (e.g., non-covered service)
- Optum Claims and Customer service phone number

Example Provider Remittance Advice:



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OPTUM™

UNITED HEALTHCARE SERVICES, INC.
P.O. BOX 1459-ROUTE MN010-S155
MINNEAPOLIS, MN 55440-1459

PROVIDER REMITTANCE ADVICE

PAYOR NAME
MAIL ADDRESS
MAIL ADDRESS2
CITY, STATE, ZIP

CHECK DATE 0X/0X/14	REF # XXXX MSPXXXXXXXX
CHECK NO. 12345678	AMOUNT $XXXX.00
TAX ID NO. 991991991	NPI ID. 456456456

QUESTIONS? CALL 1-855-202-3983 OR WRITE: OPTUM IDAHO 205 EAST WATERTOWER LANE, MERIDIAN, ID 83642

PROV NO. XX-XXXXX NAME SAMPLE UPIN NO. DXXXXX

MEMBER SMITH, JOHN *NUMBER* 10000-100000001-00 *ACCOUNT NO.* TEST

CLAIM NO. 066456645 FROM 03/04/04 TO 03/06/04 DT RCVD 03/15/04 ICD9 DIAG V70
CATEGORY

DOS	PROC	U	CLAIMED	COPAY	DEDUCT	INELIG-MEM	INELIG-PROV	CODE	DISCOUNT	WITHHOLD	AMOUNT PAID
01/01/06	XXXXX	01	XXXX.00				XXX.00	012			XXXX.00
01/01/06	XXXXX	01	XXX.00	20.00				012			XXX.00
01/01/06	XXXXX	01	XXX.00				XXX.00	032			XXX.00
CLAIM TOTAL			XXXX.00	20.00			XXXX.00				XXXX.00

	CLAIMED	COPAY	DEDUCT	INELIG-MEM	INELIG-PROV	CODE	DISCOUNT	WITHHOLD	AMOUNT PAID
PROVIDER TOTAL	XXXX.00	20.00			XX00.00				XXXX.00
PAYEE TOTAL	XXXX.00	20.00			XX00.00				XXXX.00
YTD RESERVES								20.00	

Anti - Fraud, Waste and Abuse

Optum Idaho is committed to addressing and correcting known offenses, recovering lost funds, improving overall anti-Fraud, Waste and Abuse (FWA) ability and partnering with state and federal agencies to pursue and prosecute violators to the fullest extent of the law.

Program Introduction

The Provider Network Integrity Program (PNI) incorporates multiple components leveraging technology, expertise and collaboration in a proactive way. Program components include, but are not limited to the following: education and awareness, prevention, detection, investigation, system enhancement and capability, corrective action and recovery and resolution. The PNI team consists of clinicians, investigators, pre-payment intervention specialists, data analytics staff, certified coders and executive leadership.

Potential fraud, waste and/or abuse practices include, but are not limited to, filing fraudulent claims, fraudulent authorization of claims, misrepresentation of services provided, abuse of services in order to obtain a benefit (including personal or commercial gain) from a Payor to which an individual or entity is not entitled. The identification process includes, but is not limited to, examining claims of providers to identify outlier practice patterns.

In the event potential fraud, waste and/or abuse is identified, appropriate interventions are implemented. Possible interventions may include, but are not limited to: outreach meetings and/or written correspondence to providers, records review and/or site audit, individual case peer-to-peer reviews, and referral for further investigation. You are contractually required to cooperate in this process and participate in any activities related to the identification and correction of potential fraud, waste, and abuse.

Once an intervention has occurred, we continue to monitor to ensure that providers adhere to all requirements for payment.

Education, Awareness & Compliance Training

All providers and affiliates working on Medicare Advantage, Part D or Medicaid programs must provide compliance program training and Anti - Fraud, Waste, and Abuse (FWA) training within 90 days of employment and annually thereafter (by the end of the year) to their employees and/or contractors. The training is subject to certain requirements, and may be obtained through OptumHealth or another source.

All providers and affiliates meeting the FWA certification requirements through enrollment in the fee-for-service Medicare program are deemed by CMS rules to have met the training and education requirements. It is our responsibility to ensure that your organization is provided with

appropriate training for your employees and applicable subcontractors. To facilitate that, we provide training attestation materials on the **Optum Forms** page on **Provider Express**: Home page > Admin Resources > Forms > Optum Forms – Clinical > Fraud, Waste and Abuse > Training Completion Attestation Form.

In compliance with federal regulations, you are required to administer the compliance and FWA training materials to your employees and/or contractors. If your organization has already completed a compliance and FWA training program – either on your own or through a Medicare plan – that meets CMS requirements, we will accept documentation of that training. You must maintain records of the training (e.g., sign-in sheets, materials, etc.) in compliance with CMS requirements. Documentation of the training may be requested at any time for verification that training was completed.

Prevention, Detection and Pre-Payment Process

Among the ways we address prevention are education, use of rigorous credentialing standards, and proper contracting.

We have a pre-payment program that leverages technology to search through real-time claims data to alert us to anything unusual in that data in order to make a determination to pay or to investigate further. The FWA look back period is normally determined by state and federal regulation, and is generally unlimited in scope.

Post-Payment Investigations and Corrective Action Plan (CAP)

When potential fraud, waste and abuse is reported or detected we conduct an investigation to determine potential corrective action. A sample of retrospective FWA investigation actions may include, but is not limited to, contacting providers to obtain and review medical and billing records; reviewing providers' disciplinary activity, civil or criminal litigation, and financial records; educating providers on errors in their billing and negotiating with providers on corrective action plan and settlement of overpayment. Following investigation, timely payment is made or, in the event that a claim denial is issued, the denial notification includes the provider's standard appeal rights.

Findings of billing inconsistent with our policies by in-network providers may result in such actions as clarification of proper procedure, a Corrective Action Plan (CAP), a change in network availability status, or may result in termination of your Agreement. In the case of retrospective review, Optum and our Payors reserve the right to pursue recoupment of funds paid. The Credentialing Committee may recommend termination. In that event, the provider is notified in writing and provided with information about appeal rights, if applicable, and in compliance with state and federal laws. A provider's voluntary termination from the network does not suspend or stop fraud, waste and/or abuse investigations or reviews; which may still be required by law.

Regulatory Reporting

Optum works closely with state and federal agencies in combating fraud, waste and abuse and periodically refers suspected and/or confirmed cases of fraud, waste and abuse to these agencies as required by regulation and contract.

Cooperation with State and Federal Agencies

Optum is committed to working with and cooperating fully with state and federal agencies in battling FWA. Optum will work diligently to fulfill all requests for investigative assistance, subpoenas and/or other investigative information requests. This includes but is not limited to providing information pursuant to civil and/or criminal proceedings as well as providing expert opinion or fact testimony at depositions and trials.

Optum will participate with and contribute to information sharing sessions, working groups, task forces and communication efforts to enhance the overall national anti-FWA effort. Optum will retain all records pursuant to these activities, and may be required to produce those records upon request in accordance with applicable laws and regulations.

As warranted, providers will be reported to the Idaho Department of Health and Welfare, Idaho licensing board(s), and any other regulatory agencies based on the outcome of the investigation and as required by state and federal laws. Throughout this process, we adhere to state law, ERISA guidelines, and confidentiality standards.

Code of Conduct and Conflict of Interest Policy Awareness

All providers and affiliates working on Medicare Advantage, Part D or Medicaid programs – including contracted providers – must provide a copy of our Code of Conduct to employees and contractors.

You can obtain and review our **Code of Conduct** at **unitedhealthgroup.com:** Home > About > Ethics & Integrity > UnitedHealth Group's Code of Conduct, and provide this to your employees and contractors.

Exclusion/Sanction/Debarment Checks

All providers and affiliates must review federal exclusion lists (HHS-OIG and GSA) at the time of hire/contracting with their current employees/contractors, health care professionals, or vendors that work on Medicare Advantage, Part D or Medicaid programs to ensure that none are excluded from participating in Federal health care programs. For more information or access to the publicly accessible excluded party online databases, please see the following links:

- Health and Human Services – Office of the Inspector General (HHS-OIG) List of Excluded Individuals / Entities: **Office of Inspector General**
- General Services Administration (GSA) Excluded Parties List System (EPLS) is accessible through the System for Award Management (SAM) site: **System for Award Management**.

What You Need to Do:
Review applicable exclusion/sanction/debarment lists to ensure that none of your employees or contractors are excluded from participation in federal health care programs.

We have guidelines to address suspected fraud, waste and/or abuse by providers. In accordance with your Agreement, you are required to cooperate with the review process to include any requests for medical records.

You can report potential violations using the “Tip Referral Form” located at the website link below or by calling the Fraud Tip Hotline at **1-866-242-7727**.

The Medicaid Program Integrity Unit's contact information can be found on the **Idaho Department of Health and Welfare’s website**.

Appeal and Provider Dispute Resolution

Introduction

There are two distinct processes related to an Adverse Benefit Determination regarding requests for services or payment:

- Member Appeals
- Provider Dispute Resolution

An Adverse Benefit Determination for the purposes of this section is a decision by Optum to deny, in whole or in part, a request for authorization of treatment or of a request for payment. An Adverse Benefit Determination may be subject to the Appeal process or Provider Dispute Resolution process depending on the nature of the Adverse Benefit Determination, member liability and your Agreement.

Care Advocacy decision-making is based on the appropriateness of care as defined by the Level of Care Guidelines, the Psychological and Neuropsychological Testing Guidelines, as well as the terms and conditions of the Member's Benefit Plan.

The **Level of Care Guidelines** and the **Psychological/Neuropsychological Testing Guidelines** for Optum Idaho are available at **optumidaho.com**. To request a paper copy of these guidelines, please contact Network Management at **1-855-202-0983**. All treatment certified by Optum must be outcome-driven, clinically necessary, rational, evidence-based, and provided in the least restrictive environment possible.

Optum offers no financial rewards or other incentives for providers, utilization reviewers or other individuals to reduce behavioral health services, limit the length of stay, withhold or deny benefit coverage.

Member Appeal Process

The Appeal process is available to members, or their authorized representative with their written permission, which may be their treating clinician at any level of care, in the event of an Adverse Benefit Determination when the member may incur financial liability for the services. If Optum issues an Adverse Benefit Determination, in whole or in part, then such determination will be subject to the applicable appeal process concurrently, if specifically requested, providers may ask to discuss the determination with an appropriately licensed peer reviewer.

The procedures for the appeal process, i.e. how to file an appeal and where to send it, are listed below. It is important to note that during this process the member or their representative has the right to submit any additional or new information to the medical reviewer for their reconsideration of the original determination made.

Appeals may be handled as urgent or non-urgent. Urgent timeframes apply in situations where, in your opinion, application of non-urgent procedures could seriously jeopardize the member's life, health or ability to regain maximum functioning. For an urgent appeal, contact Optum immediately at **1-855-202-0983** and press prompt 4. For an urgent appeal, Optum will make the review determination, notify you by telephone, and send written notification of the outcome to you and the member or authorized member representative within 72 hours after receipt of the request. By definition, urgent appeals are not available in situations where services have already been provided.

A non-urgent appeal must be requested within 60 calendar days from the date the Notice of Adverse Benefit Determination is mailed. Optum will make a determination and notify you and the member or the authorized member representative. This notification will be provided in writing within 30 calendar days from receipt of the request.

If you have received an authorization letter or a Notice of Adverse Benefit Determination and you wish to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, please follow the instructions in the letter and call the toll-free number provided in the letter. For additional assistance, contact Network Management to help you identify and contact the Care Advocate or peer reviewer for your specific case. Authorization is not a guarantee of payment (except as required by law), payment of benefits is still subject to all other terms and conditions of the member's plan and your Agreement.

A clinical peer who has not previously been involved in the Notice of Adverse Benefit Determination, and is not a subordinate of the person who made the initial decision will review a clinical appeal request. The reviewer will review all available information, including treatment records, in order to make a determination. For a case involving a clinical determination, the reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted license. For non-clinical administrative appeals, the reviewer will be an appropriately qualified Optum professional who was not involved in the initial Notice of Adverse Benefit Determination and who is not a subordinate of any person involved in the initial decision.

If the decision is to uphold a Notice of Adverse Benefit Determination, Optum will notify you and the member, or the Member Representative, of the outcome and any additional levels of review that are available, as applicable.

Members only have one appeal option with Optum and must exhaust that appeal option before being eligible to file a State Fair Hearing (see State Fair Hearing section below). If Optum fails to adhere to the notice and timing requirements, the member is deemed to have exhausted Optum's appeal process.

Instructions for filing a Member Appeal:
An appeal can be requested orally by the member by calling the Optum Member Line at **1-855-202-0973**, but must be followed up with a written request unless it is an urgent appeal. An Optum Appeal Request form is included in the Adverse Benefit Determination letter sent to the member and provider. You may use the Optum Appeal Request form or send the request in a letter with the following information:

- Member identifying information:
    - Name

- Identification number
- Date of birth
- Address

- Each applicable date of service
- Your identifying information:
  - Name
  - Tax identification number
  - Contact information
- Any additional information you would like to have considered as part of the Appeal process, including records relating to the current conditions of treatment, co- existent conditions, or any other relevant information
- Your explanation as to why the adverse decision should be overturned
- Written consent from the member if filing on behalf of the member

Where to submit a Member Appeal:

- Mail: Optum Idaho
  205 East Watertower Street
  Meridian, ID 83642
- Fax: **1-855-272-7053**
- Email: **optumidaho.appeals_grievance@optum.com**

For questions or assistance, call **1-855-202-0983** and press prompt 4.

State Fair Hearing (Appeal):
The member has the right to request a Fair hearing with IDHW if they are not satisfied with an Optum Appeal decision. Members must exhaust the one appeal option before being eligible for a State Fair Hearing.

Fair Hearing requests must be in writing and must be filed within 120 days from the date of the appeal resolution from Optum. The member may choose to have someone help them with this such as their legal guardian, or a provider.

The Fair Hearing Request form is included in the member's appeal resolution letter. You may use the Fair Hearing Request form or send the request in a letter. The request for a State Fair Hearing is sent directly to the State; and processed by the State.

The request for a fair hearing must explain why the member disagrees with the Optum appeal decision and include any additional information that should be considered. Include a copy of the Optum denial notice. State if the member wants to continue to receive the service being appealed at state fair hearing. To continue receiving services you must request a State Fair Hearing within ten (10) days of the postmark of the Optum appeal resolution notice by checking the box on the State Fair Hearing box that indicates that the member wants to continue to receive the service pending decision by the State Fair Hearing Officer.

If benefits are continued by the member, and the hearing officer decides that an Optum adverse benefit determination was correct, such benefits will not be reimbursed in the event the appeal decision is upheld, or Optum may take action to collect the cost of those benefits as allowed by 42 CFR 431.230(b).

To submit a Fair Hearing request:
Notify IDHW in writing or complete a 'Fair Hearing Request Form'. The form is included with the Optum appeal resolution letter. The form is also available at any Health and Welfare local office or via email at: **mybenefits@dhw.idaho.gov**. Include a copy of the Optum appeal resolution letter with your State Fair Hearing request. You can bring your appeal to any local Health and Welfare office, fax or mail it to:

- Mail: Administrative Procedures Section
  Hearing Coordinator
  Idaho Department of Health and Welfare
  P.O. Box 83720
  Boise, ID 83720-0036

- Deliver To: 450 West State Street
  10th Floor,
  Boise, ID 83720-0036

- Fax: **1-208-639-5741**

- Email**: APS@dhw.idaho.gov**

Provider Dispute Resolution Process

The Provider Dispute Resolution process is available to you, or your authorized representative, in a situation where the Member is not financially liable for the adverse decision issued by Optum, beyond applicable co-payments and deductibles. That is, the payment dispute is between you and Optum, and regulated by the Agreement, rather than the Member's Benefit Plan. You, or your authorized representative, have the right to dispute any adverse decision made by Optum when the determination is adverse to you, rather than the Member.

The Provider Dispute Resolution process must be initiated in writing by contacting Optum at the address listed below and must include the following information:

- Member identifying information:

    - Name
    - Identification number
    - Date of birth
    - Address
- The type of Service
- Each applicable date of service and units
- Your identifying information:
    - Name
    - Tax identification number
    - Contact information
- Dollar amount in dispute, if applicable
- Any additional information you would like to have considered as part of the Dispute process, including records relating to the current conditions of treatment, co-existent conditions, or any other relevant information
- Your explanation as to why the adverse decision should be overturned

Where to submit a Provider Dispute:

- Mail: Optum Idaho
  205 East Watertower Street
  Meridian, ID 83642
- Fax: **1-888-950-1182**
- Email: **optum.idaho.provider.dispute@optum.com**

For questions or assistance, call **1-855-202-0983** and press prompt 4.

The Provider Dispute Resolution process is available for post-service requests. Disputes related to pre-service and other concurrent service requests are subject to the Member appeal process previously described. To initiate a Provider Dispute, you must mail your request within 180 calendar days from the date you received the Provider Remittance Advice (PRA) from Optum. Disputes received outside of this timeframe will not be processed. Optum will notify you or your authorized representative of the dispute resolution in writing within 30 calendar days of the receipt of your request.

Manual Updates and Governing Law

Manual Updates

This manual may be updated periodically as procedures are modified and enhanced. Providers will be notified a minimum of thirty (30) calendar days prior to any material change to the manual unless otherwise required by regulatory or accreditation bodies. The current version of the manual is always available on **optumidaho.com**. You can view the manual online or download a complete copy from your computer. If you do not have internet access or printing capabilities, you may request a paper copy by contacting Network Management at **1-855-202-0983.**

Governing Law and Contract

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual conflict with the terms and conditions outlined in your Agreement, the subject matter shall first be read together to the extent possible; otherwise and to the extent permitted by, in accordance with, and subject to applicable law, statutes or regulations, the Agreement shall govern.

Member Rights and Responsibilities

In the course of care, a member has both rights and responsibilities.

Member Rights

Optum Idaho believes and supports the proposition that every member has the right to:

- Receive information about Optum's services, network practitioners and member's rights and responsibilities
- Be treated with respect and recognition of his or her dignity and right to privacy
- Participate with network practitioners in making decisions about his or her health care:
  - Provider Disputes should not interfere with the professional relationship between you and the member
- A candid discussion of appropriate or medically necessary treatment options for his or her condition
- Voice complaints or appeals about Optum for the services provided by Optum
- Make recommendations regarding Optum's members' rights and responsibilities policies
- Care that is considerate and that respects his or her personal values and belief system
- Personal privacy and confidentiality of information
- Reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability
- Have family members participate in treatment planning. Members over 12 years old have the right to participate in such planning
- Individualized treatment, including:
  - Adequate and humane services regardless of the source(s) of financial support
  - Provision of services within the least restrictive environment possible
  - An individualized treatment or program plan
  - Periodic review of the treatment or program plan

    - An adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment or program plan

- Participate in the consideration of ethical issues that may arise in the provision of care and services, including:
    - Resolving conflict
    - Withholding resuscitative services
    - Forgoing or withdrawing life-sustaining treatment
    - Participating in investigational studies or clinical trials

- Designate a surrogate decision-maker if he or she is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care

- Be informed, along with his or her family, of his or her Optum rights in a language they understand

- Choose not to comply with recommended care, treatment, or procedures and be informed of the potential consequences of not complying with the treatment recommendations

- Be informed of rules and regulations concerning his or her own conduct

- Be informed of the reason for any non-coverage determination, including the specific criteria or benefits provisions used in the determination

- Have decisions about the management based on behavioral health benefits Optum does not reward network practitioners or other individuals for issuing non-coverage determinations
- Inspect and copy their protected health information (PHI) and in addition:
    - Request to amend their PHI
    - Request an accounting of non-routine disclosures of PHI
    - Request limitations on the use or disclosure of PHI
    - Request confidential communications of PHI to be sent to an alternate address or by alternate means
    - Make a complaint regarding use or disclosure of PHI
    - Receive a *Privacy Notice*
- Receive information about Optum's clinical guidelines and Quality Assurance and Performance Improvement (QAPI) program

Member Responsibilities

In addition to the rights listed above, every member has the responsibility to:

- Supply information (to the extent possible), that Optum and its network practitioners need in order to provide care
- Follow plans and instructions for care that they have agreed on with his or her network practitioner
- Understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- Keep scheduled appointments and actively participate in treatment

Youth Empowerment Services Program System of Care

The Youth Empowerment Services Program refers to a specific population within the YES System of Care. These “YES Class Members” are individuals who are eligible for Medicaid under the 1915(i) State Plan Option. Please read below for further definitions of the YES System of Care and YES Class Members.

The State of Idaho is in the process of designing and implementing a new children’s mental health system of care for children and youth with Serious Emotional Disturbance (SED) called Youth Empowerment Services (YES). As part of the YES system of care, Optum is working with Division of Medicaid to offer new and updated Medicaid behavioral health benefits for youth and adolescents. YES has been authorized by the Idaho Department of Health and Welfare (IDHW) as part of the settlement agreement resulting from the Jeff D. class action lawsuit.

The YES system of care being developed by the State will improve the quality of care, accessibility of services, and outcomes for children served by offering a comprehensive array of services and supports to address the needs of children and youth diagnosed with a serious emotional disturbance (SED). Through a coordinated and collaborative effort, multiple child-serving agencies such as family medical and behavioral health providers, Department of Education, Department of Juvenile Corrections and Health and Welfare will work with the family to build a coordinated care plan around the unique needs and strengths of each child.

The Idaho Department of Health and Welfare and the Division of Behavioral Health have developed a website for the purpose of providing general information about the YES system of care and project: **yes.idaho.gov**.

Youth Empowerment Services (YES) Program

The Youth Empowerment Services Program refers to benefits accessed in the Idaho Behavioral Health Plan through the 1915(i) State Plan Option. The 1915(i) State Plan Option allows child and adolescent members with a Serious Emotional Disturbance (SED) as determined by the Independent Assessor to access Medicaid benefits in the Idaho Behavioral Health Plan with family income up to 300% of the Federal Poverty Level. The 1915(i) State Plan Option contains additional benefits that can only be accessed under the 1915(i) State Plan Option. As of January 1, 2018, Respite can be accessed through the 1915(i) State Plan Option.

Person Centered Plan

A coordinated care plan that results from the Independent Assessment process and reflects all of the needs and strengths of a member. The Person Centered Plan incorporates the results of the Comprehensive Diagnostic Assessment (CDA) and CANS functional assessment and is a result of Child and Family Team (CFT) Interdisciplinary Team Meetings. Person Centered Plans include the member's overall treatment goals and objectives, strengths, needs, a risk management plan, and a transition plan. The Person Centered Plan must be developed according to 42 CFR 441.725 and submitted to Optum for approval. An Optum-approved Person Centered Plan is not an approval of any service, but rather confirmation that CFR requirements have been met.

YES Practice Model

Six mandatory practice components that make up an overarching Practice Model. Many practice components will overlap throughout a member's experience in care. The six practice components are: Engagement, Assessment, Care Planning & Implementation, Teaming, Monitoring & Adapting, and Transition. All providers in the Idaho Behavioral Health Plan are required to follow the YES Practice Model.

YES Principles of Care

Eleven principles that are applied to all areas of mental health treatment planning, implementation, and evaluation as outlined in the Jeff D. settlement. The YES Principles of Care are the mandatory standards to be used by all stakeholders related to the provision of services and interaction with others and are as follows: Family-centered, Family and Youth Voice and Choice, Strengths-based, Individualized Care, Team-based, Community-based Service Array, Collaboration, Unconditional, Culturally Competent, Early Identification and Intervention, and Outcome-based. All providers in the Idaho Behavioral Health Plan are required to follow the YES Principles of Care.

Youth Empowerment Services Program: Benefits, Authorization Requirements and Access to Care

This section of the provider manual describes Youth Empowerment Services Program benefits that will be available for reimbursement beginning July 1, 2018. Network Providers should continue to utilize the Provider Manual in conjunction with the Level of Care Guidelines for the provision of these services. The Provider Manual and Level of Care Guidelines can be found at optumidaho.com > For Network Providers > **Guidelines and Policies.**

Access to Services

The majority of services developed as a result of the Jeff D. Settlement agreement are available to all Medicaid members, regardless of YES Class Membership. However, some services, such as Respite, are only available to Youth Empowerment Services Program Members, and as a result, are accessed via the Independent Assessment Process. The elements involved in accessing services in the Youth Empowerment Services Program are outlined below.

1. **Independent Assessment**
   If a member requires access to Respite, or seeks Medicaid coverage at a Family household income level of 186%-300% of the Federal Poverty Level, they must first receive an Independent Assessment completed by the Medicaid-contracted Independent Assessor (Liberty Healthcare). The Independent Assessor will conduct a Comprehensive Diagnostic Assessment (CDA) and a CANS Assessment to determine the member's SED status. Upon completion of the Independent Assessment, Liberty Healthcare will provide a letter outlining the SED determination to the individual/family. If the member does not have Medicaid based on traditional income requirements, they can apply for Medicaid based on meeting the requirements under the 1915(i) State Plan Option.

   To schedule an Independent Assessment, call Liberty Healthcare at **1-877-305-3469**.

2. **Child and Family Team**
   The Child and Family Team (CFT) will then meet to develop the Member's Person Centered Plan. Members that are eligible for Medicaid under the traditional income requirements and do not need Respite are not required to have an independent assessment, nor do they need a Person Centered Plan developed.

3. **Person Centered Plan**
   Providers may provide state plan services to children or adolescents who are Medicaid eligible prior to the Person Centered Plan being finalized. Once the Person Centered Plan is completed, Respite must be included for the Member to continue receiving the service. Prior authorization requirements will apply to some Medicaid benefits and medical necessity requirements will apply to all Medicaid benefits.

Services Offered in the Youth Empowerment Services Program

- All services in the IBHP **AND**

United Behavioral Health operating under the brand Optum

November 2018
BH1685a_11/2018

- Respite*

**Requires Person Centered Plan*

- Access currently limited:
    - Child and Family Team (CFT) Interdisciplinary Team Meeting
        - Limited to Person Centered Plans and Wraparound Plans

NO AUTHORIZATION REQUIRED

G9007	Child and Family Team (CFT) Interdisciplinary Team Meeting, per 15 min
S5150	Respite, not hospice; per 15 min

For services that do not require prior authorization, Optum will analyze claims information to identify outlier cases that may benefit from a clinical review.

Respite

Respite is in-person, short-term or temporary care for a youth with Serious Emotional Disturbance (SED) provided in the least restrictive environment that provides relief for the usual caretaker and that is aimed at de-escalation of stressful situations.

Individual Respite is provided by a credentialed agency in the member's home, another family's home, foster family home, a community-based setting and/or at the agency facility. Group Respite may only be provided at the credentialed agency facility, a community-based setting, or in the home for families with multiple children who have a diagnosis of SED. For additional information related to the provision of Respite, please see the Optum Idaho Level of Care Guidelines: Respite, on Optumidaho.com

Qualified providers of Respite services must be employed by a credentialed Optum network provider, be at least 21 years of age, be at least a HS Graduate or have a GED, have a CPR certification, and have completed the required Optum Respite Training on Relias.

Authorization: No prior authorization is required for Respite up to a hard cap of 300 hours per year. Respite must be included in the child/adolescent's Person Centered Plan for reimbursement.

Child and Family Team (CFT) Interdisciplinary Team Meeting

Child and Family Team (CFT) Interdisciplinary Team Meeting is meetings to develop, monitor, or modify a Coordinated Care Plan such as a member's Person Centered Plan. The CFT Interdisciplinary Team Meeting is a meeting scheduled by the assigned DBH Clinician (Coordinated Care Plan Facilitator). Network providers are part of the Child and Family Team but are not identified as the Member's Care Plan Facilitator. Collaboration will occur between all team members as the identified Care Plan Facilitator for the member's coordinated care plan is leading the meeting and documenting what will become the member's Behavioral Health Coordinated Care Plan (ex. Person Centered Plan).

Child and Family Team (CFT) Interdisciplinary Team Meetings may include network provider attendance or telephonic participation in the planning team meetings (in any setting identified by the Care Plan Facilitator and family) that results in a formal coordinated care plan.

Providers working with IBHP members who have a behavioral health coordinated care plan such as a Person Centered Plan must use that member's coordinated care plan and corresponding clinical documentation (i.e. Person Centered Plan, CANS results, Comprehensive Diagnostic Assessment etc.) to identify the member's strengths and functional needs and to guide development of the member's overall behavioral health treatment and service specific treatment planning. Any clinical documents used for treatment planning should be maintained in the member record.

Given this is a new benefit; Optum would like providers to know:

- Child and Family Team (CFT) Interdisciplinary Team meeting is not a service contained in the 1915(i) State Plan Option, but is currently limited to the population accessing services via the 1915(i) State Plan Option.

- Case Consultation and/or treatment planning activities (any activities that occur outside of a planned behavioral health coordinated care plan meeting i.e. CFT Interdisciplinary Team Meeting), are not billable activities using the procedure code for CFT Interdisciplinary Team Meeting. CFT Interdisciplinary Team Meetings are scheduled expressly by a DBH Clinician identified as the Care Plan Facilitator.

- Attendance at a CFT Interdisciplinary Team Meeting with other treating professionals that is not expressly scheduled by a Department of Behavioral Health Care Plan Facilitator for the purpose of developing a Person Centered Plan and Wraparound Plan are not billable activities under this procedure code. Person Centered and Wraparound Plans are only facilitated by the Department of Behavioral Health.

- Travel Time to or from a CFT Interdisciplinary Team Meeting is not a billable activity.

Please refer to the Optum Level of Care Guideline for Child and Family Team (CFT) Interdisciplinary Team Meeting for additional information required to guide the provision of this service.

Qualifications: LMSW, LCSW, LPC, LCPC, Ph.D., MD, Bachelor level Paraprofessionals, and Certified Family Support Specialists.

Authorization: Prior authorization is not required for the benefit of Child and Family Team (CFT) Interdisciplinary Team Meeting. For services that do not require prior authorization, Optum will analyze claims information to identify outlier cases that may benefit from a clinical review.

Additional Services Available

Members who have been found eligible for Youth Empowerment Services Program services have access to all medically necessary services that are included in the Idaho Behavioral Health Plan. These services include comprehensive diagnostic assessments, treatment planning, case consultation, psychological and neuropsychological testing, psychotherapy services, family therapy, pharmacological management, Skills Building/CBRS, and support services. Please see the Level of Care Guidelines for Outpatient Services and the Provider Manual for details related to services not listed in this YES System of Care – Medicaid Services Provider Manual Section.