Provider Frequently Asked Questions

Strengthening Clinical Processes Training

CASE MANAGEMENT:

Q1: Does Optum allow Case Managers to bill for services provided when the Member is not present?

A1: Optum offers three codes for Case Management work:

- Telephonic Case Management: procedure code H0023
- Substance Abuse Case Management: procedure code H0006
- Behavioral Health Case Management: procedure code T1017

When H0006 and T1017 are used, the Member should be present, so that they may participate in achieving the case management goals.

Q2: We have medical providers who request that a case manager attend appointments with Members or they will not see them. What do we do in these instances?

A2: When a physician is treating a patient, they are reimbursed for that visit rather than another provider. It is not in the scope of work for a Case Manager to attend medical appointments with Members.

Q3: For Case Management: in the past we have been told that a case manager could attend medical appointments with a Member when medically necessary for care coordination, assessment, planning, and referral needs. Is this no longer allowed?

A3: It would be outside the scope of a Case Manager to monitor the quality or effectiveness of another provider's work. Attending medical appointments with Members has never been a billable activity.

Q4: On CM services on Page 43 of the Optum Provider Manual it states that "to coordinate and manage care between behavioral health and medical professionals…Coordination and communication should take place at: the time of intake, during treatment, the time of discharge or termination of care…"

A4: The quotes above (found on page 50 of the Provider Manual) can be found under the section entitled: Communication with Primary Physicians and Other Health Care Professionals. This section specifically addresses medical care professionals (e.g., physicians and medical specialists) and behavioral health clinicians. It is not addressing case management providers.

Q5: You briefly mentioned assessment tools for case management. Is there a separate assessment that needs to be used?

A5: The Case Management Level of Care Guidelines should have everything you need. Optum does not have a specific assessment tool.

Q6: Is the annual allotment for case management still in place?

A6: Yes, annual allotments for provision of the service over the course of a year are still in place. The Service Request Form is only necessary, for example, when you have a high risk Member and additional units are medically necessary based on the specific case management needs of the Member.

CBRS:

Q7: You mentioned CBRS having a beginning, middle, and an end, and of CBRS being a short term service for the client. What determines this – diagnoses or progress measures? Can you deepen our understanding of CBRS being short term?

A7: CBRS is a rehabilitative service. Rehabilitative services always have a goal of "restoration" of skills--which infers that a Member once had the skill but has lost it. (For children, services are not always "restorative" but sometimes address Member need for assistance with developing age-appropriate functional skills.)

- Beginning: Lost skill(s) identified on a treatment plan
- Middle: CBRS services are provided to restore lost skills (or for children to teach age-appropriate skills)
- End: Lost skills have been restored or have reached baseline functioning (as close to age-appropriate functioning as possible)

CBRS is not a habilitation service. (Habilitative services are supportive rather than restorative.) CBRS is a service that is provided during periods of intensity or episodes of need. There is a point in the provision of any rehabilitation treatment plan, in which the rehabilitation services being provided are no longer restorative in nature.

A Member discharged from CBRS does not exclude the possibility that he or she may again require CBRS again in the future; it just means restoration has occurred to baseline for that individual so that maximum benefit from skills training (rehabilitation) has been achieved.

Q8: To clarify, an EBP (Evidence Based Practice) will not be requested on the Service Request Form for CBRS for adolescents?

A8: You are correct. There is no evidence to support effectiveness of Psychosocial Rehabilitation for children or adolescents. However, Optum has always collaborated with providers on these cases to review each service request unique to the Member's described condition and circumstance. The review always uses the Level of Care Guidelines as the basis, along with the information provided on the Service Request Form to consider how CBRS for the child makes sense considering multiple factors including the child's needs for skills training, the identified issues, goals and expected outcomes, access, and other clinical indicators that were documented by the provider. In addition, functional deficits identified in the CAFAS/PECFAS may be used to address medical necessity considerations.

Q9: Is CBRS going to be authorized for 120 days now instead of 90?

A9: No, the standard review process for Optum remains at 90 days for CBRS.

CRISIS SERVICES:

Q10: For clarification, does Crisis remain under the retrospective review after the 40 units have been utilized?

A10: Crisis services do not require prior authorization, and only require a Service Request Form when the annual allotment of units has been exhausted. The provider should provide the crisis service, and then submit the Service Request Form to Optum as soon as possible following the provision of the service needed by the member.

PSYCHOTHERAPY:

Q11: Is there a number of family and individual psychotherapy visits a Member can have per year?

A11: Psychotherapy is provided based upon medical necessity, rather than unit limitations. However, if you seek extended session visits, 12 units per year are allotted for certain conditions where extended sessions are considered evidence-based practice. (See the related Level of Care Guidelines document for this service.) If the annual allotment of these units is exhausted, only then do you need to submit a Service Request Form.

PEER AND FAMILY SUPPORT:

Q12: Can a peer support person accompany a client to a doctor's appointment and bill?

A12: No, it is not the role of the Peer Support specialist to transport a Member to appointments, or to attend medical appointments with a Member. The scope of this service is to mentor the Member toward recovery and resiliency and get them engaged in needed services.

Q13: By a Peer Support specialist not being able to go to appointments with a client it has now defeated the purpose. Many clients need that extra support. The physician service and peer service are two completely different services.

A13: Simultaneous service provision is not supported in Medicaid policy and has never been allowable for Peer Support. As indicated above, the role of a Peer Support Specialist is to assist the Member in developing a recovery plan and engaging in treatment, in order to mentor the Member toward recovery and resiliency. It would be outside the scope of a Peer Support Specialist to attend medical appointments with the Member, and is therefore not a billable activity.

Q14: You stated that the calendar year for Family Support in 2017 will start July 1st. How will this impact Members currently receiving Family Support Services? Will Members requesting Family Support after July 1st be awarded 208 units?

A14: The annual allotment for Family Support Services will restart on July 1st for 2017 only, since this change is being implemented mid-year. If a Member is currently receiving Family Support, then the units available to them will refresh at that time to 208.

Q15: If 208 units for Family Support Services will be allocated over a year, it's actually a decrease in units. Can you please explain?
A15: Based upon the definition and intent for Family Support Services (and Peer Support Services) described in the Level of Care Guidelines, these services are to be provided episodically. Compared to national standards, Optum offers a robust allowance of units for use episodically over the course of a 12 month period.

Q16: Will we still only be able to request 90 day Prior Authorizations?
A16: Yes, the duration of services for services authorized remains 90 days.

NEUROPSYCHOLOGICAL EVALUATIONS

Q17: Where are the neuropsychological testing forms located?
A17: They have been updated as web based forms, but are still located on Provider Express. They are also available on the Optum Idaho website. The new web-based forms may be used now, but are not required until 8/1/17.

SERVICE REQUEST FORMS:

Q18: Do the Service Request Forms save the provider-specific information?
A18: Yes, the forms will pre-populate with the provider's demographic information, including email address of the attesting clinician once the provider has used the system.

Q19: Do the Service Request Forms save the Member-specific clinical information, such as psychiatric and medical history?
A19: No, we know that clinical information changes as a result of the provision of the service, and Members' conditions change as well. The service request should provide any of the clinical information essential to document these changes and justify the medical necessity of service being requested.

We are interested in what information has changed since the Member was last seen, e.g., just hospitalized, new Primary Care Provider, medications changed, etc. We already have the Member's historical information, so we're looking for what is new or has changed.

Q20: Can a Service Request Form be forwarded, for example if a therapist is out of town?
A20: Yes, they can be sent to a different clinician's email for attestation.

Q21: Will we be able to upload a Comprehensive Diagnostic Assessment (CDA) with a Service Request Form?
A21: Yes, an attachment feature will be included in the new portal. However, the Service Request Form needs to be populated with the relevant clinical information from the CDA, as we validate the medical necessity of the request (stipulated by Level of Care Guidelines) using the information on the Service Request Form.

Q22: Many agencies have multiple people using the same computer so the auto log-in would be counter-productive. Is there a way to avoid the auto log-in to the Service Request Form page?
A22: The log-in is not based on the computer in use, but rather the combination of a staff person's name, email address, and NPI number.

Q23: Can more than one person work on a Service Request Form, e.g., a clinician starts a Service Request Form and then someone else completes it?
A23: No, the same staff needs to start and complete the request. The system identifies each request by provider name, email address, and NPI number. The same provider who starts the Member's request should complete it.

Q24: What is your anticipated length of time the form will take to fill out?
A24: The new web-based process was designed with the hope that completion of the form will take less time than the current process. We anticipate that there will be a short period of time required to become familiar with it, which is why we are allowing providers the month of July to learn the new process.

Q25: Can you print the Service Request Form?
A25: Yes, you can print it for your records and also do a search within all of your requests.

Q26: Can you save the Service Request Form and finish it later?
A26: Yes, you can save each section and complete it at a different time.

Q27: Which forms require attestation by a licensed provider?
A27: CBRS and Partial Care.

Q28: Why are you now requiring attestations?
A28: We are seeking the clinician who is providing oversight for CBRS (Clinical Supervisor) or the diagnosing clinician as the attester in order to assure that the CBRS treatment plan is accurately reflecting the Member's diagnosis, conditions and symptoms. We need to ensure the diagnoses match what has been provided by licensed clinicians and are appropriate based on the Member's condition.

Q29: Are only independently licensed providers allowed to attest on the Service Request Form, or can LMSWs also complete attestation?
A29: Because the Idaho Board of Occupational Licensing does not allow independent practice for LMSW, they may not supervise, diagnosis, or independently sign off on any assessments. For these reasons, a LMSW also may not attest to a Service Request Form.

Q30: Who do you want to attest, the diagnosing or supervising clinician?
A30: It is your choice. Either the diagnosing or supervising clinician is appropriate.

Q31: Can the attesting clinician make changes to the request form before submission?

A31: The attester cannot modify the form, but they can send the requesting provider a message about their issues or ideas should they have questions and/or concerns. The requesting provider may then edit the form and resubmit to the attester.

Q32: Is the attestation and peer-to-peer call done only with the clinical supervisor or the LCSW/LMSW that is the Member's primary provider?

A32: An attester must be a licensed independent professional who is the diagnosing provider or the CBRS Clinical Supervisor, who must be independently licensed as well. The attesting provider may be a clinician, a mid-level professional or a physician. Optum does not mandate which provider type contacts us for clinical discussions.

Q33: Who attests if the Member was recently discharged from the hospital?

A33: The agency that is treating the Member would have the clinical supervisor attest to the hospital's discharge documentation or provisional diagnosis. In cases in which the Member doesn't have Medicaid eligibility, the agency would submit a request for a retrospective review once a Member becomes eligible.

Q34: So If I have 5 LMSW's in my office that submit service requests, these will all be sent to a clinical director to be email reviewed? If this is the case, why is Optum making more steps in the process, hence wasting more money and time from providers?

A34: Network providers have a supervisory protocol that is part of their contract with Optum. Providers must also comply with the State Licensing Board related to their profession. LMSW level staff are not allowed by the Idaho Board of Occupational Licensing to "independently" assess, diagnose or treat. Thus, Optum does not accept an LMSW signature for an attestation. The role of the attester is to confirm they agree with the diagnosis and the Member's need for service.

Q35: It looks like you are asking our clinical staff to assist with Utilization Management, correct?

A35: Per the provider contract with Optum, providers are to demonstrate the medical necessity of the request they are submitting using the Level of Care Guidelines. The Optum Care Advocates complete clinical reviews of the requests submitted to determine medical necessity.

Q36: If there are questions about the Service Request Form, who will the Care Advocate call back, the requesting or attesting provider?

A36: We will contact the provider who has submitted the service request; however, Optum may outreach to other medical providers as needed.

Q37: How long are you estimating it will take between submission of request for service and the receipt of denial letter, especially if it goes to medical director?

A37: Optum continues to operate and comply with the Medicaid regulated turn-around time for a service request, which is 14 days. There is an expedited process, which can be requested per the provider alert recently distributed; however, these situations are rare as Optum Idaho is only managing outpatient services.

PEER-TO-PEER CONVERSATIONS AND APPEALS:

Q38: Regarding provider requests for an appeal: How should providers expect the scheduling to occur? Will it be around the provider's schedule? What time of day should we expect these appeals to occur? How much time will the providers be allotted?
A38: Appeal determinations are based off the documentation submitted with the appeal request. Appeals are a Member right, and starting July 1st providers will be required to obtain Member written consent before appealing an adverse benefit determination on behalf of the Member. Instructions on how to file an appeal are included in the adverse benefit determination letters sent to Members and providers.

Also beginning July 1st, the provider's copy of the Adverse Benefit Determination letter will also include instructions on how to request an appointment to speak to a Medical Director about the basis of the determination. Optum will have a Medical Director available daily for these calls. After receiving your call, our Clinical Team Assistants will schedule a 15 minute phone call with you the following day, or on a day of your choice. A Medical Director will call you at that scheduled time to discuss the basis of the determination. Appeals and complaints are not in scope for these calls – they are strictly to discuss the basis of the adverse benefit determination.

Q39: How long do we have to request a Peer-to-Peer conversation after the denial letter is sent?
A39: You may request the Peer-to-Peer conversation within 60 days after the date of an Adverse Benefit Determination letter.

Q40: If the client is notified of a denial before the provider is, the provider will have difficulty explaining to the Member.
A40: As is our practice currently, both the provider's and the Member's Adverse Benefit Determination letters are mailed on the same day.

Q41: If a service request is denied and a Peer-to-Peer conversation is requested, can the Optum Medical Director overturn the initial denial?
A41: The determination cannot be modified unless an appeal is requested and the decision is overturned. A determination will be made by an Optum Medical Director as the result of their review of the service request. When a service is determined not medically necessary, an Adverse Benefit Determination letter will be mailed to the provider and the Member. Once you receive this letter, you may call us at 1-855-202-0983, and press "1" to schedule a call with a Medical Director to understand more about the decision and determine whether you want to file an appeal. In addition, the Member (or their representative) may also file an appeal.

Q42: Can providers speak with a Medical Director prior to a decision?
A42: If the request is denied, providers will be able to schedule time with a Medical Director 24 hours after you call. The purpose of this conversation is not to change the determination, but rather for the provider to understand more about the determination and to see if an appeal is warranted. However, providers may still reach out to us at any time by calling 1-855-202-0983 and pressing "1".

MISCELLANEOUS:

Q43: Regarding the in-home therapy add-on code: If we have a client that is dual-eligible (Blue Cross and Medicaid), can we bill Optum for the add-on code if their primary insurance covered the full amount of the session? Would we only bill Optum for the add-on code? Or attach the COB?

A43: As always, payment relies on active state eligibility with Optum Idaho at the Date of Service. Each case may have claims nuances that need to be addressed specifically. Our customer service team is available to assist you with any billing questions you may have related to dual-eligible Members or other types of claims questions. You may reach them by calling the provider line at 1-855-202-0983 and pressing 3.

Q44: Are you providing claims overview training?

A44: This training is focused on clinical processes, but if you call the Customer Service team at 1-855-202-0983, and press 3, and they can walk you through any questions you may have.

Q45: In regard to these "national standards" referred to during the course of the presentation: Are these standards from states with the limited array of services similar to Idaho, or are they from states with a wide array of services?

A45: Optum has adopted Best Practice Guidelines that have been developed by nationally recognized organizations. Evidence-based practice is established using clinical evidence from systematic research that establishes the effectiveness of the service. In this way, Optum assures that Members are receiving the specific care that is demonstrated to produce the optimal outcomes for their stated condition. National guidelines apply to all geographic locations.

Q46: Where are the Evidence-Based Practice guidelines listed?

A46: A variety of guidelines are listed on Provider Express: the American Psychiatric Association, American Psychology Association, and the Substance Abuse and Mental Health Services Administration (SAMSHA). They are also referenced within the Level of Care Guidelines.

Q47: Is there a template for review processes and/or exceptions?

A47: Optum care advocates use the Level of Care Guidelines to review cases. Their questions for providers during a clinical review are related to this document.

Q48: What timeframes do providers have to learn the forms and Level of Care Guidelines?

A48: The Level of Care Guidelines are effective 7/1/17. The new Service Request Forms will be available 7/1/17, but not required until 8/1/17. This meets our contractual requirement to let providers know 30 days in advance.

Q49: What are the new authorization periods?

A49: Authorization periods are not changing, other than what is described above regarding the Family Support authorization period. It is being modified from a 6-month period to a 12-month period (Calendar Year Authorization).

Q50: Can you give a definition of what you mean by SED?

A50: Per Idaho Statute Title 16, Chapter 24, Serious Emotional Disturbance (SED) is an emotional or behavioral disorder, or a neuropsychiatric condition which results in a serious disability, and which requires sustained treatment interventions, and causes the child's functioning to be impaired in thought, perception, affect or behavior. A disorder shall be considered to "result in a serious disability" if it causes substantial impairment of functioning in family, school or community. A substance abuse disorder does not, by itself, constitute a serious emotional disturbance, although it may coexist with serious emotional disturbance.

Q51: What is your definition of para-professional?

A51: A para-professional is defined as a person who is qualified to provide a specified service through direct care, when this level of staff is allowed based upon the definition of the service. Para-professionals also must be appropriately supervised by someone who is an independently licensed clinical professional. For more information about this, see the supervisory protocol that is part of the network agreement you hold with Optum.