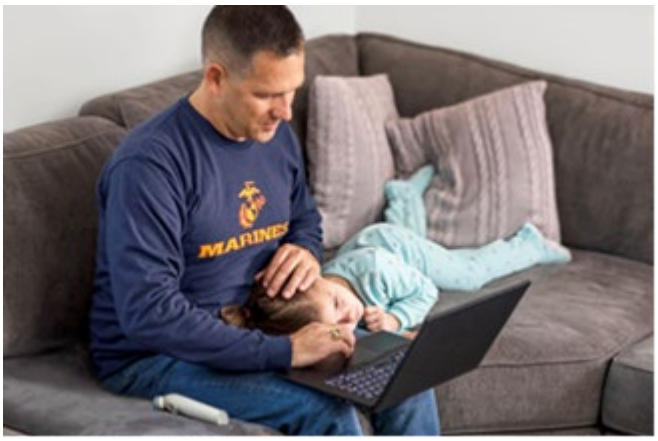
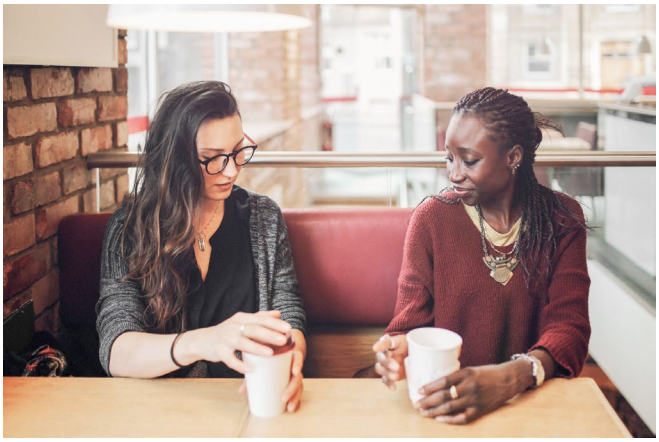
# California Network Manual



## December 2024 Edition

Providerexpress.com


U.S. Behavioral Health Plan, California doing business as Optum and OptumHealth Behavioral Solutions of California
BH00802-24-MAN_December 2024

# Important Notice

The Network Manual applies to all types of business managed by Optum[1] and OptumHealth Behavioral Solutions of California[2].

Throughout the manual, the name “Optum” is generally used to refer to both Optum and OptumHealth Behavioral Solutions of California. In a few specific instances, there are procedural or regulatory differences that apply specifically to OptumHealth Behavioral Solutions of California business that is regulated by the California Department of Managed Health Care (DMHC). In those situations, you will note separate, bold headings for OptumHealth Behavioral Solutions of California (“OHBS-CA”) and Optum. It is important to note that DMHC regulations may not apply to all California residents, Clinicians or Facilities in all cases.

[1] United Behavioral Health operating under the brand name Optum
[2] U. S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

# Table of Contents

# Change Index

*(NOTE: The change index does not include minor changes to content or formatting)*

| SECTION | PAGE(S) | CHANGE TO CONTENT |
|---|---|---|
| **Frequently Asked Questions** | 13<br>16<br>19 | • Clarified billing for MH/SUD services not performed by provider in office<br>• Added EWS portal *supportfinder.optum.com* for EAP prior authorization services<br>• Changed mailing address location for Optum PNI Department |
| **Glossary of Terms** | 29 | • Added new DMHC criteria for Qualified Autism Service Professional - A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology. |
| **Network Requirements** | 37<br>39<br>41 | • Clarified the certification for ABA Paraprofessionals or Behavior Technicians State regulatory requirements may supplement, modify or, in some cases, supersede this policy<br>• Clarified where providers should make demographic changes on the *Provider Express* secure portal, Providerexpress.com, when to call the Provider Service Line (PSL) number and who to contact for various other information or status changes<br>• Incorporated Unavailable status into a new Appointment Availability Section to clarify time standards for provider status updates |
| **Benefit Plans, Authorizations, EAP/EWS and Access to Care** | | |
| Routine and Non-Routine Outpatient Services | 46<br>47-48<br>48<br>48-49 | • Section added for Support for Members Looking for Care<br>• Section on authorization for MH/SUD benefits rewritten for clarity<br>• Updated chart to reflect that Electroconvulsive Therapy (ECT) no longer requires prior authorization for Outpatient Services<br>• Added new path to request authorization for Applied Behavioral Analysis (ABA) Assessment<br>• Added link to new ABA webpage on *Provider Express*<br>• Sub-section added for Crisis Care<br>• Added Outpatient Care Engagement language to Clinical Outcomes Models |

| SECTION | PAGE(S) | CHANGE TO CONTENT |
|---|---|---|
| | 49<br><br>49-50<br>50-51<br><br>51-52 | • Added Measurement Informed Care to Wellness Assessment language<br>• Practice Management section updated<br>• Added Emotional Wellbeing Solutions (EWS) clarification language<br>• Added that providers can use the Wellness Assessment or other clinically validated tool for EWS |
| Complex Case Management | 52-53 | • Added screening tools used for Complex Case Management (CCM) program |
| Psychological Testing | 54 | • Clarified pre-authorization requirements and billing requirements for inpatient or facility admission |
| Access to Outpatient Mental Health and EAP Care | 54-55 | • Updated to outline appointment standards for Commercial, Medicare and Medicaid plans separately; updated standards as needed for accuracy. |
| **Treatment Record Documentation Requirements** | 69-70 | • Added information to clarify requirements and timelines to respond to medical record request requests in a timely manner |
| **ACE – Clinicians** | 78 | • Section deleted as the ACE Clinicians program has ended |
| **Provider Reconsideration and Appeal** | 94-95 | • Added language to clarify the 2-step process does not apply to Medicaid plans. |

# Introduction

## Welcome

Thank you for becoming a part of our network. We are happy to welcome you and have you as a partner. Optum is dedicated to helping people live healthier lives and making the health system work better for everyone. We connect people to an extensive network of quality providers and offer innovative tools that help members access care, at the right time, in the setting of their choice. Our focus is on driving better overall health outcomes for members while making the care they receive more affordable, improving the provider experience and generating insights that drive high-impact, integrated behavioral health services.

We encourage you to use the *Provider Express* website for access to clinical guidelines, reimbursement policies, administrative updates and state-specific news. The website is also how you'll access our secure portal. Once you log in with your ID and password, you'll be able to complete patient- and practice-specific tasks such as checking member eligibility and benefits or updating practice contact information, all at your preferred time and pace. The secure portal is available 24/7. We continually expand our online functionality to better support your day-to-day operations, so be sure to check back regularly for updates.

Please take time to familiarize yourself with all aspects of the Network Manual. We've included an easy reference Resource Guide and FAQs to help get you started.

Optum is confident that together we can tackle the challenges facing the behavioral health industry and bring greater precision, speed, and ease to how people obtain behavioral health services. Your voice is important and we encourage you to reach out with feedback, ideas or questions. We'd love to hear from you.

The Optum Behavioral Health Team

# About U. S. Behavioral Health Plan, California and Optum

U. S. Behavioral Health Plan, California (USBHPC) is a wholly owned subsidiary of United Behavioral Health (UBH). UBH was officially formed on February 2, 1997, via the merger of U.S. Behavioral Health, Inc. (USBH) and United Behavioral Systems, Inc. (UBS). UBH is a wholly owned subsidiary of UnitedHealth Group. U.S. Behavioral Health Plan, California was incorporated on May 6, 1988 in the state of California. It is licensed as a specialized health care services plan under the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act).

In 2012, UBH began operating under the brand Optum and in 2024, USBHPC began doing business as Optum and OptumHealth Behavioral Solutions of California.

Optum is one of the nation's largest accredited managed behavioral health care organizations, supported by an extensive behavioral provider network of more than 450,000 Practitioners. We offer a comprehensive array of innovative and effective behavioral health care programs, as well as tools and additional support that inspire people to be invested in their own wellness.

Today, our customers include small businesses, Fortune 100 companies, school districts, Health Plans, and disability carriers. Optum and OptumHealth Behavioral Solutions of California provide coverage/services for approximately 148 million members.

Throughout this manual, the name "Optum" is used to refer to both OptumHealth Behavioral Solutions of California (USBHPC) and Optum (UBH) business unless specifically stated otherwise.

## Optum

Optum is dedicated to helping people live healthier lives and helping make the health system work better for everyone. Optum is a health services innovation company pushing the boundaries of what health care can be. People are at the center of everything we do. We are focused on giving everyone great experiences, lower costs and the best possible results. We do this by connecting people, technology, clinical insights, data and analytics to find a smarter way for every person to live their healthiest life.

By connecting people, clinical insights, data and technology we can make whole person care a reality and enable business breakthroughs that lower costs. We help deliver bold new health experiences to drive better outcomes and empower all to live their healthiest life.

Optum supports population health management solutions that address the physical, mental and financial needs of organizations and individuals – 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 delivers simple, effective and comprehensive solutions to organizations and Consumers across the whole health system through our three business units - OptumHealth, OptumInsight and OptumRx®.

# Resource Guide

## Websites

### Provider Express Secure Portal

The *Provider Express* secure portal gives you access to patient- and practice-specific information that helps you check member eligibility and benefits, check prior authorization requirements and submit requests, get updates on claims, reconsiderations and appeals, and more. It is available to network clinicians and group practices, as well as out-of-network individual clinicians.

**Register for Access**

The secure portal is accessed from the provider website **Providerexpress.com.** You must register for a One Healthcare ID and password to access the secure portal. Select the "First-time User" link in the upper right-hand corner of the home page and follow the prompts.

The Training tab has how-to guides and videos that show you how to access and use many of the features available on the secure portal

**Secure Transactions**

With access to the *Provider Express* secure portal, you can:

- Submit initial credentialing application and check status of initial credentialing
- Check member eligibility and view benefit information, including authorization requirements
- Request authorization or complete notification for higher levels of care
- View authorization details
- Update provider and practice information:
  - Add NPI
  - Add taxonomy code(s)
  - Update ethnicity, languages spoken and other areas of expertise
  - Update email address
  - Update provider gender
  - Add Medicaid/Medicare numbers
  - Manage address locations, including practice, remit, 1099 and credentialing
  - Update phone and fax numbers
  - Change availability status for accepting new patients
  - Update office information, including weekend or evening practice hours, wheelchair accessibility, public transportation access, etc.
- Submit professional claims and view status
- Request claim adjustments
- Request claim or clinical appeals
- Access Provider Remittance Advice statements
- Attest to participation in telehealth
- View performance dashboards
- Obtain pre-populated Wellness Assessments
- Attest to accuracy of directory information
- Send secure messages to Optum using the Message Center
- Create and maintain My Patients list
- Add and manage other users' access (Admin-level users only)
- Link to the clinician version of *liveandworkwell.com* to obtain patient education resources in English and Spanish (see "**Live and Work Well**" section below)

## Provider Express Public Website

The **Provider Express website** has information and updates to help us work together – from changes to administrative processes and state-specific information, to product-specific news and other topics. In addition, there are Quick Links to frequently accessed pages:

- **Behavioral Health Toolkits**
- **Claim Tips**
- **Add/Update Clinician Tax ID Form**
- **General forms**
- **Clinical Criteria and Guidelines**
- **MAUD/MOUD**
- **Navigating Optum**
- **Optum Pay**

## Live and Work Well

**Liveandworkwell.com** is our primary member website. It provides resources and patient education in English and Spanish. Information on the site is customized according to the member's benefit packages. On this site, members can:

- Manage behavioral health benefits:
  - Check eligibility/benefits
  - Submit/track claims
  - View claim status
  - Submit out-of-network claims
- Request services
- Identify network clinicians and facilities
- Take self-assessments
- Locate community resources
- Find articles on wellness and daily living
- Take computer-based trainings to learn about:
  - Depression
  - Anxiety
  - Stress
  - Alcohol & Drug Use
- Access Parent/Teen/Child integrated medical/behavioral information on adolescent health

Members can also explore articles and other resources on the following topics:

- Mental health
- Wellbeing
- Work
- Relationships
- Caregiving
- Crisis support

## Emotional Wellbeing Solutions (EWS) Services / Employee Assistance Program (EAP)

- Emotional Wellbeing Solutions (EWS) is a modern and flexible Employee Assistance Program (EAP) that offers support for everyday life
- Upon completion of EAP services, you may refer for, or begin provision of, most routine outpatient services for clients whose benefits are administered by Optum
- The Statement of Understanding is a form that describes the scope and limitations of EAP services, signed by both you and the member
- EAP Claim submission can be done through the Provider Express secure portal
- You may see EWS and EAP used interchangeably throughout this manual.

## Wellness Assessments

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 seeking treatment completes this form
- Youth Wellness Assessment — The parent or guardian completes this form when the individual you are seeing is a minor

Review **detailed instructions and access the Wellness Assessment**. Questions? Email us at **WellnessAssessmentDashboard@optum.com**.

## Claims and Customer Service

Information for claims and customer service issues can be found on the **Contact Us webpage.**

## For Further Assistance

**Providerexpress.com** and the Provider Express secure portal (accessed via **Log In** on Providerexpress.com) are available 24/7. You can check patient and practice information, review guidelines and policies, complete many administrative tasks and review the latest news and information – all without calling.

If you're not able to locate the information you need in the secure portal or on the website, you can also call the Provider Service Line at **1-877-614-0484,** Monday-Friday, 5 a.m. to 5 p.m. PT.

# California Provider Contact List

<table>
<tr><td>Provider Demographic and Availability Updates<br>CA regulations require you update us within 5 days of changes to your availability and 10 days for any demographic change to your practice.</td><td colspan="3">• Providerexpress.com*<br>• Fax: 1-866-641-5947<br>• Phone: 1-877-614-0484<br>The most efficient and timeliest way to update availability, specialty and demographic information is by submitting your request online using Providerexpress.com. (Contract related changes should be submitted to Provider Relations-see below)<br>*Login using your One Healthcare ID or obtain one by selecting "First-time User" link in the upper right corner of the home page.</td></tr>
<tr><td>Optum Provider Line<br><br>(Phones are answered 24 hours a day, 7 days a week)</td><td colspan="3">1-800-333-8724<br>• Intake and Care Management, including authorizations.<br>• Claims Status & Inquiry<br>• Member Eligibility & Benefits<br>Employee Assistance Program (EAP)<br>Authorization and Benefits<br>1-866-248-4094<br>Members may have account-specific customer service numbers. Call the phone number listed on the provider remittance advice or member ID card.</td></tr>
<tr><td>Scheduling Appointments<br>(Clients referred must be seen<br>within the indicated time frame)</td><td colspan="3"><table><tr><th>Appointment Type</th><th>Mental Health</th><th>EAP</th></tr><tr><td>Routine/Non-Emergency</td><td>Within 10 business days</td><td>Within 10 business days</td></tr><tr><td>Urgent</td><td>Within 48 hours</td><td>Within 24 hours</td></tr><tr><td>Emergency</td><td>Same day</td><td>N/A</td></tr><tr><td>Follow-Up Care - Mental Health/Substance Use Disorder (non-physician) Follow-Up Appointment</td><td>10 business days from prior appointment</td><td>N/A</td></tr></table></td></tr>
<tr><td>Claim Submission<br>(Payor ID 87726)</td><td colspan="3">Optum<br>P.O. Box 30760<br>Salt Lake City, UT 84130-0760<br>We recommend you submit claims on Providerexpress.com, a time-saving and secure method designed to streamline the claim submission process.</td></tr>
<tr><td>Provider Relations & Contracting</td><td colspan="3">Phone: 1-877-614-0484<br>Provider Relations and Contracting are responsible for developing and maintaining the Optum network of providers and can assist with questions related to network participation and/or credentialing.</td></tr>
<tr><td>Appeals & Grievances</td><td colspan="3">P.O. Box 30512<br>Salt Lake City, UT 84130-0512<br>Fax: 1-855-312-1470 | Phone: 1-800-985-2410</td></tr>
<tr><td>Wellness Assessment Forms</td><td colspan="3">P.O. Box 27430<br>Houston, TX 77277<br>Fax: 1-800-985-6894 | Phone: 1-877-369-2198</td></tr>
<tr><td>Provider Express Support</td><td colspan="3">1-866-209-9320<br>(Online chat support is also available at Providerexpress.com)</td></tr>
<tr><td>Language Assistance Program</td><td>1-800-999-9585</td><td>Hearing & Speech Impaired Line</td><td>1-800-842-9489 (TTY)</td></tr>
</table>

# Frequently Asked Questions

## Network Requirements

### How do Network Lease Partnerships work?

Some patients may have access to Optum network discounts through Network Lease Partners. All claims for members accessing your services through these arrangements are processed, paid by, and the responsibility of the Network Lease Partners and not Optum. Please submit claims directly to these Network Lease Partners for processing. Claims submission information is available on the Member's ID card.

### Do I have to notify anyone if I change my name, address, telephone number, accepting new patient status, language capability, or Tax Identification Number?

Yes. You are required to notify us within 10 calendar days, in writing, of any changes to your practice information, unless otherwise required by applicable state or federal law. This is especially important for accurate claims processing and the accuracy of the provider directory for members. We encourage you to make such changes by going to *Provider Express* to update your practice demographics.

### As a contracted facility, are we required to notify Optum if we discontinue or change a program, service or location? What if we add programs, services or locations?

Yes. You need to contact your Contract Manager whenever you add, change or end any programs, services or locations you offer. If you're not sure who your contract manager is, you can call the Provider Service Line at **1-877-614-0484**.

### Can I be considered a participating clinician at one practice location and non-participating at another?

If you are an individually credentialed/contracted clinician with Optum Behavioral Health, you are a participating (contracted) clinician at all practice locations. Your Participation Agreement is not specific to a particular location. We encourage you to keep your demographic information and accepting new patient status up-to date with all locations where you see patients. This can help avoid delays in claim processing and ensure a positive experience for members needing care.

### Since our facility or practice group is contracted, does that mean all of our affiliated clinicians are considered participating network clinicians?

No. Generally, only clinicians credentialed with Optum are considered network clinicians. The Optum network status of a facility or group does not guarantee that all clinicians in practice there are network clinicians. In situations where an agency is credentialed by Optum, their affiliated clinicians are not credentialed but are considered participating under the Agency's Agreement.

When you add clinicians to your group or facility, you should not assign clients to the clinician until you confirm that they have been added to the network. Any claim submission for a rendering clinician who has not been added to the network is subject to denial.

### May I bill for Mental Health/Substance Use Disorder (MH/SUD) services that another practitioner, intern or assistant provides to Optum members in my office?

Optum will reimburse for outpatient behavioral health services rendered by unlicensed practitioners working towards clinical licensure or other practitioners not eligible to practice independently, as governed by state licensing and scope of practice rules and regulations. This applies to all Commercial health plans in California. For billing information, please be sure to follow the most current reimbursement policy available on *Provider Express*.

### If my practice is filling up or if I am going to take a leave of absence from my practice, may I choose to be unavailable for new Optum referrals?

Yes. Individual clinicians should keep their appointment availability status up to date for all active practice locations. To do so, you'll need to update your demographic information using one of the two options outlined below. Note that your Participation Agreement requires you to adjust your appointment availability status within 10 calendar days of when you're no longer able to see new patients or when you have capacity to do so.

There are two ways to do this:

| Method | Details |
|---|---|
| **Online via the Provider Express secure portal** | • Go to **Providerexpress.com** to login (upper right corner) with your username and password<br>• Select My Practice Info from the Menu at the top of the page, then select the type of information that needs to be updated from the drop-down menu<br>  ○ For appointment availability, select "no" to the question of if you are accepting new patients, then select the reason from the drop-down menu.<br><br>Review the **training guide** for assistance |
| **Provider Service Line** | **1-877-614-0484**, Monday – Friday 5 a.m. – 5 p.m. PT |

Most updates are reflected in Optum Behavioral Health internal systems in real time. Directory updates are made nightly and will be reflected in your listing the next day. Group practices and facilities/agencies that wish to be designated as unavailable should call the Provider Service Line at **1-877-614-0484**.

### What if I'm taking a leave of absence or medical leave? Can I indicate that in the directory?

Yes. Individual clinicians may be designated as "unavailable" at one or more practice locations for up to six months at a time. To do so, you'll need to update your demographic information through one of the options noted above and select "no" to the question of if you are accepting new patients our directory listing would then be updated within 24 hours. Note that while on unavailable status, your Participation Agreement remains in effect. Group practices and facilities/agencies that wish to be made unavailable should contact Provider Relations.

Before being listed as unavailable, you're responsible for:

- Informing patients about your leave (start date, end date, who to contact with questions, etc.)
- Ensuring your current patients are referred to another network provider for behavioral health care in your absence, including what to do in an emergency situation

### Are there procedures to follow if I withdraw from the Optum network?

Yes. The terms and conditions for withdrawal from the network are outlined in your Participation Agreement. For more information or to start the process, contact your Contract Manager. If you're not sure who your contract manager is, you can call the Provider Service Line at **1-877-614-0484**. More information can be found in the "**Continuation of Services after Provider Termination"** section of this manual on page 44.

## Benefit Plans, Authorizations and Access to Care

### How can I review a member's benefits and eligibility?

The fastest way to determine eligibility and benefits is using the *Provider Express* secure portal. This tutorial gives step-by-step instructions on using the portal to obtain this information. You may also call the provider services phone number located on the back of the member's ID card.

Services and/or conditions not covered under the member's specific benefit plan are not eligible for payment. We comply with regulatory requirements related to coverage election periods and payment grace periods. These requirements can lead to delays in our knowledge of a member's eligibility status. As a result, we recommend you check with the member at each visit to ensure you have up-to-date health plan information.

### Can members initiate authorization of benefits for routine outpatient MH/SUD services?

Typically, authorization for routine outpatient services is not required. Members may use liveandworkwell.com directory to search for network providers.

### Do any Benefit Plans require prior authorization for outpatient treatment?

Most benefit plans do not require prior authorization for routine outpatient services. To check a plan's requirements, you can use the *Provider Express* secure portal. You may also call the provider services phone number located on the back of the member's ID card.

### What constitutes a "non-routine" outpatient service?

Non-routine services include services such as psychological testing and intensive outpatient care. These services typically still require authorization of benefits prior to providing those services. To obtain those authorizations, please go to *Provider Express* or call the number on the Member's ID card.

### What if I see someone due to an unforeseen crisis?

In situations where there may be an unanticipated need for a crisis session, use/bill CPT 90839. The crisis treatment session should be a minimum of 30 minutes to a maximum of 74 minutes rendering psychotherapy for a crisis. If the session goes beyond 74 minutes use CPT 90840 for each additional 30 minutes you spend with the member. (List the increments separately from CPT 90839 for the primary session). Prior authorization is not required for crisis sessions.

Documentation should reflect the crisis and time spent with the patient.

### Is the Wellness Assessment (WA) administered more than once?

Yes. The WA is administered at the first session or in the second session if the Member presents in crisis during the first session. It is administered again preferably at the third visit but may be given at either the fourth or fifth visit. The exact timing is at the clinician's discretion.

### Is there a way to ensure confidentiality with the Wellness Assessment (WA) for emancipated minors who are requesting services?

Yes. In these circumstances, you should only complete the demographic sections located at the top of the WA and return it to Optum. Fill in the bubble labeled "MRef" for Member refusal. A follow-up assessment will not be sent to the adolescent's home.

### Where can I get more information about the Wellness Assessments?

Please refer to the **"Benefit Plans, Authorization, EAP/EWS and Access to Care"** chapter of this manual or the **Wellness Assessment** information on the *Provider Express* website.

### Can I make referrals directly to other Optum network clinicians?

You or the member may identify network clinicians in 1 of 3 ways:

- Use the **Find a Provider** tool on *Live and Work Well*
- Review the **Clinician Directory** on the *Provider Express* website
- Call Optum using the number on the member's ID card

Typically, authorization for routine outpatient services is not required. Prior authorization may be required if referring a member for non-routine outpatient services such as psychological testing, intensive outpatient services or other higher levels of care.

## Employee Assistance Program (EAP) / Emotional Wellbeing Solutions (EWS)

### What is the Employee Assistance Program (EAP)?

EAP is a health and wellness service provided by an employer. It is designed to provide assessment and referral, as well as a brief counseling intervention for members and/or their families. **The Optum EAP is known as Emotional Wellbeing Solutions (EWS)**.

### How can I become identified as an EWS provider?

Optum does not have a separate EAP network. All Optum-contracted therapists can provide and bill for EAP services and are encouraged to participate. As a participating network therapist, you earn the same contracted rate for EAP services as for routine outpatient therapy services, and you are reimbursed directly from Optum.

**Note**: There are limitations around the use of EWS benefits with psychiatrists.

**Learn more** about providing EAP services and how to update your directory listing to reflect that you accept EWS clients.

### Do EAP services require prior authorization?

Yes. EWS benefits require prior authorization and an initial authorization may be obtained by the Member or by the provider. Members may make the authorization request by phone or via the EWS portal ***supportfinder.optum.com***., Providers making an authorization request on behalf of a Member should call **1-866-248-4094**. The Member will receive an EWS authorization letter and is instructed to bring that to their initial session.

### Do I need to obtain prior authorization for members who transition from EWS to Optum MH/SUD benefits for routine psychotherapy services?

Typically, authorization for routine outpatient services is not required upon completion of EAP services.

### Does use of EWS benefits change authorization or notification requirements for mental health/substance use disorder (MH/SUD) services?

No. You may check a member's benefits and eligibility requirements through *Provider Express* or by calling the number on the Member's ID card.

### If a member I am seeing through EWS benefits requires medication management services, is prior authorization of MH/SUD benefits required?

No. Medication management services under MH/SUD benefits do not require prior authorization. However, however these services are not included in most EWS benefits. If a member requires medication management services, they should be referred to a prescriber to provide these services under their behavioral health benefit.

### Am I required to give a Wellness Assessment (WA) to a Member transitioning from EWS benefits?

Yes. All Optum members should be offered the Wellness Assessment. If the member reports having already completed a Wellness Assessment with the EWS clinician, it is not necessary to complete an assessment during your initial session with the member. However, you should administer the Wellness Assessment at either session three, four or five.

### Do EWS benefits require a new authorization when a new benefit year begins?

Yes. You will need to obtain a new EWS authorization when a new benefit year begins. Remember to ask the Member for a copy of the EWS authorization letter to note the expiration date of the authorization.

### Is there a time frame in which I may seek a retrospective review of services that were provided but not previously authorized?

Yes. On occasion, emergent or other unusual circumstances will interfere with the pre-authorization processes. In those cases, requests for a retrospective review of services must be submitted within 180 calendar days of the date(s) of service unless otherwise mandated by state law.

## Treatment Philosophy

On the **Guidelines/Policies & Manuals** page of *Provider Express*, you can find information regarding various guidelines and clinical criteria used by Optum, including:

- ASAM criteria
- CALOCUS-CASII
- ECSII

- LOCUS Behavioral clinical policies
- Clinical practice guidelines
- State/contract specific criteria
- Supplemental clinical criteria

### Am I expected to coordinate care with a Member's primary care physician or other health care professionals?

Yes. We require network clinicians to pursue coordination of care with the Member's primary physician as well as other treating medical or behavioral health clinicians. A signed release of information should be maintained in the clinical record. If a Member declines consent to the release of information, his or her refusal should be documented along with the reason for refusal. In either case, the education you provide regarding risks and benefits of coordinated care should be noted.

### How can I learn more about Recovery & Resiliency?

Optum considers Recovery & Resiliency to be important in the provision of behavioral health services. For more information, see the **Recovery & Resiliency Toolkit for Providers** on *Provider Express*.

## Confidentiality of Records

### Do HIPAA regulations allow me to exchange Protected Health Information (PHI) with Optum?

Yes. The HIPAA Privacy Rule permits clinicians and Optum to exchange PHI, with certain protections and limits, for activities involving Treatment, Payment and Operations (TPO). An individual's authorization for ROI is not required by HIPAA in these cases (though disclosures should be consistent with any other applicable federal or state privacy law)[1]

[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.

## Quality Improvement

### Does Optum audit clinicians and facilities?

Optum representatives conduct site visits at Clinician offices, Agencies, such as Community Mental Health Centers (CMHCs), Facilities and Group Provider locations. On-site audits are routinely completed with CMHCs and Facilities 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 facility environment. For additional information, please see the "**Quality Improvement"** chapter of this manual.

## Compensation and Claims for Further Assistance

### Can members be billed prior to claims submission?

No. Members are never to be charged in advance of the delivery of services, with the exception of applicable co-payment. Members should be billed for deductibles and co-insurance after claims processing yields an Explanation of Benefits indicating Member responsibility.

### Is there one format to be used for diagnosis on claims?

Yes. Submit your claims using the industry-standard ICD-10 code.

### Is there an easy way for me to determine where to send my claim?

Claims submitted electronically through either EDI or the *Provider Express* secure portal are automatically routed to the appropriate claim platform.

For paper claims that you mail to Optum Behavioral Health, , you should verify the mailing address. Often, the claims payment address for a medical claim is different than the address for a behavioral health claim. To verify, call the number on the back of the member's ID card.

### Am I responsible for coordination of benefits?

Yes. You are responsible for determining if other insurance coverage is in effect and for billing the primary insurance carrier first, then notifying Optum of your findings. Optum is required to process claims using industry-wide Coordination of Benefits (COB) standards and in accordance with benefit contracts and applicable law.

### Can I bill a member when treatment is not authorized, as required, but the members elects to receive services?

Possibly. If you seek prior authorization and Optum does not authorize the requested services, the member may be billed under limited circumstances. For more detailed information, please review the *Billing for Non-Covered Services and No Shows"* section in the **Compensation and Claims Processes** chapter of this manual.

### May I submit a claim to Optum for telephone counseling or after-hours calls?

Optum covers telephone counseling in some situations when clinically necessary and appropriate, and in accordance with the member's benefit plan. Telephone counseling must be pre-authorized by Optum.

## Anti-Fraud, Waste and Abuse (FWA)

### Am I required to participate in all Anti - Fraud, Waste and Abuse programs?

Yes. All FWA investigation activities are a required component of your Agreement. This includes, but is not limited to, providing medical records as requested and timely response to inquiries.

### Do I have to complete Anti - Fraud, Waste and Abuse or Compliance training?

All providers and affiliates working on Medicare Advantage, Part D or Medicaid programs must provide compliance program training and 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 any CMS approved source.

### What should I do if I suspect Fraud, Waste or Abuse?

Any time there is a suspicion of Fraud, Waste or Abuse, please report it immediately. The faster we know about it, the faster we can intervene. We need your assistance to maximize success.

### How do I contact the Optum Program and Network Integrity Department?

Communications are confidential and may be anonymous.

**Telephone**: **1-877-972-8844**

**Email**: optum.pni.tips@optum.com
**Fax**: **1-248-733-6379**
**General Inquiries**: pni.triage.team@optum.com
**Mail**: For our current mailing address, review our Contact Information on the bottom of the **Fraud, Waste, Abuse, Error and Payment Integrity** webpage.

### Where can I find more information about Anti-Fraud, Waste and Abuse?

More information is available on the **Fraud, Waste, Abuse, Error and Payment Integrity** page on *Provider Express*.

## Prior Authorization Appeals and Disputes

### Can I initiate the Dispute or Appeals process if I disagree with the Optum decision not to authorize services I have requested?

**OptumHealth Behavioral Solutions of California (OHBS-CA) Members**: You may initiate the Dispute or Appeals process with OHBS-CA. Urgent disputes should be pursued as quickly as possible following an adverse determination. For non-urgent disputes, there is a 365-day time frame in which a clinician can submit a dispute to OHBS-CA. These time frames apply unless otherwise mandated by applicable law. At the time of an adverse determination, a letter explaining the dispute rights is sent to the treating clinician. The Member is also notified of the Member appeal process. Members have 180 days in which to request a non-urgent appeal.

### Are there different contacts for issues with claims processing or payment?

Yes. See the "**Provider Reconsideration and Appeals Process"** section of this manual on page 93.

# 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.

## Agency

A non-facility-based outpatient provider meeting specific criteria. Examples include, but are not limited to, Federally Qualified Health Centers (FQHC), Community Mental Health Centers (CMHC), State Licensed Outpatient Clinics, Community-based Service Agencies and School Based Health Centers (SBHC).

## Agreement (may be referred to as Provider Agreement or Provider Participation Agreement)

A contract describing the terms and conditions of the contractual relationship between us and a provider under which mental health and/or substance use disorder services are provided to members.

## Appeal

**OptumHealth Behavioral Solutions of California (OHBS-CA)**

- A request to change a previous OHBS-CA determination regarding payment for or provision of any service a Member or Member’s representative believes is covered by us or should have been covered by us; or
- A request to reconsider the OHBS-CA disposition of a grievance.

## 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 are 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 USBHPC contracted rate and the clinician’s or facility’s usual charge for that service.

## Behavioral Clinical Policies

Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make determinations regarding proven or unproven technologies, services and treatments.

## 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. EAP Care Advocates are referred to as Emotional Wellbeing Specialists.

## Behavioral Health Treatment

Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

- The treatment is prescribed by a licensed participating physician or developed by a licensed participating psychologist (licensed in accordance with California Business and Professions Code)
- The treatment is provided under a treatment plan prescribed by a participating Qualified Autism Service Provider and is administered by one of the following:
  - A participating Qualified Autism Service Provider
  - A participating Qualified Autism Service Professional supervised by a participating Qualified Autism Service Provider
  - A participating Qualified Autism Service Paraprofessional supervised by a participating Qualified Autism Service Provider or a participating Qualified Autism Service Professional
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the participating Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the participating Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the participating Qualified Autism Service Provider does all of the following:
- Describes the Member's behavioral health impairments to be treated:
  - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to Optum upon request.

## 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. EAP Care Advocates are referred to as Emotional Wellbeing Specialists.

## Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII)

Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18.

## Clean Claim

A UB-04 or a 1500 claim form, or their successors, 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 on the Provider Express secure portal**.**

## Co-insurance

The portion of covered health care costs for which the Member is financially responsible, usually according to a fixed percentage. Co-insurance often is applied after a deductible requirement is met.

## Co-payment

A cost-sharing arrangement in which a Member pays a specified charge for a specified service, (e.g., $20 for an office visit). The Member is usually responsible for payment at the time the health care is rendered. Typical co-payments are fixed or variable flat amounts for clinician office visits, prescriptions or hospital services. Sometimes the term "co-payment" generically refers to both a flat dollar co-payment and co-insurance.

## Community-based Service Agency

Includes peer support group services and drop-in centers (clubhouse model) that have a business license and/or state license, as applicable.

## Contract Manager

An Optum professional who manages contractual relationships with individual clinicians, group practices, facilities and agencies who provide services to our members.

## Credentialing

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

## Deductible

The annual amount of charges for behavioral health care services, as provided in the Member's Benefit Plan, which the member is required to pay prior to receiving any benefit payment under the member's plan.

## EAP (Employee Assistance Program)

A health and wellness benefit provided by one's employer. EAP services are designed for brief intervention, assessment and referral. These services are short-term in nature. The Optum EAP is known as Emotional Wellbeing Solutions (EWS).

## Early Childhood Service Intensity Instrument (ECSII)

Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for children ages 0-5.

## Emergency

(California Health and Safety Code Section 1317.1(b)). A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention (generally within twenty-four (24) hours of onset) could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

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 or less, or as mandated by state law or customer contract, 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.

## 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.

## Facility

An entity that provides inpatient, residential, or ambulatory services and has contracted to deliver behavioral health care services to members (also known as a Network Facility).

## 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 (PHS) Act, certain tribal organizations and FQHC Look-alikes. An FQHC Look-alike 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.

## Group Practice

A group of individually credentialed clinicians who participate in the network under a Group Agreement and share a single tax identification number. The Group Practice site(s) is the location of practice for at least the majority of each clinician's clinical time. In addition, medical records for all patients treated at the practice site are available to and shared by all clinicians, as appropriate.

## 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 website **HHS.gov**.

## Identification (ID) Card

Any reference to "ID Card" includes a physical or a digital identification card.

## Independent Review Organization

**OptumHealth Behavioral Solutions of California** – A member may apply for an Independent Medical Review (IMR) of benefits for a health care service denied, modified or delayed by OptumHealth Behavioral Solutions of California based in whole or in part on medical necessity.

Members whose regulatory rights are governed by the Department of Managed Health Care (DMHC) may apply to the DMHC for an IMR. Members whose regulatory rights are governed by the California Department of Insurance (CDI) may apply to the CDI for IMR.

In non-urgent situations, the member must first complete OptumHealth Behavioral Solutions of California's appeal process prior to applying for IMR through either the DMHC or the CDI.

## Language Assistance Program

A comprehensive program developed in compliance with Section 1367.04 of the Knox-Keene Health Care Service Plan Act of 1975 and Title 28 CCR Section 1300.67.04 to assess the language needs of members with limited English proficiency (LEP) and to ensure an LEP member's ability to obtain interpretation services in any language as well as translation of vital documents in any of the Optum most frequently spoken languages.

The Program includes, at a minimum: 1) member assessment of language preference; 2) standards for the provision of free language assistance services at all member points of contact, (e.g., within Optum and the contracted clinician and facility network); 3) training and education; and 4) monitoring of compliance with the Program.

## Least Restrictive Level of Care

The level of care at which the member can be safely and effectively treated while maintaining maximum independence of living.

## Legal Entities

- U. S. Behavioral Health Plan, California (USBHPC)
- United Behavioral Health (UBH)

## Level of Care Utilization System (LOCUS)

Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for adults.

## Limited English Proficient (LEP) Member

A member who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees.

## Medical Necessity

**OptumHealth Behavioral Solutions of California (OHBS-CA)[1]**

**Medical Necessity** refers to an intervention, if, as recommended by the treating Practitioner and determined by the Medical Director of OHBS-CA to be all of the following:

a. A health intervention for the purpose of treating a Mental Disorder or Substance-Related and Addictive Disorder;

b. The most appropriate level of service or item, considering potential benefits and harms to the member;

c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the member. “Cost-effective” does not necessarily mean lowest price.

e. A service or item will be covered under the Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

In applying the above definition of Medical Necessity, the following terms shall have the following meaning:

i. **Treating Practitioner** means a Practitioner who has personally evaluated the patient.

ii. A **health intervention** is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnosis, detect, treat or palliate) a Mental Disorder or Substance-Related and Addictive Disorder or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the Mental Disorder and Substance-Related and Addictive Disorder condition and the patient indications for which it is being applied.

iii. **Effective** means that the intervention can reasonably be expected to produce the intended result and to have expected benefits that outweigh potential harmful effects.

iv. **Health outcomes** are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person’s life.

v. **Scientific evidence** consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the Mental Disorder or Substance-Related and Addictive Disorder condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

vi. A **new intervention** is one that is not yet in widespread use for the Mental Disorder or Substance-Related and Addictive Disorder and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

vii. An intervention is considered **cost-effective** if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. The application of this

criterion is to be on an individual case and the characteristics of the individual patient shall be determinative.

[1] USBHPC adheres to this definition of medical necessity. For some full-service plan customers, this definition may vary. In such situations, USBHPC will support the customer's definition. For a current list of these Health Plan customers, the USBHPC regulatory affairs department may be consulted.

## Medicare Coverage Determinations

Medicare National and Local Coverage Determinations (NCDs and LCDs) are criteria used to make medical necessity determinations for Medicare benefits.

## Non-Coverage Determination (NCD)

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. The term "Adverse Determination" is sometimes used to describe NCDs.

## Notification

A Benefit Plan requirement that providers contact us when a member accesses services. Notification, when required, should occur prior to the delivery of certain non-routine outpatient services and scheduled inpatient admissions, and as soon as reasonably possible for an emergency admission. Notification requirements include clinical information to determine benefit coverage.

## Optum Pay

Optum Pay is the standard method for receiving payments and provider remittance advice (PRA) from Optum. Optum Pay delivers electronic payments and provides 835 files for health care providers or facilities.

## Payor

Entity or person that has the financial responsibility for funding payment of covered services on behalf of a member, and who is authorized to access mental health/substance use disorder services in accordance with the Participation Agreement.

## Prospective Claim Review

Claim review completed before payment is made that may be denied due to a conflict with a reimbursement policy and/or when more information is needed before a claim can be processed. When more information is needed, a request for medical records will be sent to the provider and/or member, as appropriate.

## Provider Dispute

**OptumHealth Behavioral Solutions of California –** A contracted provider's written notice to OptumHealth Behavioral Solutions of California challenging, appealing or requesting reconsideration of a claim (or group of claims) that has been denied, adjusted or contested or seeking resolution of a

billing determination or other contract dispute, disputing a request for reimbursement of an overpayment of a claim, or other dissatisfaction with OptumHealth Behavioral Solutions of California services. Any dispute submitted by a treating clinician "on behalf of a member" is handled through OHBS-CA's member grievance and appeals system according to our policy and procedure. In such cases, the provider is deemed to be assisting the member within the context of California Health and Safety Code, §1368.

"On behalf of a member" is defined as:

- A request received from a contracted or non-contracted provider in advance of services being rendered or "pre-service," or:
- A request received from a non-contracted provider explicitly stating that the non-contracted provider is filing on behalf of the member.

## Provider Relations

Consists of staff who provide services and information to providers. In addition, they may act as liaisons with other departments such as Contracting, Care Advocacy, Account Management and Sales to contract and retain experienced mental health and substance use disorder treatment professionals.

## Qualified Autism Service Provider

A Qualified Autism Service Provider is either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified
- A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee

## Qualified Autism Service Professional

An individual who meets all of the following criteria:

- Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider
- Is supervised by a Qualified Autism Service Provider
- Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
- Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program

- Is a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan

## Qualified Autism Service Paraprofessional

An unlicensed and uncertified individual who meets all of the following criteria:

- Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan

## Qualified Behavior Analyst/Specialist

Generally, a board-certified Behavior Analyst but may also include provider types designated by a specific state as eligible to serve as Applied Behavior Analysis supervisors.

## 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. Federal and state regulations typically require 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.

## Retrospective Program

Review of claims after payment has been made and claims are subsequently identified as having potential for Fraud, Waste, Abuse and/or Error activity.

## Routine Access

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

## School Based Health Center (SBHC)

Provides a comprehensive array of behavioral health services, including outpatient, case management and telehealth services.

## State Licensed Outpatient Clinic (Non-CMHC)

An organization that is licensed and/or accredited by a state entity to provide mental health and/or substance use disorder services.

## Telehealth

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.

## Termination Period

The timeline for continued treatment up to 90 calendar days from the effective date of the contract termination, or as outlined in the Agreement, or until 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

The care advocate may continue to issue authorizations for treatment during this period at the Optum contracted rate, as defined by the Agreement.

## Threshold Languages

The languages identified for Optum, pursuant to the requirements of the California Language Assistance Program, as most frequently spoken.

## Urgent Access

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

## Utilization Management

The process of evaluating and determining the coverage for and the appropriateness of behavioral health services, as well as providing assistance to a clinician or patient in cooperation with other parties, to help ensure appropriate use of resources. UM includes prior authorization, concurrent review, retrospective review, discharge planning, and case management.

## Vital Documents

Documents identified as requiring translation into a Threshold Language based on a member's language preference.

## Wellness Assessment

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.

# Network Requirements

## Clinical Network Development and Maintenance

Optum is responsible for arranging for the provision of a comprehensive spectrum of behavioral health services. To fulfill this responsibility, we administer a provider network including licensed qualified professionals in mental health and substance use disorders (MH/SUD). This network represents an array of clinical and cultural specialties and includes facility-based programs that offer a wide variety of services. The diversity of our network allows us to meet the clinical, linguistic, cultural, and geographic needs of our members.

## Participating Provider Agreements

A payor is defined as the entity or person that has the financial responsibility for funding payment of covered services on behalf of a member and that is authorized to access MH/SUD services in accordance with the Participation Agreement.

Some patients may have access to the Optum network discounts through Network Lease Partners. All claims for members accessing your services through these arrangements are processed, paid by, and the responsibility of the Network Lease Partners and not Optum. Please submit claims directly to these Network Lease Partners for processing. Claims submission information is available on the member's ID card.

## Non-Discrimination

Optum 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 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.

## CAQH – Clinician Credentialing and Recredentialing

Optum uses **CAQH ProView®** to obtain the data needed for credentialing and recredentialing of our network clinicians, and many clinicians who are contracted with us through a Group Practice, unless otherwise required by law. 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 recredentialing is quick and easy.

Once your application is completed with CAQH, Optum may use Verisys (formerly Aperture) to review the application packet for completeness and collect any missing or incomplete information. Verisys is a National Committee for Quality Assurance (NCQA) certified Credentials Verification Organization (CVO).

## Clinician Credentialing

The clinician credentialing process is used for clinicians who are individually contracted and for many clinicians who are contracted with us through a Group Practice. Optum 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:

- Current valid independent license to practice without restrictions, conditions, or other disciplinary action, in all states where the applicant practices
- For physicians, a completed psychiatric residency program or other clinical training and experience as appropriate for specialty.
- Board Certification for physicians and advanced practice nurses, when applicable.
- Current certification through the Federal Drug Enforcement Agency (DEA) for prescribing clinicians in the state of California
- Professional Liability Coverage: a minimum of $1 million per occurrence/$1 million aggregate for master's-level and doctoral-level clinicians and a minimum of $1 million/$3 million for physicians (exceptions to these required insurance amounts may be made as required by applicable state law)
- Free from any exclusion from state or federal government programs
- Attest to your area(s) of clinical specialty and appropriate training supporting the identified specialties

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

**Disclosure of Ownership** – This form may be a mandated requirement for specific state Medicaid plans. If applicable, must be collected as part of new recruitment or continued participation process.

**Release of Information** – 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.

**Specialty Areas:** Optum has specific requirements for identified specialty areas. A comprehensive list of specialty areas is available in the online applications or on the **Clinician Expertise/Specialty Attestation** form. 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.

**Credentialing Plan:** 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 Provider Relations.

## Clinician Recredentialing

We recredential clinicians every 36 months unless state law or client policies require a different recredentialing cycle. During recredentialing, 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:

- Federal Drug Enforcement Agency (DEA) certificate (if applicable) for the state of California
- Professional liability insurance
- Controlled Dangerous Substances (CDS) certificate (if applicable)
- Curriculum vitae, if required by state

You may also be asked to 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 recredentialing and prevent your continued participation in the network.

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

## Delegation of Credentialing in Groups

For contracted Group Practices that meet specific criteria, Optum may negotiate a Delegation Agreement that would allow the group to credential the providers within their Group and report their credentialing and recredentialing activities to Optum. Optum conducts oversight of Delegated Group

activities and retains final approval of all credentialing and recredentialing decisions. If your group is interested in pursuing a Delegation Agreement, contact Provider Relations for more information.

## Facility / Agency Credentialing and Recredentialing

Optum follows the guidelines of NCQA for credentialing and recredentialing unless otherwise required by law. As part of the credentialing and recredentialing process, Facilities and 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 required state licenses
- Current copies of all valid accreditations from an Optum-approved accrediting body
- General and professional liability insurance certificates:

  For Facilities:

  - With an acute inpatient component, professional/general liability $5 million/$5 million minimum coverage
  - Without an acute inpatient component, professional liability $1 million/$3 million minimum coverage
  - Comprehensive general liability $1 million/$3 million minimum coverage

  For Agencies:

  - Professional liability $1 million/$3 million minimum coverage
  - Comprehensive general liability $1 million/$3 million minimum coverage
  - Peer Run Organization - $1 million/$1 million minimum coverage (professional liability; $1 million/$1 million minimum coverage (general liability)
- W-9 forms
- Staff roster, including attending physicians, if applicable
- Daily program schedules
- Program description
- Facility Billing Information Form

**Disclosure of Ownership** – This **form for facilities and agencies** may be a mandated requirement for specific state Medicaid plans. If applicable, must be collected as part of new recruitment or continued participation process.

If your facility/agency is not accredited by an entity recognized by Optum, an on-site audit will be required prior to credentialing and again prior to recredentialing (see **Audits of Sites and Records** in the **Quality Improvement** chapter 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 Facility Contract Manager.

**Roster Maintenance** – Credentialed Agencies that are contractually required to provide a roster of their independently licensed clinicians must maintain the accuracy of that roster, including timely reporting of the addition of new clinicians and removal of clinicians who have left the agency. Roster management can be completed through "My Practice Info" on *Provider Express* or by submitting the **Agency Roster Update Form** to Provider Relations.

## Credentialing and Recredentialing Rights and Responsibilities

As an applicant to the Optum network or as a network provider in the process of recredentialing, you are entitled to:

- Be informed of your rights
- Be informed of credentialing or recredentialing status upon request
- Review information submitted to support your credentialing or recredentialing 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 recredentialing application

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

## Applied Behavior Analysis Network - Board-Certified Behavior Analyst and Applied Behavior Analysis Agencies

The Optum network includes two provider types that provide behavioral health treatment for children with autism spectrum disorders (ASD):

- Applied Behavior Analysis (ABA), and
- Intensive Behavior Therapies (IBT)

Qualified Behavior Analysts/Specialists are eligible to apply for participation in this unique Applied Behavior Analysis Network. Behavior Analyst/Specialist applicants must demonstrate expertise by meeting the minimum requirements of six months supervised experience or training in the treatment of ASD, in addition to active Board-Certified Behavior Analyst (BCBA) certification from the national Behavior Analyst Certification Board and must meet the requirements as a Qualified Autism Service Provider (California Health and Safety Code 1374.73).

Applied Behavior Analysis organizations (ABA Agencies), which use a staff model including an individual Behavior Analyst/Specialist or a California independently licensed behavioral health clinician acting in a supervisory capacity to a paraprofessional staff, are also eligible to apply for participation in the ABA Network. ABA agency applicants must demonstrate expertise by meeting the minimum requirement for their supervisors of six months supervised experience or training in the treatment of

ASD and active BCBA certification and/or applicable licensure, as well as the successful completion of an agency medical record and site review.

Paraprofessionals or Behavior Technicians are required to be a Registered Behavior Technician (RBT), a Board-Certified Autism Technician (BCAT), or a certified Applied Behavior Analysis Technician (ABAT). Any alternate certification must be approved in writing by an authorized Optum Behavioral Health contract representative.

State regulatory requirements may supplement, modify or, in some cases, supersede this policy.

## Medi-Cal Enrollment (California Medicaid)

OptumHealth Behavioral Solutions of California ("OHBS-CA") manages the behavioral health benefits for members covered through the UnitedHealthcare Community & State Medi-Cal managed care program in select counties in California. The California Department of Health Care Services (DHCS) requires providers who are rendering services to Medi-Cal members to enroll with the DHCS. At the current time, Board-Certified Behavior Analysts (BCBAs) and Applied Behavior Analysis Agencies are exempt from this requirement. However, other provider types and groups are required to enroll. Enrollment information can be found on the **DHCS website**. Some provider types are able to enroll online through the **Provider Application and Validation for Enrollment (PAVE)** provider portal. For other providers, applications are available for downloading on the website.

## Express Access Network

The Optum Express Access Network includes credentialed providers who offer routine MH/SUD appointments within 5 business days. Participation in the Express Access Network requires submission of an attestation, which can be found on the **Express Access Network** page in the Clinical Resources tab on *Provider Express*.

**Requirements for participation in the Express Access Network**

**Member Access to Care.** Express Access Providers ensure that members have timely and reasonable access to MH/SUD Services and are, at all times, reasonably available to members as is appropriate. Express Access Providers agree to offer routine appointments within five (5) business days. If an Express Access Provider, is unavailable when members call, the provider must respond to the member within 24 hours. Express Access Providers arrange for an answering machine or service that provides the office hours and emergency information and must be capable of receiving messages 24 hours a day.

**Non-Compliance.** Express Access Providers understand and agree that, should Optum receive a substantiated member complaint, it will be reviewed thoroughly and may result in removal from the Express Access program. Notification of program removal is not assured but a provider removed from the program can resubmit a new attestation to be reconsidered for participation. In addition, Optum may use a "Secret Shopper" program to periodically monitor appointment access and availability. Should a provider be identified as unavailable or unable to meet the 5-day appointment expectation through "Secret Shopper outreach or through the Optum Data Validation program, Optum will remove the Express Access designator from the provider record. Re-activation of Express Access can be requested via the **Express Access Network** page on *Provider Express*.

Either party may terminate or suspend participation in the Express Access network with thirty (30) days advance written notice to the other party. Termination or suspension of Express Access services does not terminate or suspend your existing Provider Agreement.

All other terms and conditions, as outlined in the existing Provider Agreement, remain in full force and effect.

## Telehealth

The Optum network includes credentialed providers who offer telehealth (virtual) services. Telehealth can be delivered in a variety of settings and can include such services as initial evaluations, ongoing treatment, and medication management.

All providers who wish to be considered for this service must attest to meeting our requirements for providing telehealth services in order to be listed as such in our provider directory. Providers can attest to providing telehealth via the **Network Participation Request Form** at the time of initial credentialing. If you are already a participating provider with Optum, you can complete an attestation within the secure Transactions area of the *Provider Express* secure portal. You must be a registered user of the secure portal to complete this online attestation. See **First Time Registration for Provider Express** training video.

Providers with prescriptive authority must document their prescriptive authority requirements individually for each state in which they are licensed to prescribe or dispense prescriptions, in accordance with applicable laws, rules and regulations.

Providers offering telehealth visits must be licensed in the state where the member is located at the time of service. In addition, providers must comply with all licensing laws and telehealth regulations in the jurisdiction(s) where the provider is licensed and where the member is receiving treatment. This includes but is not limited to specific telehealth documentation requirements, informed consent to treat via telehealth requirements, and other telehealth-specific laws and regulations.

Telehealth is not a separate benefit and member benefits and cost share are the same as for in person visits. Optum will reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of member or subscriber appropriately delivered through telehealth services on the same base and to the same extent that a health care service plan is responsible for reimbursement for the same service through in person diagnosis, consultation, or treatment.

Review additional information on the **telemental health** webpage.

## Contractual Obligation to Update Provider Demographic Data

Up-to-date provider data is important to ensure accurate processing of Optum Behavioral Health claims and so the provider directory presents correct information to members.

Network providers are contractually obligated to notify Optum when there are changes to practice demographic information. Notification must occur within 10 days of the change unless a different timeframe is otherwise required by state or federal law or the provider's Participation Agreement.

There are 2 ways for individual clinicians and groups to submit demographic updates:

| Method | Details |
|---|---|
| **Online via the *Provider Express* secure portal** | • Go to **Providerexpress.com** to login (upper right corner) with your username and password<br>• Select My Practice Info from the Menu at the top of the page, then select the type of information that needs to be updated from the drop-down menu<br><br>Review the **My Practice Info training guide** for assistance. |
| **Provider Service Line** | **1-877-614-0484**, Monday – Friday 5 a.m. – 5 p.m. PT |

Most updates are reflected in Optum Behavioral Health internal systems in real time. Directory updates are made nightly and will be reflected in your listing the next day Group Practices and facilities/agencies that wish to be designated as unavailable should call the Provider Service Line at **1-877-614-0484**.

### Changes that require modification and updates within 10 business days

**Clinician Information**
- Legal name of the provider
- Attested expertise/programs you offer (Services you provide must meet our credentialing criteria)

**Practice Information by TIN**
- Updates to Tax Identification Number (TIN) used for claims
- Changes in practice location, billing address, appointment phone number or secure fax number
- The *Accepting New Patients* status for each practice location

**Licenses and IDs**
- Changes in facility, agency or group ownership
- Changes in your privileges or affiliations
- Status of professional liability insurance
- Status of professional licensure and/or certification (Revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, debarment from any government program, monitoring or any other adverse action)
- Potential legal standing (Any malpractice action or notice of licensing board complaint filing)

### Other information to review and update quarterly

**Clinician or practice data**
- Website and email addresses
- Virtual appointment availability
- Ethnicity
- Language(s) spoken
- Provider gender and sexual orientation

**Training or focus on specific populations**
- LGBTQA+/Transgender
- Blindness or visually impaired
- Homelessness
- Chronic illness
- Physical disabilities
- Co-occurring disorders
- Deafness or hard of hearing

### Removal from network directory

The Consolidated Appropriations Act of 2021 requires all providers to review and attest to the accuracy of demographic information quarterly. Optum Behavioral Health may remove providers and facilities from our network directory if we are unable to verify demographic information. Please respond to notices from us within the time period indicated in the communication that we send to you.

## Periodic Validation of Data

In accordance with California Health and Safety Code ("HSC"), Section 1367.27, Optum reviews and updates our entire California provider directory annually. Individually contracted clinicians are notified at least once every six months and Group Practices, Facilities and Agencies are notified at least annually.

Notification includes:

- The information in the provider directory about the provider
- A statement that failure to respond to the notification may result in a delay of payment or reimbursement of a claim
- Instructions on how the provider can update the information in the directory

Providers must acknowledge receipt of the notification within 30 business days, either confirming that the information in the directory is current and accurate, or, alternatively, updating the information in the directory through secure "Transactions" on **Provider Express** or by notifying Provider Relations.

In addition, CMS regulations require us to contact all providers quarterly, telephonically and in writing, to validate key provider information.

It is important that participating Clinicians, Groups and Facilities respond to these requests in a timely manner. Failure to respond to the notification or outreach by Optum to confirm your directory information may result in your removal from the directory and evaluation of your status as a participating provider.

## Practice Locations and Contract Status

### Individually Contracted Clinician

Your Agreement is between you and USBHPC. It is an agreement to see all members eligible to access this Agreement. Your Agreement with USBHPC is not specific to a single location or Tax Identification Number. It is important to provide us with all practice locations and the Tax Identification Numbers under which you may bill to facilitate proper reimbursement.

### Clinicians Participating under a Group Agreement

The Agreement is between the Group Practice and USBHPC. It is an agreement to see all members eligible to access this Agreement at all locations affiliated with the group. The group must provide us with all practice locations and Tax Identification Numbers under which you may bill to facilitate proper reimbursement. Additional group Tax Identification Numbers may require a contract amendment.

### Facility/Agency Agreements

The Participation Agreement is between the facility/agency and USBHPC. It is an agreement to see all members eligible to access the Agreement. The Agreement with USBHPC is specific to a single Tax Identification Number but may include multiple practice locations. It is important to provide us with all practice locations and the Tax Identification Number under which you may bill to facilitate proper reimbursement.

## Appointment Availability Status

When necessary, individual clinicians may request that their directory listing indicate they are not accepting new patients. This can be done for one or more of your practice locations for up to six months. Some common reasons that you may not be able to accept new patients include illness, vacation or leave of absence plans, or that your appointment calendar is full of existing patients. Practice locations that are hospital-based or inpatient only, or locations where appointments are not routinely available to new patients, should be listed as unavailable indefinitely, as necessary.

Please note that your Participation Agreement remains in effect while you are designated as unable to accept new patients. As outlined in your Participation Agreement, you are required to notify us within 5 business days, when you're no longer able to see new patients or when you again have capacity to do so. If state or federal regulations require a shorter timeline, you are required to follow those guidelines.

You can update your appointment availability status through My Practice Profile on the **Provider Express secure portal**. You may also call the Provider Services Line. You will receive an electronic confirmation or be sent a letter confirming that your request has been processed.

When you have been unable to accept new patients for five consecutive months, we will send you a letter reminding you that you will be returned to active status within 30 calendar days. Should you decide that you want to return to active status sooner than expected, you may update your status in the secure portal at any time.

Group Practices and facilities/agencies that wish to be made unavailable should contact the Provider Services Line (PSL).

## 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. 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.

## Termination or Restriction of Network Participation

A provider's participation with Optum 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.

For clarification on how to terminate your Participation Agreement, refer to your Participation Agreement. If you need additional assistance, contact the Network Management contract representative **for your state**. If you're not able to reach your contract representative, you can call the Provider Service Line at **1-877-614-0484**.

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, Optum 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 thirty (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, factfinder, or initial decision-maker in the matter. You may be represented by a person of your choice at the appeal hearing, including legal counsel.

The Appeals Committee's decision is by a majority vote of the members. The decision of the Appeal Committee is final and may uphold, overturn or modify the recommendation of the Optum Credentialing Committee. Correspondence regarding the decision is sent to the clinician or facility within thirty (30) calendar days of the hearing date.

## CMS Preclusion List

The Centers for Medicare and Medicaid Services (CMS) has a Preclusion List effective for claims with dates of service on or after January 1, 2019. The Preclusion List applies to both Medicare Advantage (MA) plans, as well as Part D plans.

The Preclusion is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Providers receive notification from CMS of their placement on the Preclusion List, via letter, and will have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Optum or UnitedHealthcare.

Through the Preclusion List, which CMS updates monthly, CMS advises MA and Part D plans of the date upon which providers' claims must be rejected or denied due to precluded status ("claim-rejection date"). As of the claim-rejection date, a precluded provider's claims will no longer be paid, pharmacy

claims will be rejected, and the provider will be terminated from the Optum network; additionally, the precluded provider must hold Medicare beneficiaries harmless from financial liability for services or items provided on or after the claim-rejection date.

## Continuation of Services after Provider Termination

**Network Clinicians, Group Practices and Agencies** who withdraw from the Optum network are required to notify Optum, in writing, 90 calendar days prior to the date of termination, unless otherwise stated in your Agreement or required by applicable 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 Optum members under their care. If a member elects continued treatment, treatment must be provided for 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

Please note that state-specific laws will be followed when they provide for a different post-termination timeframe.

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 the member's next appointment or prior to the effective termination date, in compliance with your Agreement.

**Network Facilities** that withdraw from the network are required to notify Optum, in writing, 120 calendar days prior to the date of termination unless otherwise stated in your Agreement or required by applicable law. The Care Advocate may continue to issue authorizations for treatment during the Termination Period at the Optum contracted rate, as provided by your Agreement.

To ensure there is no disruption in a member's care, Optum has established a 120-calendar day transition period for voluntary terminations. If a facility's participation is terminated due to quality-related issues, suspected fraud, waste or abuse, or change in license status, requiring immediate transfer of a member to another facility, Optum and the facility will coordinate to ensure a safe and effective transition of care.

In some cases, you and the Care Advocate may determine it is in the best interest of a member to extend care beyond these timeframes. Optum will arrange to continue authorization for such care at the Optum contracted rate. You may continue to collect all applicable co-payments and deductible amounts. The facility continues under contract at the existing rates through the completion of the episode of care at any level of care provided by the facility. Members may not be balance billed.

# Benefit Plans, Authorizations, EWS/EAP and Access to Care

## Introduction

Optum establishes guidelines and requirements for providers. Where required by law, more stringent standards may be applied. However, if applicable 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.

Optum administers managed behavioral health care benefit plans for members throughout California. These plans vary in types of benefits and amounts of coverage. All 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. Covered services will be available and accessible to all members.

In San Diego County, Optum provides the behavioral health network for membership covered under UnitedHealthcare Community Plan of California's Medi-Cal plan. To learn more about the Medi-Cal requirements, see the **"State-Specific Provider Information"** for California on the **Our Network** tab on *Provider Express* or contact Provider Relations.

## Care Advocacy

Licensed behavioral health Care Advocates are responsible for the administration of benefits, including authorization of benefits when authorization is required. In addition, Care Advocates and cross-site functional areas focus on activities that impact a member's stabilization and recovery and promote active participation in their care. This approach consists of targeted interventions intended to reduce barriers in care, identify members who may be at risk, and assist you in the coordination and delivery of care to members. This approach supports a collaborative relationship between you and the Care Advocate. Care Advocacy activity may include:

- Emphasizing the integration of medical and behavioral care by promoting communication among all treating providers involved in a member's 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
- Assist with obtaining an appointment within seven (7) days from the discharge date
- Using the information on the Wellness Assessments to identify members who may be at-risk
- Collaborating to identify barriers to care/community tenure and evaluation of gaps in prior discharge plans
- Proactively reaching out to providers to discuss a member's care when the individual has been

identified as being at-risk

- Offering clinical consultations with Optum clinical 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, including identifying support systems
- Referencing web-based and written information for members and treating clinicians regarding behavioral health conditions, designed to support informed decision-making

## Care Advocate Availability

Each Care Advocacy Center is open for standard business operations Monday through Friday from 8 a.m. to 5 p.m. in their respective time zones. In addition, Care Advocates are available twenty-four hours a day, seven days a week, including holidays and weekends, to discuss urgent and emergent situations such as inpatient admissions, clinical benefit determinations and decisions, appeals, or any other questions about the care advocacy process.

Call the toll-free number on the member's ID card to reach the appropriate Care Advocacy staff member.

## Affirmative Incentive Statement

Optum expects all treatment provided to members be outcome-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 under-utilization of services.

Coverage determinations are based only on the appropriateness of care, as defined by applicable Clinical Criteria, the member's benefit plan and applicable laws.

You will find information about clinical criteria, guidelines, resources and toolkits on the **Clinical Resources for Behavioral Health Providers** webpage.

## Eligibility Inquiry

The services a member receives are subject to the terms and conditions of the Benefit Plan with which he or she participates. It is important that you inquire about what services are covered and the member's enrollment status before providing services.

You can use the **Provider Express** secure portal to check a member's eligibility. You may also inquire about eligibility by calling the phone number on the member's ID card. Be prepared to provide the following information: the member's name, address and identification number, as well as the subscriber's name and date of birth.

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. In addition, COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) rights, including election periods and payment grace periods, result in significant time periods during which Optum may not know the exact status of a member's coverage. Therefore, the member is often your best source for timely information about eligibility and coverage changes.

Under California law, services that have been authorized by Optum and rendered in good faith by the provider are eligible for payment by Optum. Members who are no longer eligible to receive services under a Benefit Plan are notified of such and may revert to the status of being a private paying patient. If you have provided services to an ineligible member, you will be notified in response to Optum's receipt of your claim, and you may bill the member directly in accordance with applicable law.

## Support for Members Looking for Care

There are several ways members can identify a network provider for their behavioral health care:

1. **Online using liveandworkwell.com**: This member website offers ways to search for a network provider, including those who offer in-person or virtual clinical services, including by geographic location, specialties and areas of expertise. Contact information is included in the provider's listing.
    - Providers and staff may also use the website to help members locate an appropriate resource. Access the site using the guest access code "Clinician."

2. **By phone using the number on the member's ID card**: The Optum representative will ask for the member's demographic information and ask questions about the type of care and type of provider they are seeking. The member will be given multiple clinician names and numbers from which to choose to schedule an appointment. These options are based on the clinical, cultural and geographic needs of the member.

    As needed, the Optum representative will explain the services available under the member's benefit plan, the number of sessions available, any deductible, co-payment and/or co-insurance amount the member may need to pay.

## Authorization or Notification for Inpatient and Sub-acute Services

In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state-specific requirements. This includes but is not limited to mental health or substance use disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining pre-authorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services. Should a provider fail to obtain or otherwise follow the required administrative

procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment).

Be prepared to provide information regarding clinical issues related to the member, such as symptom severity, functional status, medical condition(s) treatment and engagement history, risk factors, recovery environment, and discharge plan. You can access our **Guidelines/Policies and Manuals** at *Provider Express* from the Clinical Resources page. You may also request a paper copy of Optum documents from the Provider Service Line at **1-877-614-0484**.

Services provided to members in an inpatient psychiatric or substance use disorder unit are reviewed at the time of the initial request and may be reviewed concurrently by licensed clinicians. These reviews provide information regarding the patient's status and need for continued care. Optum reserves the right to require a direct conversation with the attending psychiatrist before authorizing benefits for admission or continued stay.

## Emergency Admissions

In the event of an emergency for a member requiring immediate treatment and stabilization due to an MH/SUD condition, Facilities should stabilize and treat the member as soon as possible.

Under California law, no prior authorization is required to provide emergency services and care needed to stabilize a member's psychiatric emergency medical condition. A "psychiatric emergency medical condition" is defined by California Health and Safety Code § 1317.1(k) as a mental disorder manifested by acute symptoms that render the patient: 1) an immediate danger to himself, herself, or others; or 2) immediately unable to provide for, or utilize, food, shelter, or clothing. California Health & Safety Code § 1317.1(2)(A) and (B)) defines "emergency services and care" as an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

After a member is stabilized in an emergency room, Optum requires notification within one business day after an admission for a facility to request a preauthorization, unless a longer period is required by contract or state-specific requirements.

## Routine and Non-Routine Outpatient Services

### Authorization or Notification for Mental Health/Substance Use Disorder Treatment Benefits

In accordance with the Agreement and many Benefit Plans most routine outpatient behavioral health services do not require prior authorization or notification.

**Services that require prior authorization**
Authorizations for non-routine outpatient services are specific to the requesting clinician. The clinician will receive a copy of the authorization approval. When a written authorization lists a range of CPT and/or HCPCS codes, payment for any specific code is subject to ongoing medical necessity review.

Select non-routine outpatient services may require ongoing authorization prior to providing services.

| Type of service | How to request authorization | Notes |
|---|---|---|
| **Applied Behavioral Analysis (ABA) for Autism treatment** | Log into the Provider Express secure portal and complete the online request form:<br>• **Sign In \| One Healthcare ID**<br>Select Auths and follow the prompts for ABA Assessment | Review the **ABA webpage** for additional information about services and requirements |
| **Transcranial Magnetic Stimulation (TMS)** | Submit through the Provider Express secure portal. **TMS Authorization Request Overview** online training. | Effective May 22, 2024, all TMS authorization requests must be submitted through the secure portal. Optum Behavioral Health will no longer accept the TMS Authorization Request Form. |
| **Psychological/ Neuropsychological Testing** | Complete the applicable online request form:<br>• **Optum Testing Request**<br>• **KanCare Psych Testing Request**<br>• **Medica Psych Testing Request** | The Optum Testing Request form should be used for Optum Behavioral Health and Oxford plans.<br><br>For more information refer to the **Psychological Testing** section of this manual on page 55. |
| **Other non-routine outpatient services including Assertive Community Treatment** | Call the number on the member's ID Card | |

**Crisis Care**
Prior authorization is not required for crisis sessions. For a crisis situation that necessitates an extended office visit, claims should be billed with CPT code 90839 (psychotherapy for crisis services) to bill for the first 60 minutes of psychotherapy. For more information, review the **Psychological and Neuropsychological Testing reimbursement policy**.

## Outpatient Care Engagement and Clinical Outcomes Models

Optum is committed to working with our network providers to achieve optimal therapeutic outcomes for the individuals we mutually serve. This approach focuses on assisting the network in making consumer-directed, outcome-based, cost-effective and clinically necessary treatment decisions.

The Clinical Outcomes Model uses member responses to a validated tool, the one-page Wellness Assessment, along with claims data. Both Wellness Assessment and claims information are analyzed through a set of algorithms to measure a member's behavioral health status and identify potential risks.

In addition, the algorithms identify cases that may benefit from a review. Such reviews may include consideration of Clinical Criteria found on the **Guidelines/Policies & Manuals** webpage.

The algorithms present opportunities for earlier intervention on potential treatment complications. The Care Advocacy team 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 and focus on those members with the greatest potential for benefit from such collaboration.

## Wellness Assessments and Measurement Informed Care

Optum recommends that providers administer clinical assessment tools on a regular frequency and use data to inform and guide treatment. Optum recommends that providers not only measure symptom severity, but also additional factors such as quality of life, functioning and feedback about the therapy process. To support providers who may not have access to industry standard assessment, Optum makes available the Wellness Assessment. The Wellness Assessment includes a range of questions to measure symptom severity and overall well-being, and screens for functional impairment, substance use disorder risk and medical co-morbidity risks.

**Administration of the Wellness Assessment:**

- Non-prescribers may offer the one-page WA to each new Optum member or to the parent/guardian of a child or adolescent patient at the initial appointment.
- Return each completed WA to Optum as instructed on the form.
- A second WA is administered between sessions 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.
- Optum will send 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 with the member's employer, medical benefit plan or medical providers without the member's consent. A member may also decline to complete the WA. If this occurs, submit a WA to Optum by completing the provider 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. Forms can be found on the **Wellness Assessment** webpage.

## Practice Management

The clinical Practice Management team, in coordination with other Optum teams, collaborates with providers, groups, and facilities to:

- Identify practices that fall outside of typical billing patterns, established guidelines and expected utilization

- Evaluate compliance with clinical and administrative practices governed by external clinical guidelines, Optum reimbursement policies and contractual obligations

Practice Management intervention methods include education and links to resources that help the provider self-correct outlier practices and billing patterns. Interventions may include:

- Direct conversations with providers
- Written communication
- Treatment record documentation audits/re-audits
- Site audits

Potential results of a Practice Management intervention could include:

- Ongoing monitoring
- Performance Improvement Plans (PIPs)
- Referral to the Credentialing Committee for network termination
- Referral to Program and Network Integrity (PNI) for recoupment and/or prepayment review

For additional information, please see the chapters on **"Anti-Fraud, Waste and Abuse"** and **"Treatment Record Documentation Requirements"** in this manual.

## WorkLife

A member who is actively engaged in an Emotional Wellbeing Solutions (EWS) program or in Behavioral Health treatment may also have WorkLife (WL) benefits. In many cases, the WorkLife benefit can complement needs while in treatment by providing educational materials or verified community resources. Support groups, financial assistance programs, and referral to community social service Agencies are only some examples of what can be provided.

Please direct the member or family member to call their EAP/WL toll-free number. Members will be directed to a WorkLife Specialist who will assess and consult with the caller about how to best meet his or her needs.

## Emotional Wellbeing Solutions (EWS) Benefits and Authorization

The EWS benefit is designed to provide assessment and referral, as well as a brief counseling intervention for members and their families. The typical EWS benefit offers a limited number of sessions with an MH/SUD provider and is not designed to provide a course of psychotherapeutic treatment. Not all Optum members have an available EWS benefit, but those who do can generally see any contracted Optum clinician for EWS services. There are limitations around the use of EWS benefits with psychiatrists.

**EWS benefits require pre-authorization**
Authorizations for EAP services are required and must be initiated by members or network clinicians prior to the first appointment.

**Member authorization request:**
Members with an EWS benefit can request EWS authorization for services through

liveandworkwell.com or by phone. Most members with an EWS benefit have a dedicated EWS number listed on their member ID card.

- An EWS authorization letter is sent to the member and allows them to see any Optum network non-psychiatrist provider for the number of sessions authorized:
  - The member is instructed to bring a copy of the letter to the provider.
  - This letter includes the authorization number which should be included on the claim. You may also obtain the authorization number through the Provider Express secure portal using the Authorization Inquiry function.
- When a member presents for EAP services, you should inquire whether any of the authorized visits have already been used.

**Provider authorization request:**
To obtain an EWS authorization, call **1-866-248-4094.** You must obtain a new EWS authorization when a new benefit year begins.

**Referrals**
Optum makes every effort to refer members with EWS benefits to clinicians with EAP expertise. However, when a clinician with an EAP specialty is not available in the area, Optum will refer to an appropriate network clinician based on the member's presenting needs. As a clinician in the Optum network, you are expected to accept members who present with an EWS benefit in compliance with your Participation Agreement.

In an EWS benefit, all pre-authorized sessions are paid by Optum at 100% of the Optum-contracted reimbursement rate for the EWS-eligible procedure code billed. The member has no financial responsibility for a deductible, co-payment or co-insurance amount.

## EWS Transition to Mental Health/Substance Use Disorder Treatment Benefits

Some members will have a managed behavioral health care benefit through Optum in addition to their EWS benefit.

In most cases, once a member has exhausted their EWS benefit, you may continue to see the member under their behavioral health care benefit, when indicated. Note that once a member's benefits have transitioned from EWS to mental health/substance use disorder coverage, his or her financial responsibility will vary according to the member's benefit plan. The member may be responsible for a deductible, co-payment and/or co-insurance amount.

## EWS and Medication Management

Medication management services are rarely covered under EAP benefits. Those that do cover medication management services require prior authorization or notification.

## EWS and Wellness Assessments

If the member you are seeing has a combined EWS and mental health/substance use disorder benefit through Optum, administer the Wellness Assessment **or other clinically validated tool** at the initial EAP session. If the member eventually transitions to mental health/substance use disorder benefits, it

is not necessary to have them complete another initial WA at the time of the transition; however, you should administer the second Wellness Assessment between sessions three and five of the MH/SUD benefits. For greater detail about the Wellness Assessment, please see the complete "**Wellness Assessments and Measurement Informed Care"** section on page 50 of this manual.

### Mental Health/Substance Use Disorder Medication Management Services

Psychiatrists and prescribing APRNs or PAs 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, 90832, 90834 and evaluation and management codes, as applicable.

### Pharmaceutical Management Services

Pharmacy benefits are not managed by the behavioral Health Plan. For information about formularies, pharmacy benefits and cost management programs, please contact the medical or pharmacy number on the member's ID card.

### Lab Services

Patients with substance use disorders may require laboratory testing services in addition to the inpatient and/or outpatient psychotherapy and medical interventions included in their recovery plan. Urine drug testing services for a patient in an active Substance Use Disorder (SUD) treatment program may be needed to monitor levels of, and/or detect the presence of, prescribed therapeutic drugs, prescription drugs of abuse, and/or illicit drugs to support diagnosis and to assess adherence with the recovery plan.

Participating providers should refer to your Provider Agreement, which reflects contracted services and associated Fee Schedule for acceptable billing codes. Unless otherwise specified in your Agreement, lab charges are included in your contracted rates for services and will not be reimbursed separately. Claim submissions by participating providers which are not in compliance with your Agreement will be denied.

Please identify and refer members to in-network labs based on the particular member's Benefit Plan. When referring for lab services, providers are expected to refer to an in-network lab based on a member's benefits.

### Applied Behavior Analysis (ABA) Services

Coverage for ABA services usually requires prior authorization by an Optum Care Advocate. Please be aware that not all Benefit Plans provide coverage for ABA services and, prior to beginning care, network Board-Certified Behavior Analysts (BCBA) and ABA Agencies must contact Optum, via the number on the back of the member's ID card, to verify eligibility, review treatment plans and obtain authorization.

## Complex Case Management

Optum offers a Complex Case Management (CCM) program for members who may benefit from more intensive coordination of services. This program is intended to help members with complex behavioral health conditions connect with needed services and resources.

Optum staff screen individuals using the PHQ-2 and CAGE-AID, as well as the Youth Wellness Assessment to screen youth and their families. Then, staff work intensely with individuals in the development of a comprehensive plan of care. For more information, including criteria for inclusion in the program and referring a member, visit the **Complex Case Management Program** webpage.

## Retrospective Review Process

In extenuating circumstances, and at our sole discretion, Optum reserves the right to retrospectively certify coverage of admissions for emergency services provided. Any certification is dependent upon the specific circumstances of each individual case. Optum reserves the right to deny coverage for all or part of an admission.

Requests for retrospective reviews must be received by Optum within 180 calendar days of the date the services were provided to the member unless applicable law mandates otherwise. A retrospective review occurs on those occasions when an initial request for authorization or notification, when required, is made after services have already been delivered but no claim has been filed.

Requests for retrospective review must include information regarding the reason or circumstances preventing required prior authorization or notification and include the medical record and will be processed at the sole discretion of Optum.

For all retrospective reviews, Optum will issue a determination within 30 calendar days of receipt of the request, unless otherwise required by applicable law or customer contract. Any retrospective review requests received outside the established time frame will not be processed by Optum.

## The Important Message (IM) from Medicare

Hospitals must deliver valid, written notice of a Medicare beneficiary's rights as a hospital inpatient, including discharge appeal rights, using the standardized CMS-10065 form.

## Medicare Outpatient Observation Notice (MOON)

Hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any Medicare beneficiary, including a Medicare Advantage Plan enrollee, who receives observation services as an outpatient for more than 24 hours. The hospital must provide the notice using the CMS-10611 form no later than 36 hours after outpatient observation services begin.

## Pilot Projects Affecting Authorization Requirements

We may occasionally launch pilot projects that alter the pre-authorization requirements described above. We will advise you of any initiatives affecting authorization requirements in a separate mailing. Follow the expected pre-authorization requirements as described above unless you have received notice from us of your participation in a pilot project.

## Psychological Testing

Psychological testing must be pre-authorized when required by a member's benefit plan. Psychological testing is not billable separately when delivered as part of an inpatient or facility admission. It must be delivered as an outpatient service.

Psychological testing is considered after a standard evaluation (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

In some cases where a member in need of testing has already received sufficient evaluation to conclude testing is necessary, it is permissible to conduct initial interview intake on the same day of service as testing.

Generally, psychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered. Also not covered are tests performed routinely as part of an assessment. We recommend that you contact Optum pre-service to determine authorization requirements and procedures.

## Psychological Assistants and Interns

Participating clinicians using psychological assistants, interns or other clinicians for help with conducting test administration should follow the guidance for psychometricians. Information regarding test administration and scoring by a psychometrician is available in the **APA Psychological and Neuropsychological Testing Billing and Coding Guide**. This guide also addresses other procedures related to testing and report writing. You can also call the number on the member's ID card for behavioral health benefits.

## Access to Outpatient Mental Health and EAP Care

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. If more stringent time frames are required by applicable law or customer contract, we require that the provider adhere to the more

stringent time frames.

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.

**Commercial**

| Type of Appointment | Required Response Time |
|---|---|
| **Urgent** | • Emotional Wellbeing Solutions (EAP) – within 24 hours<br>• Mental health/substance use disorder – within 48 hours |
| **Emergency/Life-Threatening** | • An immediate appointment must be offered for any life-threatening emergencies<br>• Appointments for non-life-threatening emergencies must be offered within 6 hours |
| **Emergency/Non-Life-Threatening** | • Non-life-threatening emergencies must be offered an appointment within 6 hours |
| **Routine and preventive outpatient care** | • Respond to a member appointment request within 24 hours*<br>• Initial appointment must be offered within 10 business days of the request<br>• For Emotional Wellbeing Solutions (EAP), an appointment must be offered within 3 business days |
| **Follow Up Appointment** | • A non-physician appointment must be offered within 10 business days from prior appointment |
| **Discharge** | • An outpatient appointment must be offered within 7 days of an acute inpatient discharge or emergency department discharge for mental health/substance use disorder<br>• This appointment should be included in the facility discharge plan. If you are unable to take a referral, immediately direct the member to the number on his or her ID card so that he or she can obtain a new referral |

**Medicare Advantage**

| Type of Appointment | Required Response Time |
|---|---|
| **Emergency or urgently needed care services** | • Seen immediately |
| **Medical attention needed (not urgent or emergency)** | • Within 7 business days |
| **Routine and preventative outpatient care** | • Within 30 business days |

**Medicaid**

Appointment standards and response times for Medicaid health plans varies by state. Please refer to your state page on Providerexpress.com > Our Network > **State-Specific Provider Information** or UHCprovider.com > **Health Plans by State**.

**Note:** The time for a non-emergency appointment may be extended if it is determined[1] and documented that a longer waiting time will not have a detrimental impact on the member's health. Rescheduling of appointments, when necessary, must be consistent with good professional care and ensure there is not detriment to the member.

In accordance with applicable state-specific law, Optum or any health plan or insurer is prohibited from preventing, discouraging or disciplining a participating provider or employee for informing Members about timely access standards.

### Interpreter Services:

Interpreter services are available to Optum members at the time of the appointment, as requested by the member or provider. To request interpreter service contact Optum at **1-800-999-9585.** Language interpretation services are available at no cost to the member.

You may contact Optum for assistance by calling **1-800-999-9585**. Additionally, the DMHC Help Center may be contacted at **1-888-466-2219** to file a complaint if the member is unable to obtain a timely referral to an appropriate provider.

Compliance with these standards will be monitored by, but not limited to, the administration of an annual provider survey to solicit perspective and concerns regarding compliance with the standards; tracking network capacity and availability; evaluating accessibility, availability, and continuity of care at least quarterly; and conducting site reviews of high-volume providers.

Your recognition and incorporation of these standards into your practice illustrates your shared commitment to ensuring that members are always able to receive clinically appropriate and timely access to care.

## Language Assistance Program

The OptumHealth Behavioral Solutions of California Language Assistance Program includes assessment of the language needs of members, provision of free language assistance services, and monitoring of compliance with the Program. Language assistance services are available at no cost to you or to covered members. Oral interpretation services are available for all language assistance needs. Written translation of vital documents is available for members whose identified language preference is a Threshold Language.

---

[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.

We maintain documentation of a member's specified language preference, if available, and that information is relayed to providers upon inquiry or during referral discussions with our customer service or care advocacy staff. In addition, information about a member's spoken and written language preference is available to contracted providers via **Provider Express**.

You are required to post written notice in your waiting room regarding the availability of free language services (Appendices E and F). In addition, you are required to offer interpretation services to Limited English Proficiency (LEP) members at the time of their initial assessment. This assistance must be offered even if you have self-attested to your ability to conduct treatment in the member's language and/or when the member is accompanied by a family member or friend who can interpret on their behalf. The offer of interpretation services, as well as the member's acceptance or declination of that assistance, must be documented in the treatment record. It is also important that you have a process in place for your staff to identify members who desire language assistance in all contacts.

To access language assistance services for an identified LEP Member, contact us at **1-800-999-9585**. Our staff will connect you and the member with the interpretation services vendor, where certified interpreters are available to provide telephonic interpretation services.

Upon member request, you are also required to provide grievance documents in the member's identified Threshold Language. The English version of the Member Grievance Form can be found in Appendix D of this manual. Additionally, English and pre-translated **Grievance Forms** are available at *Provider Express*. Applications for Independent Medical Review are available on the websites of the California Department of Managed Health Care (DMHC), **dmhc.ca.gov**, and the California Department of Insurance (CDI), **insurance.ca.gov**, as applicable to the Member's Benefit Plan, and include instructions about the member's right to file a grievance with the DMHC or the CDI. The member may also contact us to obtain a hard copy of these forms.

Optum monitors network compliance with the Language Assistance Program through site visits, treatment record reviews, and the member grievance process. Any deficiencies noted require a corrective action plan from the provider to ensure future compliance.

# Treatment Philosophy

## Introduction

We are committed to creating and maintaining relationships with 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. Based on more than 30 years of experience, we know it is the efforts of our clinical network that give 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 collaboration we look to foster personally defined outcomes for members receiving behavioral health services.

In accordance with your Agreement, you are required to provide services in a manner that is consistent with professional and ethical standards as set forth by national certification and state licensing boards and applicable law and/or regulation, regardless of a Member's Benefit Plan or terms of coverage. Resources are available to you which outline the expectations for Optum 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** chapter of this manual).

Additional resources in these areas can be found at *Provider Express*: Home page > Clinical Resources > **Guidelines/Policies & Manuals**. You will find the following, including, but not limited to:

- **Clinical Criteria**
- **Behavioral Clinical Policies**
- **Clinical Practice Guidelines**
- **State-Specific Criteria**
- **Medicare Coverage Summaries**
- **Reimbursement Policies and Protocols**

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

## Clinical Criteria

**Clinical Criteria** are intended to promote optimal clinical outcomes and consistency in the authorization of benefits by Care Advocacy staff and Peer Reviewers.

For guidance on clinical criteria decisions for the treatment of behavioral health conditions, Optum uses:

- LOCUS – for adults (Level of Care Utilization System)
- CALOCUS-CASII – for children and adolescents ages 6-18 (Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Utilization System)
- ECSII – for children ages 0-5 (Early Childhood Service Intensity Instrument)

LOCUS/CALOCUS-CASII/ECSII were created and updated based on the changing landscape or evidence informed care, market and regulatory considerations, and feedback from stakeholders across the care system. They meet three main concepts that need to be considered and balanced in effectively managing behavioral health services: (1) Use of wrap-around services; (2) tailored to specific age of the member; and (3) adopts a system of care approach.

***The ASAM Criteria*** are clinical guidelines designed by the American Society of Addiction Medicine (ASAM) to improve assessment and outcomes driven treatment and recovery services. It is also used to match patients to appropriate types and levels of care. Your Participation Agreement sets forth the levels of care for which you are contracted and may not cover all ASAM-defined levels of care.

## Medicare Coverage Summaries

Our **Medicare Coverage Summaries** are intended to promote optimal clinical outcomes and consistency in the authorization of Medicare benefits by Care Advocacy staff and Peer Reviewers. Medicare Coverage Summaries offer the guidance found in CMS national coverage determinations, local coverage determinations, and CMS benefit policy manuals.

## The Clinical Technology Assessment Committee

The Clinical Technology Assessment Committee meets quarterly and as needed to review current medical and scientific literature. An Optum medical director chairs this multidisciplinary committee. 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 peer-reviewed and published scientific evidence of efficacy and safety. This evidence includes randomized 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 Care Advocacy Center with which you most often work. Make your request to the Medical Director for that region and he or she will notify the Committee chair of your interest.

## Assisting with Recovery

We support your efforts to assist 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 recovery, enhance self-management, including use of personally defined outcomes and support of 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, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this manual is intended to interfere with your relationship with members as patients.

*Provider Express* includes a **Recovery and Resiliency Toolkit** that contains resources for providers and the individuals and families you serve.

## Assessment

A thorough clinical assessment is essential to treatment planning. You are required to document your assessment, including negative findings as applicable, in the member's clinical record. A clinical assessment must include:

- A biopsychosocial history, including previous medical and behavioral health conditions, interventions, outcomes, and which lists current and previous medical and behavioral health providers
- The mental status exam, including an evaluation of suicidal or homicidal risk
- A substance use screening should occur for members over the age of 11 years, noting any substances abused and treatment interventions
- Other areas to be covered in the assessment are:
  - Developmental history
  - Education
  - Legal issues
  - Social support

Your assessment should also consider:

- An evaluation of why the member is seeking treatment at this level of care at this time
- Services you can offer to meet the member's immediate needs and preferences
- Alternatives that exist in the service system to meet those needs
- The member's broader recovery, resiliency and wellbeing goals
- Unique cultural and spiritual needs of the member

For routine outpatient services, a **Wellness Assessment** should be part of every new treatment episode. This screening tool helps to identify symptoms, conditions and co-morbidities that may be important to address in a comprehensive treatment plan.

# Treatment and Discharge Planning

**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. Optum expects that the provider will collaborate with the member during treatment, recovery and discharge planning whenever possible.

- Effective treatment planning should take into account significant variables such as age and level of development, the history of treatment, whether the proposed services are covered in the member's benefit plan and are available in the community, and whether community resources such as support groups, consumer-run services and preventive health programs can augment treatment.

- The provider should also take into account the member's preferences as directly expressed or documented in an advance directive or crisis plan, if applicable. For some members, treatment is part of a broader recovery and resiliency effort, so the recovery & resiliency goals which may be documented in a recovery plan should also be considered.

- Optum Care Advocates monitor discharge planning and are available to assist with identifying and facilitating access to available treatment services and community resources.

**Member Reassessment**

A change in the member's condition should prompt a reassessment of the treatment plan and selection of level of care:

- When a member's condition has improved, the reassessment should determine whether a less restrictive level of care may be adequate to treat the condition, or whether the member no longer requires treatment.

- When a member's condition has not improved or it has worsened, the reassessment should determine whether the diagnosis is accurate, if the treatment plan should be modified, or if the condition should be treated in another level of care.

**Discharge Planning**

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 provider anticipates the discharge date and forms an initial impression of the member's post-discharge needs.

- The initial discharge plan may evolve in response to changes in the member's condition and preferences.

- The final discharge plan should document the anticipated discharge date, the proposed post-discharge services, and the plan to coordinate discharge with the provider at the next level of care, when indicated.

- The discharge plan should also address ways 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.

**Post-Discharge**
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 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. Optum assesses the compliance of its network facilities in meeting this standard on an annual basis.

## Communication with Primary Physicians and other Health Care Professionals

When a member is receiving services by more than one professional, it is critical that the service providers collaborate and coordinate effectively to ensure that care is comprehensive, safe and effective.

**Benefits of Care Coordination**
Optum expects providers to make a good faith effort at coordinating care with other behavioral health clinicians or facilities and medical care professionals who are treating the member. Coordination of services may improve the quality of care to members in several ways:

- Allows behavioral health and medical providers to create a comprehensive care plan
- Allows a primary care physician to know that his or her patient followed through on a behavioral health referral
- Minimizes potential adverse medication interactions for members who are being treated with psychotropic and non-psychotropic medication
- Allows for better management of treatment and follow-up for members with coexisting behavioral and medical disorders
- Promotes a safe and effective transition from one level of care to another
- Reduces the risk of relapse

**Communication Touchpoints**
To coordinate and manage care between behavioral health and medical professionals, Optum expects that you will request 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). Coordination and communication should

take place:

- At the time of intake
- During treatment
- At the time of discharge or termination of care
- At the point of transition between levels of care, and
- At any other point in treatment that may be appropriate

**General Guidelines**

The following guidelines are intended to facilitate effective communication among all behavioral health and medical professionals involved in a member's care:

- During the diagnostic assessment session, request the member's written consent to exchange information with all appropriate behavioral health and medical professionals who are providing treatment
- After the initial assessment, provide other behavioral health and medical 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 medical professionals when there is a change in the member's condition or medication(s)
- Update other behavioral health and medical professionals when serious medical conditions warrant closer coordination
- At the completion of treatment, send a copy of the discharge summary to the other behavioral health and medical professionals
- Attempt to obtain all relevant clinical information that other behavioral health and medical professionals may have pertaining to the member's mental health or substance use conditions

It is understood that some members may refuse to consent to release information to other behavioral health and medical professionals. Optum expects providers to discuss with members the benefits of sharing information and the potential risks of not sharing information, and to document the discussion in the member's clinical record.

## Member Rights and Responsibilities

You will find copies of **OptumHealth Behavioral Solutions of California Enrollee Rights and Responsibilities** and **Optum Member Rights and Responsibilities** at the end of this manual and

on **Provider Express**. You may request a paper copy by contacting provider Relations at **1-877-614-0484** (see **Resource Guide** in 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.

# Treatment Record Documentation Requirements

## Introduction

In accordance with your Agreement, you are required to maintain high quality medical, financial and administrative records (including appointment or scheduling records) 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, payment, 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.
- Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to Optum and its Payors, Customers, Clinicians and Facilities.

**Onsite Audits**

We may review your records during a scheduled on-site Audit or may ask you to submit copies of the records to us 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 Facilities and Agencies without national accreditation, such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF) or other agencies approved by Optum
- Audits of services and programs, including, but not limited, to Applied Behavioral Analysis (ABA), services delivered through telehealth platforms, and Peer Support Services
- Audits of high-volume providers
- Routine audits
- Audits related to claims coding or billing issues
- Audits concerning quality of care issues
- Audits concerning potential practice or billing patterns

**Audit Results**

Routine, standard monitoring and quality of care audits may focus on the physical environment (including safety issues), policies and procedures, and/or thoroughness and quality of documentation within treatment records and/or accuracy of billing and coding.

- We have established a passing performance goal of 85% for both the treatment record review and onsite audit
- Onsite audit or treatment record review scores under 85% will require a written Corrective Action Plan
- Scores under 80% require submission of a written Corrective Action Plan and a re-audit within 6 months following implementation of the plan. However, in some cases, a requesting committee may require a Corrective Action Plan and/or re-audit regardless of the scores on the audit tools

## Treatment Record – Content Standards

When billing services for more than one family member, separate treatment records must be maintained.

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

- The member's name or identification number on each page of the record
- The member's address; employer or school; home and work telephone numbers, including emergency contacts; marital or legal status; appropriate consent forms; and guardianship information
- The date of service, either start and stop time or total time in session (for time-based services), notation of session attendees, diagnosis, services rendered the rendering clinician's name, professional degree, license and relevant identification number as applicable:
  - For group sessions, the subject covered in the session on the date of service must be indicated.
  - For family sessions, list everyone who attended the session and their relationship to each other
- An indication of whether or not the member is of Limited English Proficiency (LEP); if determined to be LEP, the record indicates that the member was offered language interpretation services and whether the member accepted or declined those services
- Treatment records entries should be made on the date services are rendered and include the date of service; if an entry is made more than 24 hours after the service was rendered, the entry should include the date of service, date of the entry, and a notation that this is a late entry
- Clear and uniform modifications; any error is to be lined through so that it can still be read, then dated and initialed by the person making the change
- Clear documentation of medication allergies, adverse reactions and relevant medical conditions; if the member has no relevant medical history, this should be prominently noted

- Clear and uniform medication tracking that provides a comprehensive summary of all medications taken by the patient from the onset of care through discharge includes the following (applicable for all prescribers):
  - Standing, P.R.N. and STAT orders for all prescription and over-the-counter medications
  - The date medications are prescribed along with the dosage and frequency
  - Informed member consent for medication, including the member's understanding of the potential benefits, risks, side effects and alternatives to the medications
  - Changes or rationale for lack of changes in medication and/or dosage should be clearly documented along with the clinical rationale for the changes
  - Discharge summaries should specify all medications and dosages at the time of discharge
- A clear summary of presenting problems, the results of mental status exam(s), relevant psychological and social conditions affecting the member's medical and psychiatric status, and the source of such information
- Prominent documentation (assessment and reassessment) of special status situations, when present, including, but not limited to, imminent risk of harm, suicidal or homicidal ideation, self-injurious behaviors, or elopement potential (for all overnight levels of care). It is also important to document the absence of such conditions
- A medical and psychiatric history including previous treatment dates, clinician or facility identification, therapeutic interventions and responses, sources of clinical data and relevant family information
- The behavioral health history includes an assessment of any history of abuse the member has experienced
- For adolescents, the assessment documents a sexual behavior history
- For children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic)
- For members 12 years of age and older, documentation includes past and present use of nicotine or alcohol, as well as illicit drugs, prescribed or over-the-counter medications
- Documentation of a DSM diagnosis consistent with the presenting problem(s), history, mental status examination and other assessment data
- Medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of mental health condition. This can include elements of a physical examination, writing a prescription, or modifying psychiatric treatment
- Treatment plan documentation needs to include the following elements:
  - Specific symptoms and problems related to the identified diagnosis of the treatment episode
  - Critical problems that will be the focus of this episode of care are prioritized; any additional problems that are deferred should be noted as such
  - Relates the recommended level of care to the level of impairment
  - Member (and, when indicated, family) involvement in treatment planning

- Treatment goals must be specific, behavioral, measurable and realistic
- Treatment goals must include a time frame for goal attainment
- Progress or lack of progress toward treatment goals
- Rationale for the estimated length of the treatment episode
- Updates to the treatment plan whenever goals are achieved or new problems are identified
- If the member is not progressing towards specified goals, the treatment plan should be re-evaluated to address the lack of progress and modify goals and interventions as needed

- Progress notes include:
  - Signature of the practitioner rendering services
  - The date of service
  - Documentation of the use of telehealth technology, if applicable
  - Member strengths and limitations in achieving treatment plan goals and objectives
  - Treatment interventions that are consistent with those goals and objectives noted in the treatment plan
  - Dates of follow-up visits
  - Documentation of missed appointments, including efforts made to outreach to the member
  - For time-based services only, either start and stop time or total time in session
- Documentation of on-going discharge planning (beginning at the initiation of treatment) includes the following elements:
  - Criteria for discharge
  - Identification of barriers to completion of treatment and interventions to address those barriers
  - Identification of support systems or lack of support systems
- A discharge summary is completed at the end of the treatment episode that includes the following elements:
  - Reason for treatment episode
  - Summary of the treatment goals that were achieved or reasons the goals were not achieved
  - Specific follow up activities/aftercare plan
- Documentation of coordination of care activities between the treating clinician or facility and other behavioral health or medical clinicians, facilities or consultants. If the member refuses to allow coordination of care to occur, this refusal and the reason for the refusal must be documented. Coordination of care should occur:
  - At the time of intake
  - During treatment
  - At the time of discharge or termination of care
  - At the point of transition between levels of care, and

    - At any other point in treatment that may be appropriate
- Documentation of referrals to other clinicians, services, community resources, and/or wellness and prevention programs
- Telehealth Services: If the service is being provided virtually, this must be noted in the treatment record. Many states have specific documentation requirements for telehealth services. Please review the telehealth regulations in the state(s) in which you are licensed to practice
- Records related to billing must include all data elements required for submission of the claim

The **Fraud, Waste, Abuse, Error and Payment Integrity** webpage on *Provider Express* includes additional resources to support documentation requirements.

## Guidelines for Storing Member Records

Below are additional guidelines for completing and maintaining treatment records for members.

- Practice sites and Facilities must have an organized system of filing information in treatment records
- Records for members who desire interpretation services must be identified in a manner so office or facility staff is aware of the need for language assistance in all contacts
- Treatment records must be stored in a secure area and the practice 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 law, 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
- Providers with Electronic Health Records must have an established procedure to maintain a backup copy of all electronic health records

## Member Access to Medical/Mental 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.

Unless otherwise stated in your Participation Agreement, as a network provider you are required to:

- Send copies of our members' medical, financial, administrative or purchasing and leasing records
- Provide electronic medical records (EMR) 24/7 access to Optum
- Submit records to Optum within 14 calendar days upon request, free of charge

    - If the request for records is urgent, you must send us the records faster – generally 24/48/72 hours via electronic file transfer for urgent requests. The request will indicate the required timeframe.
- Maintain and protect records for 10 years
- Give access to records for all dates of service that occurred when you were a contracted provider
- Assist us, or our designee, in completing chart reviews for Medicare Advantage Members

# Confidentiality of Records

## Introduction

We strive to protect member confidentiality by complying with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, its implementing regulations, and other applicable federal and state privacy laws, including 42 CFR Part 2 ("Part 2"), and substance use disorder and mental health laws. It is our expectation that participating providers also follow these laws to protect the confidentiality of member records, as well as:

- Providing us with protected health information as needed and permitted for treatment, payment and health care operations purposes;[1]
- Obtaining member consent when needed to provide requested information to us; and
- Notifying us whether and when you are providing or disclosing data that is covered by Part 2.

## Release of Member Information

It is our policy to release information only to the member, or to other parties designated in writing by the member, unless otherwise required or allowed by law.

A member may authorize release of his or her PHI by submitting a signed, dated and legally compliant Release of Information (ROI) that specifies what information may be disclosed, to whom, for what purpose(s), and during what period of time. A member's authorization for ROI is not required when PHI is being exchanged between a provider and Optum for the purposes of Treatment, Payment or Health Care Operations as provided in HIPAA (and consistent with other applicable federal and state law).

## Identification and Authentication

Anyone requesting access to PHI be reasonably identified and authenticated.

**Provider authentication:** To identify and authenticate you or your administrative staff, we may require certain information including, but not limited to, your federal tax identification number or physical address and member information.

**Member verification:** Member information we may require for identification and authentication includes, but is not limited to, member's full name, full date of birth, full address, and member number

[2] "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.



or Subscriber number. If you or your administrative staff are unable to supply an identification or address administrative staff are unable to supply an identification or address, we may require the member's full telephone number or the last four digits of their Social Security Number.

# Quality Improvement

## Participation in the Optum Quality Improvement Program

We are committed to the highest quality of care provided in a manner consistent with the dignity and rights of members. Our Quality Improvement program monitors the following items:

- Accessibility
- Quality of care
- Appropriateness, effectiveness and timeliness of treatment, and
- Member satisfaction

The program is comprehensive and incorporates the review and evaluation of all aspects of the managed behavioral health care delivery system. If you have any feedback regarding QI projects and processes, please contact Provider Relations.

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

**Key Requirements**

- Ensuring that care is appropriately coordinated and managed between you and the member's primary medical physician and other treating clinicians and/or facilities
- 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)
- Responding to inquiries by our Quality Improvement staff
- Participation in Quality Improvement initiatives related to enhancing clinical care or service for members
- Assisting us in maintaining various accreditations as appropriate and as requested
- Submission of information related to Optum's review of potential quality of care concerns and sentinel events
- Helping to ensure members receive rapid follow-up upon discharge from an inpatient level of care

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

## Sentinel Events

Sentinel events 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/facility providing services, which has, or may have, deleterious effects on the member, including death or serious disability, that occurs during the course of a member receiving behavioral health treatment. If you are aware of a sentinel event involving a member, you must notify Optum Care Advocacy within one business day of learning about the occurrence by calling the number on the member's ID card.

### OptumHealth Behavioral Solutions of California Sentinel Events

We have established processes and procedures to investigate and address sentinel events. Cases that are considered representative of a sentinel event with an identified Quality of Care (QOC) concern are forwarded to the Peer Review Committee (PRC) for additional review and discussion. The PRC is chaired by medical directors within Optum and incorporates appropriate representation from the various behavioral health disciplines. You are required to cooperate with sentinel event investigations.

## Member Satisfaction Surveys

On at least an annual basis, as customers allow, we conduct a Member Satisfaction Survey of a representative sample of members receiving behavioral health services within the Optum network. The results of the survey are reviewed. Action plans are developed to address opportunities for improvement.

## Clinician Satisfaction Surveys

We regularly conduct a satisfaction survey of a sample of clinicians who delivered behavioral health services to members. This survey obtains data on clinician satisfaction with Optum services.

The results of the survey are compared to previous years for tracking and trending. Action plans are developed to address opportunities for improvement.

## Prevention Programs

Optum provides resources for early intervention in behavioral health problems. The interventions are for Depression, Substance Use/Addiction and Attention-Deficit/Hyperactivity Disorder (ADHD). For each of these conditions, Optum offers member resources:

- A screening tool to help the member decide whether to seek care
- Articles about the behavioral health conditions and how they are treated
- A list of organizations the member can contact if they want more information about a condition and its treatment
- Contact information for self-help groups if the member wants to talk with others who can provide support and encouragement
- Information on how to contact us if the member has questions or concerns

These resources can be accessed on **prevention.liveandworkwell.com** by all members, medical providers, and Optum network clinicians (enter Guest Access Code “Clinician”).

## Practice Guidelines

Optum has adopted **clinical guidelines** from nationally recognized behavioral health organizations and groups. Annually, Optum reviews standard HEDIS® measures as supplemental and measurable guidelines to inform ongoing quality initiatives.

Your feedback is encouraged on all guidelines and any suggestions on new guidelines to be considered for adoption are welcome.

## Quality Assurance and Complaint Investigation

You are required to fully cooperate with Optum in the complaint investigation and the Quality Assurance Review process.

Complaints staff, in conjunction with Quality Improvement and Provider Relations staff, monitor complaints filed against all practitioners and facilities. This includes soliciting information from them to properly address complaints and potential quality of care concerns.

In general, the resolution of most service complaints is communicated to the member when the complaint is received from, or on behalf of, the member. Clinical quality of care concerns initiated by members do not routinely include notification of resolution, except as required by applicable law or contractual agreement.

**Record Requests**
If we request written records for a Quality Assurance Review, you must submit these to Optum within 14 calendar days or sooner, as requested to meet customer/regulatory guidelines). In matters involving member safety, immediate responses may be requested.

Complaints filed by members should not interfere with the professional relationship between you and the member. Even if you use a third-party medical records vendor or other unique contractual agreement, you are required to provide records in the requested timeframe to ensure that all customer/regulatory requirements are met.

### OptumHealth Behavioral Solutions of California Quality Assurance

If we request written records for a Quality Assurance Review, you must submit these to Optum within the requested timeframe (within at least 10 business days, or sooner, as requested to meet customer/regulatory guidelines). Under California Civil Code, Sections 56.104 and 56.10(c)(4), Optum may obtain medical information relating to outpatient treatment with a psychotherapist if it submits the proper written request to the clinician and member. You are responsible for obtaining any release of information or consent form that may need to be signed by the Member or the Member’s guardian(s). Complaints filed by members should not interfere with the professional relationship between you and the Member. Even If you use a third-party medical records vendor or other unique contractual agreement, you are required to provide records in the requested timeframe to ensure that all customer/regulatory requirements are met.

Complaints staff, in conjunction with QI and Provider Relations staff, monitors complaints filed against

all Clinicians and Facilities and solicits information from them to properly address complaints and potential quality of care concerns. In general, the resolution of most service complaints is communicated to the Member when the complaint is received from, or on behalf of, the member. Clinical Quality of Care concerns initiated by members do not routinely include notification of resolution except as required by applicable law or contractual agreement.

### Corrective Action Plans

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

- Require you to submit a written response and/or submit and adhere to a CAP
- Require you to participate in an on-site audit or treatment record review audit (please refer to the following **Audits of Sites and Records** section)
- 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 facility
- Terminate your participation status with Optum
- Report concerns to the appropriate entity, such as the applicable licensing board

### Unavailable Status

Cooperation with an unavailable status associated with complaint, quality of care or sentinel event investigations may include:

- Informing members of unavailable status at the time of an initial request for services and identifying other network clinicians or facilities 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 facility
- Assisting members with stable transfers to another network clinician or facility at the member’s request

## Audits of Sites and Records

On-site and record-only audits may occur with any contracted provider. Both types of audits involve reviewing a sampling of treatment records. The on-site audit also 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 facility or office site.

Optum representatives conduct site visits at Clinician offices, Agencies such as Community Mental Health Centers (CMHCs), Facilities, and Group Provider locations. On-site audits are routinely completed with Agencies and Facilities 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 facility environment. Routine audits, either on-site or as a record-only review, may also occur in support of various health plan initiatives to monitor service delivery quality.

**National Accreditation Considerations**

Facilities and Agencies that hold national accreditation through organizations such as The Joint Commission, CARF, COA, HFAP, NIAHO, CHAP, and/or AAAHC receive credit for meeting those standards of care for the identified accredited services or programs without additional review prior to the initial credentialing process. When it is determined that a service or program is not part of the accreditation, we will audit that particular service or program.

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

**Chart Documentation**

During on-site and record-only audits for all typed of providers, chart documentation is reviewed, including, but not limited to, the assessment (which is distinct from any questionnaire the member may complete), 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. See the **Treatment Record Documentation Requirements** chapter of this manual for more information.

California legislation, Senate Bill (SB) 1207, updated the requirements for the state's existing maternal mental health program by making the following changes effective 7/1/2023:

- Health care service plan shall develop a maternal mental health program designed to promote quality and cost-effective outcomes
- Encourages health care service plans and health insurers to improve screening, treatment, and referral to maternal mental health services
- Incorporates quality measures to encourage screening, treatment, and referrals.

As a result of this legislation and to ensure members receive appropriate care, OptumHealth Behavioral Solutions of California (Optum) will begin monitoring for screening for pregnancy/post-partum depression as part of our ongoing provider treatment record audits as well as for initial credentialing and recredentialing audits. If depression is identified for this population, we will monitor for documentation of treatment and/or referrals as appropriate. 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" chapter 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 *Provider Express* for reference: Home page > Forms > Optum Forms - Administrative > **Site Audit Tools**.

## Member Education

We offer members convenient 24/7 confidential access to professional care, self-help programs and information and the member website **liveandworkwell.com**. It's available around the clock, from the convenience of your desk or the comfort of your home. Best of all, it's absolutely free to you and to members and their families.

Practitioners are also able to access these resources using the access code 'Clinician' on **liveandworkwell.com**. From self-assessments to videos and apps, find a variety of helpful educational materials for members. We encourage you to visit the site often and direct members to take advantage of these resources.

# Facility Platinum Designation

The Platinum Designation is for facility-based programs. Formerly known as ACE Facility, Platinum is a facility measurement and recognition designation that acknowledges facilities for delivering both effective and efficient clinical care for all levels of facility-based care. Claims-based date for inclusion in the program is run annually and facilities are notified by mail when one or more of their programs have achieved the Platinum Designation or when there is a change in the Designation status.

Facilities are responsible for following prior authorization and discharge notification procedures associated with the Platinum Designation. Failure to notify Optum at time of discharge or when the patient is being stepped down to a lower level of care may result in claim processing delays or denials.

# Compensation and Claims Processing

## Compensation

**Providers**

The contracted rate for eligible outpatient visits is reimbursed to practitioners at:

- The lesser of your customary charge, less any applicable co-payments, co-insurance and deductibles due from the member, or
- The Optum contracted rate, less any applicable co-payments, co-insurance and deductibles due from the member

**Facilities**

The contracted rate for Facilities is referenced in the Payment Appendix of the Facility Agreement and defines rates applicable to inpatient and/or higher levels of care rendered at the facility. When the contracted rates include physician fees, the facility is responsible for payment of all treating physicians and for notifying the physicians that payment will be made by the facility and not Optum. The contract rate for an admission to MHSUD, also known as MHSA, services is the contract rate in effect on the date the admission begins.

**General Information**

It is important that, as a contracted provider, you follow your fee schedule to ensure proper payment of claims. Failure to follow the terms and conditions as set forth on your fee schedule may result in claim denial(s).

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.

## Co-payments, Co-insurance and Deductibles

In most Benefit Plans, members bear some of the cost of behavioral health services by paying a co-payment, co-insurance and/or deductible (the “member expenses”). Deductible amounts and structure may vary from plan to plan. To abide by applicable law, including without limitation, parity laws, some deductibles may be combined with medical services. Members should be billed for deductibles after claims processing yields an Explanation of Benefits indicating member responsibility.

For co-payments, we encourage you to require payment at the time of service. It is your sole responsibility to collect member payments due to you. Members are never to be charged in advance of the delivery of services.

Benefit Plans often provide for annual co-payment or co-insurance maximums. If a member states that he or she has reached such a maximum, call the telephone number listed on the member’s ID card to confirm the amount and status of the member’s co-payment maximum. If a specific behavioral health

number is not listed, call the medical number and follow the prompts for behavioral health.

## 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. This means you may not charge members the difference between your billed usual and customary charges and the aggregate amount reimbursed by Optum and member co-payment, co-insurance or deductible amounts.

## Billing for Non-Covered Services and "No Shows"

If you seek prior authorization of benefits for behavioral health services or authorization for continued treatment, and Optum does not authorize the requested services, the member may be billed under limited circumstances.

- If a written statement is signed by the member after the non-coverage determination and in advance of receiving such services. Please note that a financial responsibility waiver signed by the member at the onset of treatment or at the time of admission is not applicable.

- The signed statement must include:
  - A statement that you have informed the member that Optum is unable to authorize such services for coverage under the member's benefit plan.
  - The reason given by Optum for not authorizing the services.
  - A statement that, as a result, the member has been denied coverage for such services under their benefit plan and will be financially responsible for them.

We encourage you to use this **Patient Financial Responsibility Form** or a similar form when billing members for non-covered services.

In the event a member exhausts the covered benefits under the benefit contract, you may bill the member directly for those services. Members may be charged no more than the applicable network fee schedule or the facility contracted rate for such services.

**No Show Appointments**
Optum does not pay for sessions that a member fails to attend. You may not bill Optum for such sessions or services.

A member who misses a scheduled appointment may be billed directly, provided you have advised the member in advance that this is your policy and the member has acknowledged the policy in writing:

- The member should be billed no more than your applicable network fee schedule or facility contracted rate for such services.

- Note that some plan designs, including Medicaid and Medicare, prohibit billing members for no-shows under any circumstance. Members are never to be charged a deposit or advance payment for a potential missed appointment.

Note that some plan designs, including Medicaid (Medi-Cal) and Medicare, prohibit billing members for no-shows under any circumstance. Members are never to be charged a deposit or advance payment for a potential missed appointment.

Optum may reimburse its network providers for business expenses to prevent the spread of diseases causing public health emergencies declared on or after January 1, 2022, such as personal protective equipment, additional supplies and materials, as defined by Optum.

Failure to follow this or any other required billing practice may result in referral to the Credentialing Committee for termination.

## 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 claims (whether electronic or paper claims). For more information about obtaining an NPI, you may contact the **Centers for Medicare and Medicaid**.

## Claim Submission

Unless otherwise directed by Optum, providers shall submit outpatient claims using the current 1500 claim form (v 02/12) or facility-based claims using a UB-04 form (its equivalent or successor), whichever is appropriate,

- Services billed using a CPT or HCPCS code must be billed on a current 1500 claim form and consistent with your fee schedule.
- Revenue codes or revenue codes with accompanying CPT or HCPCS codes should be billed on a UB-04 claim form.

The claim submission should all data elements necessary to process a claim, including:

- Applicable coding including, ICD diagnosis code(s), CPT, revenue and HCPCS coding
- Code modifiers and/or other identifiers requested by Optum
- The member ID number
- Customary charges for the MH/SUD services rendered to a member during a single instance of service,
- The provider's Federal Tax Identification Number (TIN), National Provider Identifier (NPI)

Billing inconsistent with the above or your contracted fee schedule will result in an initial claim denial. The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable state or federal laws.

In addition, you are responsible for billing of all members in accordance with the nationally recognized **CMS National Correct Coding Initiative** billing standards.

Although claims are reimbursed based on the network fee schedule or facility contracted rate, your

claims should be billed with your usual and customary charges indicated on the claim.

For more information, review **Improve the Speed of Processing – Tips for Claims Filing**.

**Claim Submission Options**

1. **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 EDI.
   - Behavioral Health claims sent via EDI should be routed to Payor ID #87726. Because Optum has multiple claims payment systems, it is important to use this number so the claim goes to the correct system.

   Facilities may file claims through an EDI vendor and can view claim status on the **Provider Express** secure portal.

2. **Claim Entry on Provider Express:** secure portal online training. Submitting claims on the *Provider Express* secure portal closely mirrors the process of completing the Form 1500 claim form (v 02/12). The secure portal can be used by network clinician or group practices, or by out-of-network individual clinicians. Users must have a registered One Healthcare ID and password for the *Provider Express* secure portal. To obtain a One Healthcare ID, click on the **First-time User** link from our home page.

   EAP claims can also be submitted through the secure portal. The table below reflects the codes for services included in the EWS benefit:

| | | | | |
|---|---|---|---|---|
| 90832 HJ | 90834 HJ | 90846 HJ | 90847 HJ | 90853 HJ |

   EAP claims must use the standard “HJ” code in the first modifier field of section 24 D to differentiate between EAP and standard mental health/substance use disorder claims. For telehealth visits, the place of service code “02” must also be used. Optum also recommends including an appropriate diagnosis code (e.g., “Z” code).

3. **Clinician claim forms:** Paper claims should be submitted to Optum using the Form 1500 claim form (v 02/12) or its successor form, as outlined in your Participation Agreement. Claims should include all itemized information, such as:

   - Member and subscriber names and dates of birth
   - Member identification number
   - ICD diagnosis code
   - Date(s) of service
   - Length of session
   - Type and duration of service
   - Clinician Information:
     - Name (i.e., individual who actually provided the service)

- Credentials
- Tax ID
- NPI number

4. **Facility claim forms:** Paper claims for a facility should be submitted to Optum using the UB-04 claim form or its successor. The form includes all itemized information, including:

   - Member identification number
   - Date(s) of service
   - ICD diagnosis code
   - CPT procedure code(s) and/or revenue code(s)
   - Billed charges for the service(s) rendered
   - Name of facility
   - Facility federal tax ID number
   - Member name and date of birth

### Updating Demographic Information

To ensure proper processing of claims, it is important to promptly update your demographic information if your Tax ID number (TIN), practice address, phone number, appointment availability or other information changes. You may submit changes online using the My Practice tool in the *Provider Express* secure portal.

### Claims Help

Optum has dedicated service departments with staff available 5 days a week during regular business hours to assist network providers. The Provider Services Line for Behavioral Health providers is **1-877-614-0484**. You may also call the number listed on the back of the member's ID card.

## 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.

## Claim Processing and Payment

**Timely Filing**
All information necessary to process claims must be received by Optum no more than 90 calendar days from the date of service, or as allowed by state or federal law or the member's specific benefit plan.

- Claims received after this time period may be rejected for payment due to timely filing requirements, 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, using the claim submission options previously noted. We strongly recommend that you keep copies of all claims for your own records.

**Payment Timelines**
Generally, claims that contain all required information and have the required authorization, if applicable, will be paid within 45 calendar days after Optum receives the claim, or as required by state and federal laws. This may exclude claims that require coordination of benefits determinations.

**Payment Details**

- 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 previous payments for services and may audit claims submissions and payments to ensure compliance with applicable policies, standards, procedures, including without limitation, the network provider manual, the Optum Behavioral **Credentialing Plan**, the provider's Participation Agreement, and state and federal laws.
- Optum may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law.

**Retroactive Payments**
Optum will not assign a retroactive effective date or pay claims retrospectively unless mandated by federal or state laws. This applies in the event a Participation Agreement with Optum has not been executed in a timely fashion or within a commercially reasonable amount of time is not provided to align Optum systems with a Participation Agreement.

No interest or penalty otherwise required under applicable law will be due on any claim which was initially processed timely and accurately, but which requires reprocessing as a result of the untimely execution of a Participation Agreement or amendment; or the inability to align Optum systems in a commercially reasonable period of time.

**Insolvency**
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 member's employer or Optum, your sole redress is against the assets of Optum or the applicable payor, 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 Participation Agreement has no bearing on this requirement.

**Payment Methods**
You may choose to receive electronic payments by direct deposit into your business bank account (automated clearinghouse or ACH) or by virtual card payment (VCP). Review the **Optum Pay** webpage for more information.

The initial set-up of direct deposit, transition to VCP, or a change in banking information will take approximately 10 business days for processing and bank account validation.

# Fraud, Waste and Abuse Prevention

## Overview

Optum believes that providers are an integral part of our program of integrity work. Protecting clients, providers and stakeholders through the prevention, early detection, investigation and ultimate resolution of potential Fraud, Waste and Abuse (FWA) issues is a fundamental component of quality care and sound clinical practice. We are pleased to work in consultation with providers to find solutions that address potential FWA without adding unnecessary burdens to your office.

**Special Investigations Unit**
CMS requires payers establish a Special Investigations Units or their equivalents, as well as an develop an effective system for routine monitoring, auditing and identification of risks and to carry out appropriate corrective action.

At Optum, our “Special Investigations Unit” is called the Program and Network Integrity (PNI) department. This group of professionals is committed to a balanced approach to potential FWA, including open and clear communication with the provider community.

The PNI department is committed to appropriate corrective action on a continuum commensurate with the questionable activity. Actions include addressing simple mistakes and the need for education and addressing fraudulent activity and the referral to law enforcement. There is also a requirement to recover payments – it is critical that dollars not appropriately directed get recovered while education and other appropriate action are underway.

Optum is committed to:

- A comprehensive view of how Program and Network Integrity interacts with you
- Building and sustaining trust in provider communities regarding fraud, waste and abuse initiatives and activities
- Transparency into our activities
- Ensuring reliability and timeliness in our practice and methodology
- Overall education and awareness for the network
- Soliciting critical feedback from the network and professional associations in developing long-term strategies for identifying and avoiding potential fraud, waste and abuse

In summary, Optum is committed to addressing and correcting questionable activity and known offenses, recovering inappropriately paid funds, improving overall anti-Fraud, Waste and Abuse (FWA) ability and partnering with the network and with state and federal agencies to educate, pursue and prosecute violators to the fullest extent of the law.

## Program Introduction

The FWA Program 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 investigators, prospective intervention specialists, data analytics staff, certified coders and executive leadership.

Potential fraud, waste and/or abuse practices include, but are not limited to the following:

| Fraud | Waste | Abuse |
|---|---|---|
| Intentional misrepresentation to gain a benefit | Any unnecessary consumption of health care resources | Unsound business practice that can include inappropriate utilization and/or inefficient use of resources |
| **Example**: Knowingly billing for a service(s) that was never performed | **Example:** Billing for services 5X per week when 1X per week would have been medically appropriate. Please note that Medical Necessity is not something monitored or managed by PNI | **Example:** Billing for a 90792 (diagnostic evaluation) when individual therapy was performed |

The identification process includes, but is not limited to, examining claims to identify outlier claims billing patters.

In the event potential fraud, waste and/or abuse is identified, appropriate corrective actions are implemented using a range of tools from education of providers to full recoupment of improperly paid funds. 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 reviews, and
- Referral for further investigation

Providers 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 than 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 sources outside your organization.

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 and educational materials on *Provider Express*: Home page > Admin Resources > **Fraud, Waste, Abuse, Error and Payment Integrity**.

In compliance with the federal regulations, providers 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. Providers 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 Prospective Process

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

Optum has a prospective 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 or period of claims reviewed is normally determined by state and federal regulation.

## Retrospective 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
- Negotiating with providers regarding a corrective action plan and settlement of overpayment

Following an investigation, 2 actions may occur:

1. Timely payment is made, or,
2. A denial notification is issued which includes the provider's standard appeal rights.

Findings of billing inconsistent with our policies by 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 a Provider's Agreement

In the case of retrospective review, Optum and our Payors reserve the right to pursue up to full 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 law. 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 their respective State Department of Insurance, licensing board(s) and any other regulatory agencies based on the outcome of the investigation and as required by state and federal law. 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.

## Exclusions, Sanctions and Debarment

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: **oig.hhs.gov/exclusions/index.asp**
- General Services Administration (GSA) Excluded Parties List System (EPLS) is accessible through the System for Award Management (SAM) site: **sam.gov/SAM/**

**What You Need to Do:** Review applicable exclusion/sanction/debarment lists to ensure that none of your employees or contractors is 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.

When medical records are requested, you will receive a letter outlining specific information required, which may include but is not limited to:

- Counseling session start and stop times
- Medication prescription monitoring, if applicable
- Modalities and frequencies of treatment furnished
- Results of clinical tests, if applicable
- Any summary of the following: diagnosis, functional status, treatment plan/goals, prognosis and progress to date

# Appeals and Provider Dispute Resolution

## Introduction

There are two distinct processes related to Non-Coverage Determinations (NCD) regarding requests for services or payment: (1) Member Appeals and (2) Provider Dispute Resolution. An NCD, 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 NCD may be subject to the Member Appeals process or Provider Dispute Resolution process depending on the nature of the NCD, member liability and your Agreement. Providers must submit a separate Member Appeal or Provider Dispute for each member.

Care advocacy decision-making is based on the appropriateness of care as defined by Clinical Criteria. These criteria include LOCUS, CALOCUS-CASII, ECSII, the APA *Psychological and Neuropsychological Testing Billing and Coding Guide, The ASAM Criteria* any state or contractually required criteria, as well as the terms and conditions of the Member's Benefit Plan.

**Information regarding the Clinical Criteria is** available at *Provider Express* > **Guidelines/Policies & Manuals**. To request a paper copy of Optum documents, please contact the Provider Service Line at **1-877-614-0484**.

Optum expects that all treatment provided to members 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.

**Important:** A Member Appeal or Provider Dispute must be submitted separately for each member to ensure compliance with HIPAA requirements.

## OptumHealth Behavioral Solutions of California Member Appeals Process

Our care advocacy process offers every member, clinician and facility the opportunity to discuss a potential Non-Coverage Determination (NCD) based on medical necessity with an appropriate peer reviewer at OptumHealth Behavioral Solutions of California ("OHBS-CA") before an NCD is made. You or the member may request to discuss an NCD with us during the authorization of benefits process.

When a request for coverage of behavioral health services is not granted due to medical necessity or administrative decisions, the member or authorized member representative will be informed of the appeals process. Member Appeals can be requested as expedited (urgent) or standard (non-urgent). The appeal request should be submitted as soon as possible and must be received by OHBS-CA within 180 days from receipt of the NCD.

Expedited/urgent ("Expedited") appeals apply in situations where care is underway or has not yet been provided and the case involves "an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb or major bodily function" (California Health and

Safety Code, Section 1368.01(b)). Expedited/urgent appeals may be requested by the provider on behalf of the member. In these cases, the OHBS-CA peer reviewer (Appeal Reviewer) makes a reasonable effort to contact the treating provider within 24 hours of the receipt of the appeal request. We will make the review determination, notify the treating clinician by telephone, and send written notice of the appeal outcome to the treating provider (when applicable), and member or authorized member representative, as indicated, within 72 hours of the receipt of the appeal request. If the Appeal Reviewer is unable to reach the treating provider, the Appeal Reviewer will make a determination based on the available information. By definition, expedited appeals are not available in situations where services have already been provided.

When the situation is not of an urgent nature, a standard, or non-urgent, appeal may be requested. We will make an appeal determination and notify the member or authorized member representative in writing within 30 calendar days of receipt of the request.

A clinical peer who has not previously been involved in the NCD and is not a subordinate of any person involved in the NCD will review the appeal request and all available information, including treatment records in order to make a determination. For inpatient cases, the Appeal Reviewer will be a board-certified psychiatrist from the same or similar specialty area with an active, unrestricted California license. For outpatient cases involving a clinical determination, the Appeal Reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted California license. Non-licensed appeals staff may review and make determinations for non-clinical administrative appeals.

If the appeal decision is to uphold an NCD, OHBS-CA will notify the Member or Member representative of the outcome and any additional levels of appeal, if applicable.

Clinicians and Facilities may continue to provide service following an NCD, but the member must be informed of the NCD in writing. The member or member's representative is informed that the care will become their financial responsibility beginning from the date of the NCD. The member must agree to these terms in writing before continuing services can be provided. You may charge no more than the OHBS-CA contracted fee for continuing services, although a lower fee may be charged. The consent of the member to continuing care will not impact the appeals process as described above but will impact your ability to collect reimbursement from the member for these services. If the member does not consent to continuing care in writing, and OHBS-CA upholds the NCD regarding the cessation of coverage for such care, you cannot collect reimbursement from the member.

## Independent Medical Review

**For members whose regulatory rights are governed by the Department of Managed Health Care (DMHC):** If the appeal involves coverage that was denied, modified, or delayed by Optum on the grounds that the service was not medically necessary, (in whole or in part), the member has a right to request an external Independent Medical Review (IMR). Requests for IMR are made to the DMHC in accordance with California law. You or the member must first appeal Optum's decision and wait for at least 30 calendar days before the member requests external IMR. However, if the matter would qualify for an expedited decision, the member may immediately request an external IMR following receipt of notice of denial.

The member may initiate this review by completing an application for external IMR, a copy of which can be obtained by contacting Optum. The DMHC will review the application and, if the request qualifies for external IMR, will select an external review agency and have the member's medical records submitted to a qualified specialist for an independent determination of whether the care is medically necessary.

There is no cost to the member for external IMR. This review is in addition to any other procedure or remedies available to the member and is completely voluntary. However, failure to participate in external review may cause the member to give up any statutory right to pursue legal action against Optum, regarding the disputed service. For more information regarding the external IMR process, please contact our Grievance Department at **1-800-999-9585**.

**For members whose regulatory rights are governed by the California Department of Insurance (CDI):** If the appeal involves coverage that was denied, modified, or delayed by Optum on the grounds that the service was not medically necessary, (in whole or in part), the member has a right to request an external Independent Medical Review (IMR). Requests for IMR are made to the California Department of Insurance (CDI) in accordance with California law. You or the member must first appeal Optum's decision and wait for at least 30 calendar days before the member requests external IMR. However, if the matter would qualify for an expedited decision, the member may immediately request an external IMR following receipt of notice of denial.

The CDI will review the application and, if the request qualifies for external IMR, will select an external review agency and have the member's medical records submitted to a qualified specialist for an independent determination of whether the care is medically necessary. There is no cost to the member for external IMR. This review is in addition to any other procedure or remedies available to the member and is completely voluntary. However, failure to participate in external review may cause the member to give up any statutory right to pursue legal action against Optum regarding the disputed service. For more information regarding the external IMR process, please contact the Grievance Department at **1-800-999-9585**.

For member's, whose regulatory rights are governed by a state other than California, contact the number on the member's ID card for information regarding Independent Medical Review.

## Provider Reconsideration and Appeals Process

Network providers must follow a 2-step process if you disagree with the outcome of a Commercial or Medicare Advantage clinical prior authorization request or claim processing decision.* Providers should request reconsideration before filing an appeal.

| | Step 1: Request Reconsideration | Step 2 (if needed): File an Appeal |
|---|---|---|
| When to Use | If you disagree with the outcome of a prior authorization or claim decision, you should first request reconsideration of the decision. | If you disagree with the outcome of the reconsideration decision in Step 1, you may submit an appeal. |
| Deadline | The 2-step process allows for a total of 12 months for submission for both steps (Step 1: Reconsideration and Step 2: Appeals). If a different deadline is required by state law or outlined in your Participation Agreement, that timeline supersedes the 12 months noted. | |

<table>
<tr><td>Required Documentation</td><td colspan="2">Include member-specific treatment plans, clinical records, payment appendices or other items that support why you believe our decision was incorrect. We make our review decision based on the materials available at the time of the review.<br><br>Proof of Claim Timely Filing<br>Include confirmation we received and accepted your claim within your timely filing requirement. Timely filing limits vary based on state requirements and contracts. Refer to your Participation Agreement for specific timely filing requirements.</td></tr>
<tr><td>Submission Methods</td><td>  By mail:<br><br>Complete a reconsideration request form to outline the reason you disagree with our decision.<br><br>Then mail the form and supporting documentation to:<br><br>Optum Behavioral Health Solutions<br>P.O. Box 30757<br>Salt Lake City, UT 84123</td><td>  Online via the Provider Express secure portal:<br><br>1. Go to Providerexpress.com and click Log In (located in the upper right corner). Then, sign into the secure portal with your One Healthcare ID and password.<br><br>2. In the secure portal, click Appeals, then click Appeals Summary & Submission<br><br>3. In the Appeals Submission section of the page, select Submit Claim Appeal to start the process. Be sure to include:<br><br>• The factual or legal basis for appeal<br>• Any additional information, clinical records or documentation that will help in the review of your request</td></tr>
<tr><td>Decision</td><td colspan="2">Once each review is complete, you'll be notified in writing of the outcome:<br>• Overturned claim decisions: If the claim requires an additional payment, the Provider Remittance Advice (PRA) will serve as notification of the review outcome.<br>• Upheld decisions: If the original prior authorization denial or claim decision is upheld, you'll be sent a letter outlining the details of the review.</td></tr>
</table>

**The reconsideration and appeal process applies to prior authorization requests and claim submissions for Commercial and Medicare Advantage benefit plans for dates of services July 5, 2023 or later. Your state rules and regulations, as well as the member's benefit plan, will govern whether reconsideration of decisions is available or whether decisions are to be resolved solely through the appeals process. The terms and conditions of your participation in a network administered by United Behavioral Health or its Affiliates and your reimbursement for covered services are determined by your Participation Agreement or the member's benefit plan. Should any item listed in this section conflict with your Participation Agreement or the member's benefit plan, the terms of your Participation Agreement or the member's benefit plan will control.*

# OptumHealth Behavioral Solutions of California Provider Dispute Resolution Mechanism

A Provider Dispute is a contracted provider's written notice to OptumHealth Behavioral Solutions of California ("OHBS-CA") requesting review or reconsideration of a claim that has been denied, adjusted or contested; or seeking resolution of a billing determination or other contract dispute; or disputing a request for reimbursement of an overpayment of a claim. Provider Disputes are resolved through the Dispute Resolution Mechanism.

Disputes must be submitted in writing and must include the following:

- Provider's name
- Provider's identification number
- Provider's contact information
- If about a claim, specific claim information including claim number, dates of service, procedure codes, amounts, etc.
- If not about a claim, a detailed explanation of the issue
- If about a member, the name and identification number of the member and a detailed explanation of the issue

Provider Disputes may be submitted through secure "Transactions" on **Provider Express** or a written dispute can be sent to the OptumHealth Behavioral Solutions of California Appeals Department:

OptumHealth Behavioral Solutions of California
Attn: Appeals and Grievances Department
P. O. Box 30512
Salt Lake City, UT 84130-0512

Telephone: **1-800-999-9585**
Fax: **1-855-312-1470**

Providers may contact Network Management for guidance with the Dispute Resolution Process. Providers have up to three hundred sixty-five (365) days from the date of OHBS-CA's action, inaction or incident causing dissatisfaction to submit a dispute. OHBS-CA will send written acknowledgment to the provider within 2 days of receiving an electronically submitted dispute or within 15 working days of receiving the written dispute. OHBS-CA will send written notice of the resolution to the provider within 45 working days of receiving the dispute.

Any dispute submitted by a treating clinician on behalf of an Enrollee is handled through OHBS-CA's member grievance and appeals system according to our policy and procedure. In such cases, the provider is deemed to be assisting the Enrollee within the context of California Health and Safety Code, §1368.

Providers are offered one level of dispute review unless otherwise required by applicable law or regulation or contractual requirement. The outcome of the dispute is OHBS-CA's final determination.

## Resolving Adverse Benefit Determinations

On occasion, the reconsideration and appeal process may not resolve your concerns about a clinical prior authorization request or claim processing decision for a Commercial or Medicare Advantage plan. If that occurs, please follow the dispute resolution process outlined in your Participation Agreement for further review.

## Member Appeals for Prior Authorizations

When a prior authorization request is denied, the member or an authorized representative may file an appeal when the member may:

- Incur financial liability beyond the normal cost share, or
- Experience a reduction in services requested.

The authorized representative may be the member's treating clinician at any level of care. The member appeals process, including any applicable requirements for the filing and handling of an appeal, is detailed in the Member Rights enclosure sent with the prior authorization request denial notice sent to the member and the authorized representative.

**Member appeals decisions**

If the appeal decision is to uphold a non-coverage decision, Optum will notify you and the member, or the member's representative, of the outcome and any additional levels of appeal that are available.

You may continue to provide service following a non-coverage decision, but the member should be informed of the non-coverage decision by you in writing. The member or the member's representative should be informed that the care will become the financial responsibility of the member from the date of the non-coverage decision. In order for the provider to receive payment from the member, the member must agree in writing to these continued terms of care and acceptance of financial responsibility. You may charge no more than the Optum contracted fee for such services, although a lower fee may be charged.

The consent of the member to receive such care and responsibility will not impact the appeals determination, but it will impact your ability to collect reimbursement from the member for these services. If the member does not consent in writing to continue to receive such care, and Optum upholds the determination regarding the cessation of coverage for such care, you cannot collect reimbursement from the member pursuant to the terms of your Participation Agreement.

# Member Complaints / Grievances

Questions and/or concerns from members regarding any aspect of Optum services may be submitted orally, in writing, or online and directed to the Grievance Department.

**OptumHealth Behavioral Solutions of California Appeals and Grievances Department:**

OptumHealth Behavioral Solutions of California
Attn: Appeals and Grievances Department
P.O. Box 30512
Salt Lake City, UT 84130-0512

Telephone: **1-800-999-9585**
Fax: **1-855-312-1470**

Members may request your assistance with any aspect of the complaint process. The **Member Grievance Form** and complaint filing instructions located in **Appendix D** must be readily available at your office location and promptly provided to the member upon request. When providing the Grievance Form, it is important to also provide the appropriate Short Notice (also included in Appendix D) to advise the member of the availability of free language assistance services. The member may also contact Optum directly for a Member Grievance Form and filing instructions or access the form through the Member website, **liveandworkwell.com**.

Optum will provide written acknowledgement of member complaints within five calendar days of receipt by Optum or, if applicable, by the entity contracted with Optum to administer its complaint system. member complaints will be resolved by Optum within 30 calendar days of receipt. Notice of resolution will be communicated in writing to the member or complainant within 30 calendar days of receipt of the complaint.

**For members under the jurisdiction of the Department of Managed Health Care (DMHC):** When Optum receives a complaint or grievance requesting expedited review, Optum will immediately notify the member of his/her right to contact the DMHC. In addition, Optum will inform the member, Subscriber and the DMHC, in writing, of the disposition or pending status of the complaint/grievance within three calendar days of receipt.

# Manual Updates, Governing Law and Contract

## Manual Updates

This manual is updated periodically as procedures are modified and enhanced. The current version of the manual is always available on **Provider Express**. 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 the Provider Service Line at **1-877-614-0484**.

## 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.

# Appendix A – OptumHealth Behavioral Solutions of California Enrollee Rights and Responsibilities (English)

## OptumHealth Behavioral Solutions of California (OHBS-CA) Enrollee Rights & Responsibilities

- Enrollees have the right to be treated with personal dignity and respect.
- Enrollees have the right to care that is considerate and respects Enrollee's personal values and belief system.
- Enrollees have the right to personal privacy and confidentiality of information.
- Enrollees have the right to receive information about OHBS-CA's services, clinicians, clinical guidelines, quality improvement program, and enrollee rights and responsibilities.
- Enrollees have the right to reasonable access to care, regardless of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, ethnicity, age, or disability.
- Enrollees have the right to participate in an informed way in the decision-making process regarding

their treatment planning.

- Enrollees have the right to discuss with their Clinicians and Facilities the medically necessary treatment options for their condition regardless of cost or benefit coverage.
- Enrollees have the right of Enrollees' families to participate in treatment planning as well as the right of Enrollees over 12 years old to participate in such planning.
- Enrollees have the right to 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, and
  - An adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.
- Enrollees have the right to participate in the consideration of ethical issues that arise in the provision of care and services, including:
  - Resolving conflict,
  - Withholding resuscitative services,
  - Forgoing or withdrawing life-sustaining treatment, and
  - Participating in investigational studies or clinical trials.
- Enrollees have the right to designate a surrogate decision-maker if the Enrollee is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- Enrollees and their families have the right to be informed of their rights in a language they understand.
- Enrollees have the right to voice complaints or appeals about OHBS-CA, Clinicians and Facilities, or privacy practices.
- Enrollees have the right to request to inspect and obtain a copy of their Protected Health Information (PHI), to amend their PHI, to restrict the use of their PHI, and to receive an accounting of disclosures of PHI.
- Enrollees have the right to make recommendations regarding OHBS-CA Enrollee rights and responsibilities policies.
- Enrollees have the right to be informed of rules and regulations concerning Enrollee's conduct.
- Enrollees have the responsibility to give their Clinicians and Facilities and OHBS-CA information needed in order to receive care.
- Enrollees have the responsibility to follow their agreed upon treatment plan and instructions for care.
- Enrollees have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with their clinician mutually agreed upon treatment goals.

# Appendix B – OptumHealth Behavioral Solutions of California Enrollee Rights and Responsibilities (Spanish)

## OptumHealth Behavioral Solutions of California (OHBS-CA) Derechos y Responsabilidades del Miembro

- Los miembros tienen el derecho de ser tratados con respeto y dignidad personal.
- Los miembros tienen el derecho de recibir un cuidado que considere y respete sus valores y creencias.
- Los miembros tienen el derecho a la privacidad individual y la confidencialidad de la información.
- Los miembros tienen el derecho de recibir información sobre los servicios de OHBS-CA, sus proveedores, sus guías clínicas, el programa de Mejoramiento de Calidad, y los derechos y responsabilidades del paciente.
- Los miembros tienen el derecho de recibir servicios sin consideración a su raza, grupo étnico, religión, género, orientación sexual, edad o incapacidades.
- Los miembros tienen el derecho de participar en forma bien informada en el proceso de tomar decisiones y desarollar el plan de tratamiento.

- Los miembros tienen el derecho de discutir con sus proveedores de servicio, las opciones medicas relacionadas con su condición sin importar el costo o la cobertura de los beneficios.
- Los miembros tienen el derecho de incluir la participación de sus familiares en el tratamiento. Los miembros mayores de 12 años tienen el derecho de participar en la planificación de su tratamiento.
- Los miembros tienen el derecho de recibir un tratamiento individualizado incluyendo el derecho:
  - De recibir servicios adecuados y humanitarios sín importar el orígen del apoyo económico
  - De recibír servicios dentro del medioambiente menos restrictivo posible
  - De implementar un plan de tratamiento individualizado
  - De revisar periódicamente el plan de tratamiento y;
  - De tener un número adecuado de profesionales competentes, cualificados y con experiencía para implementar y supervisar el plan de tratamiento.
- Los miembros tienen el derecho de participar en el proceso de consideración de problemas éticos que surjan durante el transcurso del tratamiento, incluyendo:
  - Resolución de conflictos
  - El derecho de rechazar medidos resucitativas
  - El derecho de rechazar tratamiento que prolonguen la vida
  - El derecho a participar en estudios e investigaciones clínicas
- Los miembros tienen el derecho de nombrar y autorizar a personas para tomar decisiones en su nombre en caso de que el paciente se encuentre incapacitado para entender el tratamiento propuesto o no pueda communicar sus deseos y decisiones.
- Los miembros y sus familias tienen el derecho de ser informados sobre sus derechos en una lengua que puedan entender.
- Los miembros tienen el derecho de quejarse acerca de OHBS-CA, sus proveedores de servicio, o las prácticas privadas, y someter apelaciones sobre las decisiones de los mismos.
- Los miembros tienen el derecho de solicitar una petición para inspeccionar y obtener una copia de su infomación protegida de salud (PHI), para enmendar su PHI, para restringir el uso de su PHI, y para recibir una contabilidad de descubrimientos de PHI.
- Los miembros tienen el derecho de presentar recomendaciones con relacion a las pólizas de derechos y responsabilidades del paciente que OHBS-CA promulga.
- Los miembros tienen el derecho de ser informados sobre los reglamentos y reglas que aplican a su conducta.
- Los miembros tienen la responsabilidad de proveer a los proveedores y OHBS-CA la información nece saria para su tratamiento.
- Los miembros tienen el deber de cumplir con el plan de tratamiento y las instrucciónes prescritas por su proveedor.
- Los miembros tienen la responsabilidad de participar, en la medida posible, en desarollar un entendimiento de sus problemas de salud mental y en establecer metas e tratamiento conjuntamente con su proveedor.

# Appendix C – Member Grievance Form and Notice

If you are not satisfied with any aspect of your contact with OptumHealth Behavioral Solutions of California (OHBS-CA), also known as U.S. Behavioral Health Plan, California (USBHPC), or its representatives, please complete this form and return it to the address or fax number listed below.

**Please provide the name, address, and phone number of the provider involved in the report, if applicable:**

_____

_____

**Please describe your grievance in as much detail as possible, including dates and names:**

_____

_____

_____

_____

_____

_____

_____

_____

**Please complete the following information:**

Member Name: _____ Member Date of Birth: _____

Member Address: _____

Contact Phone Number: _____

Subscriber Name: _____ Relationship to Subscriber: _____

If someone other than the member is completing this form, please include name, address, and relationship to the member: _____

_____

Date: _____

Please send the completed form by mail or fax to: OptumHealth Behavioral Solutions of California
Attn: Grievances and Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512

Fax: **1-855-312-1470**

You may also file your appeal online by visiting **liveandworkwell.com.** To access OHBS-CA's online Grievance Form, enter your access code to login and click on "**Grievance/Complaint Form**" in the **Quick Links** section on the Home page.

**Please see next page for important information regarding member grievance rights.**

**Expedited Appeal.** An expedited appeal may be requested in those cases that involve an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb or major bodily function. You or your provider should call OHBS-CA as soon as possible at 1-800- 999-9585. Your appeal will be reviewed, a decision made, and you and your treating provider will be notified as soon as possible to accommodate your clinical condition, but not to exceed seventy-two (72) hours of OHBS-CA's receipt of the expedited appeal request. You will be notified in writing of OHBS- CA's determination. Additionally, OHBS-CA will provide the California Department of Managed Health Care ("Department") with a written statement on the disposition or pending status of the expedited appeal within three (3) days of receipt of the appeal request. If you are requesting an expedited appeal, you may also request that a separate expedited Independent Medical Review be conducted at the same time by the California Department of Managed Health Care.

**California Department of Managed Health Care Notification**
**Grievance Process and Independent Medical Review**

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-999-9585** or **711 for TTY (at operator request, say "1-800-985-2410")** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

**English**

**IMPORTANT LANGUAGE INFORMATION:**

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. If you need more help, call HMO Help Line at 1-888-466-2219.

**Spanish**

**INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:**

Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de U.S. Behavioral Health Plan, California al 1-800-999-9585 / TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la HMO al 1-888-466-2219.

**Chinese**

**重要語言資訊：**

您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如需取得您語言的協助，請撥打下列電話與您的健保計畫聯絡：U.S. Behavioral Health Plan，California 1-800-999-9585 / 聽力語言殘障服務專線 (TTY)：711。若您需要更多協助，請撥打 HMO 協助專線 1-888-466-2219。

**Arabic**

**معلومات مهمة عن اللغة:**

ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. قيمكنك الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: U.S. Behavioral Health Plan, California على الرقم 711 / TTY: 1-800-999-9585. وإذا احتجت لمزيدٍ من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ HMO على الرقم 1-888-466-2219.

**Armenian**

**ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝**

Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY՝ 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք HMO-ի Օգնության հեռախոսագիծ 1-888-466-2219 համարով:

**Cambodian**

**ព័ត៌មានសំខាន់អំពីភាសា៖**

អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាការបកប្រែ ដោយឥតគិតថ្លៃ។ ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលជំនួយជាភាសា របស់អ្នក សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក នៅ៖ U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711។ លើសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ HMO តាមលេខ 1-888-466-2219។

**Farsi**

**اطلاعات مهم در مورد زبان:**
شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینه دریافت کنید. اطلاعات کتبی نیز ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: U.S. Behavioral Health Plan, California به شماره 1-800-999-9585/ TTY: 711 تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی HMO به شماره 1-888-466-2219 تماس بگیرید.

**Hindi**

**भाषा-संबंधी महत्वपूर्ण जानकारी:**

आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ़्त में दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी आपको मुफ़्त में उपलब्ध कराई जा सकती हैं। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपने स्वास्थ्य प्लान को यहाँ कॉल करें: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711। पर। अतिरिक्त सहायता की आवश्यकता पड़ने पर, HMO Help Line को 1-888-466-2219 पर कॉल करें।

**Hmong**

**COV NTAUB NTAWV LUS TSEEM CEEB:**
Tej zaum koj yuav muaj cai rau cov cai pab cuam hauv qab no. Koj tuaj yeem tau txais ib tug kws txhais lus los sis txhais ntawv pub dawb. Cov ntaub ntawv sau no muaj sau ua qee yam ntaub ntawv pub dawb rau sawd daws. Yuav tau txais kev cov ntaub ntawv sau ua koj lus, thov hu rau qhov chaw npaj kho mob rau ntawm: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HMO Help Line ntawm tus xov tooj 1-888-466-2219.

**Japanese**

**言語支援サービスについての重要なお知らせ：**
お客様には、以下のような権利があり、必要なサービスをご利用いただけます。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください：U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711。この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

**Korean**

**중요 언어 정보:**
귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. 더 많은 도움이 필요하신 분은 HMO 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

**Punjabi**
**ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:**

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਬਿਨਾ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: 'U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

**Russian**
**ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:**
Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: U.S. Behavioral Health Plan, California 1-800-999-9585 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HMO по телефону 1-888-466-2219.

**Tagalog**
**MAHALAGANG IMPORMASYON SA WIKA:**
Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalin nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HMO Help Line sa 1-888-466-2219.

**Thai**
**ข้อมูลสำคัญเกี่ยวกับภาษา :**
**คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้ โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : U.S. Behavioral Health Plan, California 1-800-999-9585 / สำหรับผู้มีความบกพร่องทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ HMO ที่หมายเลขโทรศัพท์ 1-888-466-2219**

**Vietnamese**
**THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:**
Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HMO theo số 1-888-466-2219.

# Appendix D – DMHC Language Assistance Program Long Notice

**English**
**IMPORTANT LANGUAGE INFORMATION:**
You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. If you need more help, call HMO Help Line at 1-888-466-2219.

**Spanish**
**INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:**
Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de U.S. Behavioral Health Plan, California al 1-800-999-9585 / TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la HMO al 1-888-466-2219.

**Chinese**
**重要語言資訊：**
您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如需取得您語言的協助，請撥打下列電話與您的健保計畫聯絡：U.S. Behavioral Health Plan，California 1-800-999-9585 / 聽力語言殘障服務專線 (TTY)：711。若您需要更多協助，請撥打 HMO 協助專線 1-888-466-2219。

**Arabic**
**معلومات مهمة عن اللغة:**
ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكنك الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: U.S. Behavioral Health Plan, California على الرقم TTY: 711 / 1-800-999-9585. وإذا احتجت لمزيدٍ من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ HMO على الرقم 1-888-466-2219.

**Armenian**
**ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝**
Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY՝ 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք HMO-ի Օգնության հեռախոսագիծ 1-888-466-2219 համարով:

**Cambodian**
**ព័ត៌មានសំខាន់អំពីភាសា៖**
អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាការបកប្រែ ដោយឥតគិតថ្លៃ។ ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលជំនួយជាភាសា របស់អ្នក សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក នៅ៖ U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711។ បើសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ HMO តាមលេខ 1-888-466-2219។

**Farsi**

**اطلاعات مهم در مورد زبان:**
شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینه دریافت کنید. اطلاعات کتبی نیز ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: U.S. Behavioral Health Plan, California به شماره /1-800-999-9585 TTY: 711 تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی HMO به شماره 1-888-466-2219 تماس بگیرید.

**Hindi**

**भाषा-संबंधी महत्वपूर्ण जानकारी:**

आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ़्त में दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी आपको मुफ़्त में उपलब्ध कराई जा सकती हैं। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपने स्वास्थ्य प्लान को यहाँ कॉल करें: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711। पर। अतिरिक्त सहायता की आवश्यकता पड़ने पर, HMO Help Line को 1-888-466-2219 पर कॉल करें।

**Hmong**

**COV NTAUB NTAWV LUS TSEEM CEEB:**
Tej zaum koj yuav muaj cai rau cov cai pab cuam hauv qab no. Koj tuaj yeem tau txais ib tug kws txhais lus los sis txhais ntawv pub dawb. Cov ntaub ntawv sau no muaj sau ua qee yam ntaub ntawv pub dawb rau sawd daws. Yuav tau txais kev cov ntaub ntawv sau ua koj lus, thov hu rau qhov chaw npaj kho mob rau ntawm: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HMO Help Line ntawm tus xov tooj 1-888-466-2219.

**Japanese**

**言語支援サービスについての重要なお知らせ：**
お客様には、以下のような権利があり、必要なサービスをご利用いただけます。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください：U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711。この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

**Korean**

**중요 언어 정보:**
귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. 더 많은 도움이 필요하신 분은 HMO 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

**Punjabi**

**ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:**

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਬਿਨਾ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: 'U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

**Russian**

**ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:**

Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: U.S. Behavioral Health Plan, California 1-800-999-9585 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HMO по телефону 1-888-466-2219.

**Tagalog**

**MAHALAGANG IMPORMASYON SA WIKA:**

Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalin nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HMO Help Line sa 1-888-466-2219.

**Thai**

**ข้อมูลสำคัญเกี่ยวกับภาษา :**

**คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้ โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : U.S. Behavioral Health Plan, California 1-800-999-9585 / สำหรับผู้มีความบกพร่องทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ HMO ที่หมายเลขโทรศัพท์ 1-888-466-2219**

**Vietnamese**

**THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:**

Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: U.S. Behavioral Health Plan, California 1-800-999-9585 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HMO theo số 1-888-466-2219.

# Appendix E – CDI Language Assistance Program Long Notice

**IMPORTANT**: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in (your language), first call your insurance company's phone number at 1-866-374-6060.

Someone who speaks (your language) can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

**Español**

**IMPORTANTE:** Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o compañía de seguros de salud. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros de salud al 1-866-374-6060.

Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la Línea Directa del Departamento de Seguros al 1-800-927-4357.
(Spanish)

**中文**

**重要資訊：**您可以免費取得口譯員服務，與您的醫師或醫療保險公司聯絡。欲取得口譯員服務，或索取以您的語言撰寫的書面資料，請先致電您的保險公司，電話為 1-866-374-6060

與您說同樣語言的服務人員會協助您。若您需要額外協助，請致電 1-800-927-4357 與加州保險局聯絡。
(Chinese)

عربي

**هـام:**يمكنك الحصول على مترجم بدون تكلفة للتكلم مع طبيبك أو مزود خدماتك الطبية. للحصول على مترجم أو لطلب معلومات متوفرة باللغة العربية، رجاء أن تتصل أولاً برقم شركة تأمينك على الرقم 1-866-374-6060

سيساعدك شخص يتكلم العربية. إذا احتجت لمساعدة إضافية، اتصل بالخط الساخن لإدارة شركات التأمين 1-800-927-4357.
(Arabic)

**Հայերեն**

**ԿԱՐԵՎՈՐ՝** Կարող եք անվճար թարգման ձեռք բերել ձեր բժշկի կամ առողջական ապահովագրության ընկերության հետ խոսելու համար: Թարգման ձեռք բերելու կամ հայերենով գրավոր տեղեկություն խնդրելու համար, նախ զանգահարեք ձեր ապահովագրական ընկերության հեռախոսահամարին՝ 1-866-374-6060

Հայերեն խոսող մի անձ կարող է օգնել ձեզ: Եթե ձեզ լրացուցիչ օգնություն է հարկավոր, զանգահարեք Ապահովագրության Բաժանմունքի Հրատապ Գծին 1-800-927-4357 համարով:
(Armenian)

**ភាសាខ្មែរ**

**សារៈសំខាន់** : អ្នកអាចទទួលជំនួយពីអ្នកបកប្រែ ដោយឥតអស់ថ្លៃ ដើម្បីនិយាយទៅកាន់គ្រូពេទ្យ ឬក្រុមហ៊ុនធានារ៉ាប់រងសុខភាពរបស់អ្នក ។ ដើម្បីទទួលជំនួយពីអ្នកបកប្រែ ឬដើម្បីសាកសួរអំពីព័ត៌មានដែលបានសរសេរជាភាសាខ្មែរ ជាដំបូងអ្នកត្រូវទូរស័ព្ទទៅក្រុមហ៊ុនធានារ៉ាប់រងរបស់អ្នក តាមលេខ 1-866-374-6060

គេមានមនុស្សដែលនិយាយភាសាខ្មែរ អាចជួយអ្នកបាន ។ បើសិនជាអ្នកត្រូវការជំនួយថែមទៀត សូមទូរស័ព្ទទៅលេខពិសេសក្រសួងការធានារ៉ាប់រង តាមលេខ 1-800-927-4357 ។

(Khmer)

**فارسی**

**نکته مهم:** میتوانید از خدمات یک مترجم شفاهی برای صحبت کردن با پزشک یا شرکت بیمه بهداشتی\درمانی خود بطور مجانی استفاده کنید. برای دریافت خدمات مترجم شفاهی و یا سئوالات راجع به اطلاعات کتبی به فارسی، ابتدا با شرکت بیمه خود با این شماره تماس بگیرید: 1-866-374-6060

یک نفر که به زبان شما صحبت میکند به شما کمک خواهد کرد. برای دریافت کمک بیشتر، به خط کمکی اداره بیمه به شماره 1-800-927-4357 تلفن کنید.
(Farsi)

**Hmoob**

**LUS TSEEM CEEB**: Yuav muaj ib tug neeg los txhais lus uas koj yuav tsis tau them nqi li los nrog koj tus kws kho mob los sis lub tuam txhab them nqi kho mob tham. Yog xav tau ib tug neeg txhais lus los sis xav nug txog cov lus qhia uas sau rau hauv ntawv ua lus Hmoob, hu rau koj lub tuam txhab tus xov tooj ntawm 1-866-374-6060.

Yuav muaj ib tug neeg uas hais lus Hmoob los pab koj. Yog hais tias koj xav tau kev pab, hu rau Lub Caj Meem Fai Muab Kev Tuav Pov Hwm Tus Xov Tooj Muab Kev Pab ntawm 1-800-927-4357.
(Hmong)

**Tiếng Việt**

**QUAN TRỌNG:** Quý vị có thể được một thông dịch viên trợ giúp miễn phí để nói chuyện với bác sĩ hay hãng bảo hiểm sức khỏe của quý vị. Để có dịch vụ thông dịch hoặc để hỏi về văn bản tài liệu bằng tiếng Việt, trước hết xin gọi hãng bảo hiểm của quý vị tại số 1-866-374-6060.

Sẽ có nhân viên biết nói tiếng Việt giúp đỡ quý vị. Nếu quý vị cần giúp đỡ thêm, xin gọi Đường Dây Khẩn của Ban Bảo Hiểm tại số 1-800-927-4357.
(Vietnamese)

# Appendix F – Medicaid; CHIP; Federal/State Medicare-Medicaid (MME) enrollees Regulatory and Client-Contractual Program Requirements

**Medicaid; CHIP; Federal/State Medicare-Medicaid (MME) enrollees Regulatory and Client-Contractual Program Requirements**

The following state-specific or program-specific appendices set forth certain regulatory or contractual requirements that Network Behavioral Health Providers shall comply with, as applicable.

Click the appropriate bolded link(s) to access currently active state-specific regulatory or contractual requirements:

**California**

a. **California Regulatory Requirements – Individual**
b. **California Regulatory Requirements – Group**
c. **California Language Assistance Program Regulatory Requirements – Individual**
d. **California Language Assistance Program Regulatory Requirements – Facility**
e. **California Regulatory Requirements – Third Amendment – Individual**
f. **California Regulatory Requirements – Third Amendment – Groups**
g. **California Regulatory Requirements – Fourth Amendment – Individual**
h. **California Regulatory Requirements – Fourth Amendment – Groups**
i. **California Regulatory Requirements – Fourth Amendment – Facility**