Network Manual

August 2016

U. S. Behavioral Health Plan, California, doing business as OptumHealth Behavioral Solutions of California

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 and Optum. It is important to note that DMHC regulations may not apply to all California residents, clinicians or facilities in all cases.

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[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

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Introduction

Welcome!

We are pleased to have you in our network. We are focused on creating and maintaining a structure that helps people live their lives to the fullest. At a time of great need and change within the health care system, we are energized and prepared to meet and exceed the expectations of consumers, customers and partners like you.

Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. As we work together, you will find that we seek and pursue opportunities to collaborate with you to set the standard for industry innovation and performance.

We encourage you to make use of our industry-leading website, *providerexpress.com*, where you can get news, access resources and conduct a variety of secure transactions at the time and pace you most prefer. We continuously expand our online functionality to better support your day-to-day operations. Visit us often!

Please take time to familiarize yourself with all aspects of the Network Manual. We've included an easy reference Resource Guide and FAQs to get you started. There is much work to be done. We are interested in your contributions to constructive innovation. Let us hear from you!

Deb Adler

S.V.P. Behavioral Network Services

Optum

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).

UBH, now operating under the brand Optum, and USBHPC, doing business as OptumHealth Behavioral Solutions of California, offer a comprehensive array of innovative and effective behavioral health care programs, including integrated behavioral and medical programs, depression management, employee assistance, work/life management, disability support and pharmacy management programs. Today, our customers include small businesses, Fortune 100 companies, school districts, health plans, and disability carriers. At the time of this publication, Optum and OptumHealth Behavioral Solutions of California support more than 43 million Members nationwide.

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

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

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

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

Mission and Vision

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

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

Core Values

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

Resource Guide

Websites

providerexpress.com

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

To Register for Access

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

Secure Transactions

Provider Express offers a range of secure transactions, including:

- Check eligibility and authorization or notification of benefits requirements
- Obtain initial authorization or notification requests, if applicable
- Create and maintain My Patients list
- Submit professional claims and view claim status
- Make claim adjustment requests
- Register for Electronic Payments and Statements (EPS), including Electronic Funds Transfer (EFT)
- Update practice information
  - Add NPI
  - Add Taxonomy Code(s)
  - Update languages spoken
  - Update e-mail address
  - Update gender
  - Add Medicaid/Medicare Numbers
  - Update expertise
  - Update ethnicity
  - Manage address locations, including practice, remit, credentialing and admitting privileges

  - Update phone and fax numbers
  - Availability status
  - Accessibility – practice hours, wheelchair accessibility, public transportation, etc.
- Send secure messages to a number of Optum departments
- Admin-level users can add and manage other users' access
- View performance and ALERT Online Scorecards
- Obtain pre-populated Wellness Assessments
- Link to Clinician version of **liveandworkwell.com** to obtain patient education resources in English and Spanish (see *liveandworkwell.com* below)

Public Pages

The *Provider Express* home page includes "Quick Links" to our most frequently accessed pages as well as recent news and updates.

- Access the latest information about ALERT®
- Obtain ACE Clinicians and ACE Facility program updates
- Download standard forms (see "Frequently Used Forms…" section below)
- Find staff contacts
- Review clinical guidelines
- Locate current and archived issues of *Network Notes*, the provider newsletter

Training Page

Information includes Webinar offerings and **Guided Tours** of secure transaction features such as: Claim Entry, Eligibility and Benefits, and Secure Message Center. The Guided Tours provide quick overviews of key transactions.

liveandworkwell.com

You may use this member site to:

- Obtain patient behavioral health education information (access Clinician version of site from *Provider Express* or at **liveandworkwell.com** using anonymous access code, "Clinician")
- Refer patients to appropriate benefit specific online resources
  - Members may register and log in or use the anonymous access does assigned to their company/organization
  - There is an access code lookup tool located above the entry field

Our primary Member website makes it simple for eligible Members to:

- Manage behavioral health benefits
  - Check eligibility/benefits
  - Submit/track claims
  - Obtain visit authorizations, if required

- Quick Links Claims & Coverage

- Request services
- Identify network clinicians and facilities
- Take self-assessments
- Send out caring, positive eCards
- Use Computer Based Trainings
  - Depression
  - Anxiety
  - Stress
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Find articles on a variety of wellness and daily living topics
- Parent/Teen/Child integrated medical/behavioral information on adolescent health
- Locate community resources

Eligible Members can explore topics by category:

- *Live Well:* supportive information on relationships, parenting, safety, military
- *Be Well:* healthy living, recovery & resiliency and behavioral health condition information
- *Work Well:* education and work related concerns

Liveandworkwell provides resources and patient education in English and Spanish. Website content varies according to Member benefit packages so advise Members to use the access code assigned to their company/organization for personalized information.

Frequently Used Forms and What you Need to Know

You may obtain forms by going to ***Provider Express***.

Employee Assistance Program (EAP) Services

- Upon completion of EAP services, you may request most routine MH/SUD authorization for outpatient services using the *Provider Express* Auth Request feature

- Statement of Understanding – A mandatory form that describes the scope and limitations of EAP services, signed by both you and the Member

- EAP Claim Submission through *Provider Express* secure “Transactions”

ALgorithms for Effective Reporting and Treatment (ALERT®)

The one-page Wellness Assessment (WA) is a reliable, confidential, consumer-driven instrument used to help identify targeted risk factors in addition to establishing a baseline

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

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

For questions and/or comments about ALERT, feel free to e-mail us at **ALERT_CNS_Ref@uhc.com**.

Claims and Customer Service

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

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

For Further Assistance

For general information and contractual questions, contact Network Management or your Facility Contract Manager using the Provider Service Line at **(877) 614-0484**.

Behavioral Solutions of California

CALIFORNIA
PROVIDER CONTACT LIST

providerexpress.com

<table>
<tr><th></th><th colspan="3">OptumHealth Behavioral Solutions of California</th><th colspan="3">Optum</th></tr>
<tr><td>Behavioral Network Services</td><td colspan="6">PO Box 880609
San Diego, CA 92168-0609
Phone: (877) 614-0484
Fax: (855) 833-3724
BNSWest@optum.com</td></tr>
<tr><td>Wellness Assessment Forms (ALERT®)</td><td colspan="6">Wellness Assessments
PO Box 27430
Houston, TX 77277
Phone: (877) 369-2198
Fax: (800) 985-6894</td></tr>
<tr><td>Care Advocacy Teams and Inpatient Authorizations
(All inpatient care must be pre-authorized)</td><td colspan="6">(800) 333-8724
• Phones are answered 24 hours a day, 7 days a week
• In the event of an emergency, notify us immediately
• Facilities will send admission and discharge summaries to OptumHealth Behavioral Solutions of California/Optum for the purpose of ongoing treatment planning</td></tr>
<tr><td>24-Hour Intake Line</td><td colspan="6">(800) 888-2998</td></tr>
<tr><td rowspan="4">Scheduling Appointments
(Clients referred to you must be seen within the following time frame)</td><th colspan="2">Appointment Type</th><th colspan="2">Mental Health</th><th colspan="2">EAP</th></tr>
<tr><td colspan="2">Routine/Non- Emergency</td><td colspan="2">Within 10 business days</td><td colspan="2">Within 3 business days</td></tr>
<tr><td colspan="2">Urgent</td><td colspan="2">Within 48 hours</td><td colspan="2">Within 24 hours</td></tr>
<tr><td colspan="2">Emergency</td><td colspan="2">Same day</td><td colspan="2">N/A</td></tr>
<tr><td rowspan="4">We highly recommend that claims be submitted electronically at providerexpress.com

If you are unable to file electronically, please use the appropriate address shown on the right.</td><th colspan="3">University of California, Care1st & Wells Fargo Members</th><th colspan="3">Optum (UBH) Members</th></tr>
<tr><td colspan="3">PO Box 30760
Salt Lake City, UT 84130-0760</td><td colspan="3">PO Box 30755
Salt Lake City, UT 84130-0755</td></tr>
<tr><th colspan="3">Mail Handlers</th><th colspan="3">UnitedHealthcare</th></tr>
<tr><td colspan="3">PO Box 30756
Salt Lake City, UT 84130-0756</td><td colspan="3">PO Box 30757
Salt Lake City, UT 84130-0757</td></tr>
<tr><td rowspan="2">Appeals & Grievances</td><th colspan="6">OptumHealth Behavioral Solutions of California & Optum</th></tr>
<tr><td colspan="6">Appeals & Grievances
PO Box 30512
Salt Lake City, UT 84130-0512
Phone: (800) 999-9585
Fax: (855) 312-1470</td></tr>
<tr><td>Claims & Eligibility</td><td colspan="6">(800) 333-8724</td></tr>
<tr><td>Provider Express Support</td><td colspan="6">(866) 209-9320</td></tr>
<tr><td>Language Assistance Program</td><td colspan="6">(866) 374-6060</td></tr>
<tr><td>Hearing & Speech Impaired Line</td><td colspan="6">(800) 842-9489 (TTY)</td></tr>
</table>

Frequently Asked Questions

Network Requirements

Who can I contact with specific questions or comments?

For general information and contractual questions, contact Network Management at **(877) 614-0484** or your Facility Contract Manager.

What is a Payor?

Our Payor definition is 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 Agreement.

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 back of the Member's ID card.

Do I have to notify anyone if I change my name, address, telephone number, 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. This is especially important for accurate claims processing. 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 in the event that we discontinue or change a program or service?

Yes. Contracted facilities are required to provide us with written notification of changes in the services they offer within 10 calendar days.

As a contracted facility, would the addition of programs, services or locations require review of our current contract with USBHPC?

Yes. Contact your Facility Contract Manager to initiate a review.

If I am individually contracted with USBHPC, can I be considered a participating clinician at one practice location and non-participating at another?

No. Your Agreement with us requires that you see all Members eligible to access this Agreement and is not specific to a location or Tax Identification Number. It is important to provide us with all practice locations and the Tax Identification Numbers under which you submit claims.

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.

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?

No. You can bill only for services which you personally provide. Please follow the Optum Psychological and Neuropsychological Testing Guidelines regarding the use of psychometrists. These are available on *Provider Express* under **"Guidelines and Policies"** .

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. You may request to be listed in our database as unavailable at one or more of your practice locations for a period of up to six months. You are required to notify Network Management within 5 calendar days of your lack of availability for new referrals. Group practices and facilities / agencies that wish to be made unavailable should contact Network Management.

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 Agreement. For additional details, or to initiate the process, contact Network Management or your Facility Contract Manager. Please also see information about Continuation of Services after Termination in the "Network Requirements" chapter of this Manual.

Benefit Plans, Authorizations and Access to Care

Should I routinely contact Optum regarding eligibility, benefits, and language assistance needs?

Yes. You can inquire about eligibility, benefits and language assistance needs at ***Provider Express*** or by calling the phone number 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, the Member is the best source for timely information about eligibility, coverage changes and services utilized to-date.

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

Yes. The authorization for routine outpatient services, when required, is typically obtained through a telephone contact between the Member or family member and Intake staff. It can also be initiated by eligible Members via the Member website.

However, if a required authorization has not been issued at the time you inquire about eligibility, then you need to request it. You may do this through ***Provider Express*** or by calling the phone number on the back of the Member's ID card.

Do all Members require prior authorization for outpatient treatment?

No. For Members whose Benefit Plan does not require prior authorization, there is no need to obtain an authorization. To inquire about a Member's Benefit Plan requirements, contact us through *Provider Express* or by calling the number on the back of the Member's ID card.

Are all the services I provide covered under the MH/SUD Authorization?

No. Authorization that is issued to Members (when required) covers most common but not all routine outpatient MH/SUD services you provide.

Non-routine services include, but are not limited to, psychological testing and intensive outpatient care. These services may still require clinician-specific or program-specific authorization of benefits prior to providing those services. To obtain those authorizations, please call the number on the back of the Member's ID card.

Do the 2013 CPT codes 90837/+90838 require prior authorization?

Yes. As described in the American Psychological Association 2013 CPT code crosswalk, the CPT codes for extended sessions (90808/90809 – 78-80 minutes) have been replaced by the new codes 90837/+90838 (53 minutes or more) and will continue to require prior authorization. For authorizations, call the toll-free number on the back of the Member ID card.

What if I see someone for an extended period due to an unforeseen crisis?

For unforeseen crises for which there may be an unanticipated need for an extended office visit, you should use the new crisis code, 90839, to bill for the first 30-74 minutes of psychotherapy. Prior authorization is not required for crisis sessions.

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 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 ALERT and Wellness Assessments?

Please refer to the "Benefit Plans, Authorization, EAP and Access to Care" chapter of this Manual or to the **ALERT** information on *Provider Express*.

Is there a time limit in which an authorization of routine services is valid?

Yes. The authorization of routine services is valid for one year from the date of issue

up to the benefit limit as long as the Member's eligibility remains active.

Can I make referrals directly to other Optum network clinicians without prior authorization of benefits?

Yes, in some cases. The authorization for routine services is open to any Optum network clinician and allows you to transfer a Member to another network clinician for routine outpatient MH/SUD services. Additionally, if you are referring a Member to a network clinician for routine medication evaluation and management, prior authorization is not required. However, a prior authorization is still required for services such as psychological testing, intensive outpatient services and other levels of care.

Employee Assistance Program (EAP) Procedures

Do EAP services require prior authorization?

Yes. EAP 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 through liveandworkwell.com. Providers making an authorization request on behalf of a Member should call the number on the back of the Member's ID card or obtain the EAP toll-free number from the member. The Member will receive an EAP authorization letter and is instructed to bring that to their initial session.

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

Some Members have a managed behavioral health care benefit through Optum in addition to their EAP benefit. In some instances, an authorization or notification may be necessary for those Members who transition from EAP to MH/SUD benefits for routine psychotherapy services. To obtain an authorization or notification, use the "Auth Request" function through ***Provider Express***. Upon completion of the "Auth Request", Optum will generate an MH/SUD benefit authorization.

When a Member is referred to me following an EAP session, am I required to ensure that an MH/SUD authorization is in place before the Member begins MH/SUD services with me?

Yes. The EAP clinician should have requested MH/SUD authorization, if required. However, you need to verify that a required authorization has been obtained. If not, you should obtain the authorization.

Does use of EAP benefits change authorization or notification requirements for MH/SUD services?

No. You may inquire about benefit requirements through *Provider Express* or by calling the number on the back of the Member's ID card.

If a Member I am seeing through EAP 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.

Should EAP Members be given the Wellness Assessment at their initial visit?

Yes. All Optum Members should be asked to complete the WA.

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

Yes. All Optum Members should be offered the WA. If the Member reports having already completed a WA with the EAP clinician, it is not necessary to complete an initial session WA. However, you should administer the WA at either session three, four or five.

Do EAP benefits require a new authorization when a new benefit year begins?

Yes. You will need to obtain a new EAP authorization when a new benefit year begins. Remember to ask the Member for a copy of the EAP 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 applicable law.

Treatment Philosophy

Are Optum's Guidelines accessible online?

Yes. **Guidelines/Policies** are posted under "Quick Links" on the home page of *Provider Express*. You may also contact Network Management (see the "Resource Guide" section of this Manual under "For Further Assistance") to have a paper copy of these documents mailed to you.

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

Yes. We require network clinicians, both in and out of facilities, 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. In the event that 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** on *Provider Express*.

Privacy Practices

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 when PHI is being exchanged with a network clinician, facility or other entity for the purposes of Treatment, Payment or Health Care Operations as enumerated in HIPAA (and consistent with applicable law)[1].

Do I need a National Provider Identification (NPI) to submit electronic claims?

Yes. We require the billing clinician to include NPI information on all electronic claims. In addition to all electronically submitted claims, some states mandate that the NPI be used on all claims (whether paper or electronic submission is used).

Quality Management and 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 Management and Improvement" chapter of this Manual.

Compensation and Claims

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 copayment. Members should be billed for deductibles 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 code as mapped to DSM defined conditions.

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[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.

Are there different methods or claim forms I should use when submitting claims to Optum?

Yes. See below.

Electronic Claims: Optum recommends electronic submission of claims for the most efficient claim processing. Network clinicians and group practices can submit MH/SUD and EAP claims electronically through ***Provider Express*** using the "Claim Entry" function. This and other secure transactions are accessed through a registered User ID. To obtain a User ID, go online to "chat" with a *Provider Express* representative or call toll-free **(866) 209-9320**. In addition, any clinician, group practice or facility provider can submit claims electronically through an EDI clearinghouse using Payer ID #87726.

Clinician Claim Forms: Paper claims for MH/SUD or EAP services should be submitted to Optum using the 1500 claim form, the UB-04 claim form, or their successor forms as based upon your contract. All paper claims must be typewritten.

Facility Claim Forms: Paper claims should be submitted to Optum using the UB-04 billing format, or any successor forms as appropriate.

With all of the different products that Optum manages, is there some easy way for me to determine where to send my claim?

Yes. Claims submitted electronically through *Provider Express* are automatically routed to the appropriate claims office. You may also elect to submit electronically through an EDI vendor. EDI claims are also automatically routed to the correct claims offices. We pay claims for Members using a number of different claims systems. In order to assure prompt and accurate payment for claims submitted using the U.S. Postal Service, you should verify the mailing address for your claim by calling the number on the back of the Member ID card. Often, the claims payment address for a medical claim is different than the address for a behavioral health claim.

Do I have to submit my claims within a certain time frame in order for them to be paid?

Yes. All information necessary to process claims must be received by Optum no more than 90 calendar days from the date of service, or as required by applicable law or specific Member Benefit Plans.

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?

Yes. In the event that you seek prior authorization of benefits for behavioral health services, or authorization for continued treatment when required, 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

Processing" chapter of this Manual.

May I submit a claim to Optum for "no-shows"?

No. However, the Member may be billed if a written statement explaining your billing policy for appointments not kept or cancelled is signed by the Member prior to such an occurrence. You may bill the Member no more than your contracted rate. Note that some plans and government funded programs prohibit billing for no-shows under any circumstances.

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.

May I balance bill the Member above what Optum pays me?

No. You may not balance bill Members for services provided during eligible visits, which means you may not charge Members the difference between your billed usual and customary charges and the aggregate amount reimbursed by Optum and Member expenses.

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?

Telephone: (877) 972-8844

E-mail: optum.pni.tips@optum.com

Mail: P. O. Box 30535, Salt Lake City, UT 84130-0535

Fax: (248) 733-6379

General Inquiries: ohbs.pni.communications@optum.com

Communications are confidential and may be anonymous.

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

More information is available on the **Anti - Fraud, Waste and Abuse** page on *Provider Express*.

Appeals and Disputes

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

OptumHealth Behavioral Solutions of California (OptumHealth) Members: You may initiate the Dispute or Appeals process with OptumHealth. 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 OptumHealth. 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.

Optum Members: You may initiate the Appeals process with Optum. Urgent appeals should be pursued as quickly as possible following an adverse determination. For non-urgent appeals, Optum has established a 180-day time frame in which a clinician or Member can request the appeal. These time frames apply unless otherwise mandated by applicable law.

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

Yes. You may need to call different customer service numbers to request assistance for some Members.

We have several main customer service phone numbers (see the “Resource Guide” or “Compensation and Claims Processing” chapters of this Manual); however, it is best to call the phone number listed on the Provider Remittance Advice.

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.

Adverse Determination

See definition for “Non-Coverage Determination”.

Affiliate

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

Agency

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

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.

ALERT®

ALgorithms for **E**ffective **R**eporting and **T**reatment (ALERT®) is an outcomes-based system using Member responses to a validated survey, in conjunction with claims data, for the identification of Members who are at moderate to high risk for poor clinical outcomes.

Algorithm

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

All-Payer Contract

An arrangement allowing for payment of health services delivered by a contracted clinician regardless of product type (e.g., HMO, PPO, indemnity) or revenue source (e.g., fully funded or self-funded).

Appeal

OptumHealth Behavioral Solutions of California (OptumHealth)

- A request to change a previous OptumHealth 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 OptumHealth's disposition of a grievance.

Optum

A specific request to reverse a non-coverage (adverse) determination or potential restriction of benefit reimbursement.

Applied Behavior Analysis (ABA) Agency

A Qualified Autism Service Provider organization that has entered into a Group Participation Agreement with USBHPC for the treatment of pervasive developmental disorders or autism and is directed/supervised by a Board Certified Behavior Analyst or a California licensed psychiatrist, psychologist, or Master's Level clinician. The ABA Agency employs Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals in the delivery of treatment.

Authorization

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

Balance Billing

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

Behavioral Health Care

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

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 of the California Business and Professions Code or developed by a licensed participating psychologist
- 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 and employed by the participating Qualified Autism Service Provider
  - A participating Qualified Autism Service Paraprofessional supervised and employed by a participating Qualified Autism Service Provider
- 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 EAP Specialists.

Clean Claim

A UB-04 claim form or a 1500 claim form, or its successor, submitted by a facility or clinician for MH/SUD health services rendered to a Member which accurately contains all the following information: Member's identifying information (name, date of birth, subscriber ID); facility or clinician information (name, address, tax ID); date(s) and place of service; valid ICD-9 code or its successor code; procedure narrative; valid CPT-4 or revenue code; services and supplies provided; facility charges; and such other information or attachments that may be mutually agreed upon by the parties in writing.

The primary avenue for clinician claims submissions is electronically through ***Provider Express***.

Clinician

A California-licensed professional contracted to deliver behavioral health care services to Members (also known as a network clinician or network provider).

Coinsurance

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

Community-based Service Agency

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

Community Mental Health Center (CMHC)

An entity that meets all applicable licensing or certification requirements for CMHCs in the State in which it is located.

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 usually is 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 coinsurance.

Coverage Determination Guidelines

These guidelines are intended to standardize the interpretation and application of terms of the Member’s Benefit Plan including terms of coverage, Benefit Plan exclusions, and limitations.

Credentialing

The process by which a clinician or facility is accepted into the Optum 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.

Dispute:

OptumHealth Behavioral Solutions of California (OptumHealth) - A contracted provider’s written notice to OptumHealth 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 services.

Optum - A contracted provider’s written notice to Optum challenging, appealing or

requesting reconsideration of a claim (or group of claims) that has been denied, adjusted or contested and for which the Member has no financial liability.

EAP (Employee Assistance Program)

Services that are designed for brief intervention, assessment and referral. These services are short-term in nature.

EPS (Electronic Payments and Statements)/EFT (Electronic Fund Transfer)

A service which supports electronic claim payments and remittance advices. Claim payments are deposited directly into the designated bank account with access to all payment and remittance advice information via ***Provider Express***.

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

For appointment access standards see "Emergency - Life-threatening", "Emergency - Non-life-threatening" and "Urgent".

Emergency — Life-threatening

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

Emergency — Non-life-threatening

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

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).

Facility Contract Manager

An Optum professional dedicated to managing contractual relationships with hospitals and freestanding behavioral health programs and services for the Optum network.

Federally Qualified Health Centers (FQHC)

A federally qualified health center is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-a-Likes. An FQHC Look-a-Like is an organization that meets all of the eligibility requirements of an organization that receives a PSH Section 220 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.

FWAE (Fraud, Waste, Abuse, and Error)

Fraud: Intentional misrepresentation or concealing facts to obtain something of value. The complete definition has three primary components:

- Intentional dishonest action or misrepresentation of fact
- Committed by a person or entity
- With knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit

Waste: Inaccurate payments for services, such as unintentional duplicate payments, and can include inappropriate utilization and/or inefficient use of resources.

Abuse: Practices which directly or indirectly result in unnecessary costs to health care benefit programs. This includes any practice that results in the provision of services that:

- Are not medically necessary
- Do not meet professionally recognized standards for health care
- Are not fairly priced

Error: Mistakes, inaccuracies or misunderstandings that can usually be identified and fixed quickly.

Group Practice

A group of individually credentialed clinicians who participate in the network under a group contract 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.

Independent Medical Review

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.

Optum – An Independent Review Organization (an independent entity/individual) retained by a private health plan, governmental agency to review adverse determinations (based on medical necessity) that have been appealed by, or on behalf of, a Member (also sometimes known as External Review Organizations).

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 Optum's 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 (LOC) at which the Member can be safely and effectively treated while maintaining maximum independence of living.

Legal Entity

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

Level of Care (LOC) Guidelines

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

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.

liveandworkwell.com

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

Medical Necessity

OptumHealth Behavioral Solutions of California ("OptumHealth")[1]

Medical Necessity refers to an intervention, if, as recommended by the treating Practitioner and determined by the Medical Director of OptumHealth 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.

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.

Optum : Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or applicable law (also referred to as Clinical Necessity).

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 and Local Coverage Determinations.

Member

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

MH/SUD

Mental Health and/or Substance Use Disorder.

Network Management

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

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.

Payor

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

Prospective Program

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.

Optum – A contracted provider's written notice to Optum disputing or requesting reconsideration of a claim (or group of claims) that has been denied, adjusted or contested and for which the Member has already received service and for which the Member has no financial liability. Under your Agreement, one level of dispute is available (unless two levels of dispute are required by Payor or law). For more information, see the Appeals and Provider Dispute Resolutions sections of this Manual.

Provider Express

Website providing resources for clinicians and facilities. General information, manuals, forms and newsletters are available to both clinicians and facilities. A variety of secure, self-service transactions including authorization inquiry and claim entry are available to network clinicians and group practices

Qualified Autism Service Provider

A Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervised or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that 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, supervised, 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
- Is employed and 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 approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior

management assistant, behavior management consultant, or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations

- 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

Qualified Autism Service Paraprofessional

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

- Is employed and supervised by a Qualified Autism Service Provider
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
- Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the California Welfare and Institutions Code
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider

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 Management and 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)

Provide a comprehensive array of behavioral health services, which is inclusive of 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.

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.

Vital Documents

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

Wellness Assessment (WA)

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

NETWORK REQUIREMENTS

Clinical Network Development and Maintenance

Optum is responsible for arranging for the provision of a comprehensive spectrum of behavioral health services. In order to fulfill this responsibility, we administer a provider network 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.

All Payor Provider Agreement

Our Payor definition is the entity or person that has the financial responsibility for funding payment of covered services on behalf of a Member.

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 back of 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 applicable discrimination laws.

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

Clinician Credentialing and Recredentialing

Optum uses the Universal Provider Data Source®, developed by **CAQH®**, 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 utilize Aperture, a National Committee for Quality Assurance (NCQA) certified Credentials Verification Organization (CVO), to review the application packet for completeness and collect any missing or incomplete information.

Clinician Credentialing

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:

- Independent licensure or certification in your state(s) of practice, except as required by applicable law
- License is in good standing and free from restriction and/or without probationary status
- Board Certification or Board Eligibility (to complete prior to the recredentialing cycle) for psychiatrists
- 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 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 law)
- Free from any exclusion from government programs

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

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 does or may have information pertaining to your professional standing. Obtaining and reviewing this information is necessary to complete the credentialing process. Failure to provide such a release will preclude completion of your credentialing and prevent your participation in the network.

Optum has specific requirements for identified specialty areas. A comprehensive list

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

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

Clinician Recredentialing

In accordance with our commitment to the highest quality of clinical treatment, we re-credential clinicians every 36 months unless applicable 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:

- Professional licensure and/or certification
- Federal Drug Enforcement Agency (DEA) certificate (if applicable) for the state of California
- Controlled Dangerous Substances (CDS) certificate (if applicable)
- Professional and general liability insurance
- Curriculum vitae

You may also be asked to:

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

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

Facility / Agency Credentialing and Re-credentialing

Optum follows the guidelines of the 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 licenses required by your state for the services you offer
- Current copy of accreditation certificate and/or letter from accrediting body
- General and professional liability insurance certificates (Professional Liability Coverage for acute care: a minimum of $5 million occurrence/$5 million aggregate; and, for non-acute services: a minimum of $1 million/$3 million. Exceptions to these required insurance amounts may be made as required by applicable law)
- W-9 forms
- Disclosure Ownership Form (if applicable)
- Signed malpractice claims statement/history
- Staff roster, including attending physicians
- Daily program schedules
- Program description
- Facility Billing Information Form

In the event that 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 Management and 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.

Board Certified Behavior Analyst and Applied Behavior Analysis Agencies

Optum has added two provider types to its network to provide Behavioral Health Treatment, specifically Applied Behavior Analysis (ABA) and Intensive Behavior Therapies (IDT) in the treatment of enrollees diagnosed with Autism Spectrum Disorders (ASD).

Qualified Board Certified Behavior Analysts (BCBAs) are eligible to apply for participation in this unique Applied Behavior Analysis Network. BCBA applicants must demonstrate expertise by meeting the minimum requirements of 6 months supervised

experience or training in the treatment of ASD, in addition to active 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).

In addition, Applied Behavior Analysis organizations (ABA Agencies), which are directed and supervised by a qualified BCBA or a California independently licensed behavioral health clinician and meet the requirements as Qualified Autism Service Providers (California Health and Safety Code 1374.73), are eligible to apply for participation in the Applied Behavior Analysis Network. ABA Agency applicants must demonstrate expertise by meeting the minimum requirement for their supervisors of 6 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.

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.

Written Notification of Status Changes

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

- The status of the practice, including changes in practice location, billing address, or telephone or fax number
- Changes in facility, agency, or group ownership
- The status of professional licensure and/or certification such as revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, debarment from any government program, monitoring or any other adverse action
- The status of professional liability insurance

- Potential legal standing (any malpractice action or notice of licensing board complaint filing)
- The Tax Identification Number (TIN) used for claims filing
- The programs you offer (services you provide must continue to meet our credentialing criteria)

Registered users of ***Provider Express***, except facilities and agencies, are strongly encouraged to use the “My Practice Info” function to update this information. Otherwise, clinicians and group practices should submit changes in writing, via fax or mail, to your Network Management team. Facilities and agencies should submit their changes, in writing, via fax or email, to the Facility Contract Manager or Network Manager for your state. For information on how to contact Network Management, see the “Resource Guide” chapter of this Manual.

Provider Initiated Unavailable Status

Individual clinicians may request to be made unavailable for new referrals at one or more of your practice locations for up to six months. You are required to notify Network Management within 5 business days of your lack of availability for new referrals. If you become available for new referrals, you are required to notify Network Management within 5 business days of your availability. You may make these notifications through secure “Transactions” on ***Provider Express***, or by contacting Network Management. You will be sent a letter confirming that your request has been processed.

When you have been on unavailable status for five consecutive months, we will send you a letter reminding you that you will be returned to active status within 30 calendar days. You may contact Network Management to request an extension of your unavailable status. Should you decide that you want to return to active status sooner than expected, you may update your status on ***Provider Express*** or notify Network Management.

Some common reasons for requesting unavailable status are extended illness, vacation or leave plans, and lack of available appointments. Please note that while on unavailable status your Agreement remains in effect.

Group practices and facilities/agencies that wish to be made unavailable should contact Network Management within 5 business days of their lack of availability for new referrals. If the group, facility/agency becomes available for new referrals, they are required to notify Network Management within 5 business days of their availability.

If you are not accepting new members and are contacted by a member or potential member seeking to become a new patient, you are required to direct the individual to both Optum and to the Department of Managed Health Care (“DMHC”) to report any inaccuracy with the Optum directory.

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 Network Management.

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 Contract

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 Contracts

The 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.

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.

Psychological Assistants and Interns

In accordance with the Agreement, the services you provide must be provided directly by you for all Members. Participating clinicians may not submit claims in their name for treatment services that were provided by a psychological assistant, nurse practitioner, intern, or another clinician. For information regarding test administration by a psychometrician, please refer to the operational guidelines for **Psychological and Neuropsychological Testing** at *Provider Express*. These guidelines also address other procedures related to testing and report writing. You can also contact the appropriate Care Advocacy Center for assistance with such questions.

Physician Assistants and Residents in Facility Settings

Attending physicians must provide services directly to all Members. In general, attending physicians may not submit claims in their name for treatment or psychodiagnostic services that were provided by a resident, psychological assistant or intern. We expect network physicians to be assigned as the attending doctor for Optum Members.

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.

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

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, fact-finder, or initial decision-maker in the matter. You may be represented by a person of your choice at the appeal hearing, including legal counsel. At the conclusion of the hearing, you have five business days to submit further documentation for consideration. The Appeals Committee's decision is by a majority vote of the members. The decision of the Committee is final and may uphold, overturn, or modify the recommendation of Optum. Correspondence regarding the decision is sent to you via First Class mail, postage prepaid and properly addressed, overnight delivery, facsimile, or email, within thirty (30) calendar days after the due date of your submission of any final written statements to the Appeals Committee.

Continuation of Services after 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, or change in license status, clinicians are obligated to continue to provide treatment for all Optum Members under their care. The timeline for continued treatment is up to 90 calendar days from the effective date of the contract termination, or as outlined in your Agreement, or until one of the following conditions is met, whichever is shortest.

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

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. In the event that 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, EAP and Timely Access to Care

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.

Benefit Plans

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.

Care Advocacy

The Care Advocacy team is responsible for the administration of benefits including authorization of benefits when authorization is required. In addition, Care Advocacy Centers (CACs) 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 facilitate Member services, 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
- 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
- Referencing web-based and written information for Members and treating Providers 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 back of the Member's ID card to reach the appropriate Care Advocacy staff member.

Affirmative Incentive Statement

Care Advocacy decision making is based only on the appropriateness of care as defined by the **Coverage Determination Guidelines, Level of Care Guidelines, Psychological and Neuropsychological Testing Guidelines**, the Member's Benefit Plan, and applicable law. The Level of Care Guidelines were developed to produce consistency in decision-making by the Care Advocacy and medical staff and to help you reach optimal clinical outcomes. You will find these, along with the **Best Practice Guidelines, Medicare Coverage Summaries** and the **Supplemental and Measurable Guidelines** at *Provider Express* or you can receive a paper copy from Network Management.

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

Eligibility Inquiry

The services a Member receives are subject to the terms and conditions of the 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.

We encourage you to use ***Provider Express*** secure "Transactions" to conduct eligibility inquiries. This service is only available to USBHPC-contracted providers who are registered with *Provider Express*. First-time users may request a user ID online or by calling (**866) 209-9320**. 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. In addition, in the event that an authorization is required but is not already in place, Providers may initiate a request for pre-authorization of routine outpatient services online.

In addition to contacting Optum to inquire about eligibility, we encourage you to discuss with the Member the importance of keeping you informed of changes in coverage or eligibility status. Optum will not always have the eligibility information at exactly the same time as the organization that controls the eligibility decisions. 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.

Routine Outpatient Services

Authorization or Notification for Mental Health/Substance Use Disorder Benefits

In accordance with the Agreement and many Benefit Plans, some in-network outpatient behavioral health services require an initial pre-authorization or notification. Clarification of these requirements may be obtained through a telephone contact between the Member or Member representative and Optum staff. The Member website, **liveandworkwell.com**, is another avenue for Members to request authorization. However, if a required pre-authorization has not been issued or notification has not been made at the time you are inquiring about eligibility, then you need to initiate it. Eligibility inquiries and authorization requests may be completed on ***Provider Express*** or by telephone. 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.

When a Member calls seeking referrals, Optum staff will collect demographic information, request coordination of benefits information, explain the services available under the Member's Benefit Plan, and obtain a brief description of the presenting problem(s). Referrals are based on the clinical, linguistic, cultural, and geographic needs of the Member. The Member is responsible for contacting the Provider to schedule an appointment. The Member is advised of the number of sessions available under the Benefit Plan and any deductible, co-payment, and/or coinsurance amount for which he or she will be financially responsible. The Member will be given multiple Provider names and numbers from which to choose to schedule an appointment. Routine authorization or approval letters are mailed directly to the Member. The approval of benefits is valid for any participating Optum network Provider for routine outpatient services.

When pre-authorization or notification is required, Members are instructed to bring the letter to their initial session. This document includes Member information needed to check benefits and limits of coverage through the secure functions available at *Provider Express* or by calling Optum. If the Member does not bring the letter to the session, you

should contact Optum to ensure that an authorization or approval has been issued.

This initial session is also the time to initiate the ALERT® process with the administration of the first Wellness Assessment. For greater detail about ALERT, please see "Clinical Outcomes Model: ALERT" and "Wellness Assessments" in this chapter of the Manual. There is also an **ALERT** page on *Provider Express* that provides additional information.

This authorization or notification will be valid for one year from the date of issue subject to the Member's continued eligibility and terms of the Benefit Plan. Optum expects all treatment provided to Optum Members to be outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. If the Member is still in treatment when the authorization or notification expires, you will need to request continued authorization or provide notification using secure "Transactions" at *Provider Express* or by calling the number on the back of the Member's ID card.

Clinical Outcomes Model: ALERT®

Optum is committed to partnering with our network to achieve optimal therapeutic outcomes for the individuals we mutually serve. This approach focuses on assisting the network to make consumer-directed, outcomes-based, cost-effective and clinically necessary treatment decisions. With that goal in mind, we have developed the ALERT model, which includes an authorization or notification process, when required.

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

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

Psychiatrists and prescribing nurses are not required to submit Wellness Assessments, unless they wish to view data related to their outcomes on *Provider Express*. Please note that claims-based ALERT algorithms do apply to prescribing providers and may require Care Advocacy reviews, as noted above.

Wellness Assessments (WA)

The WA 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. The following process is for Optum Members who are receiving

routine MH/SUD outpatient services.

- Member contacts Optum, either online or by phone, to request authorization when required by the Benefit Plan for outpatient treatment. If not required by the Benefit Plan, the Member may still call for referrals.

- Optum provides referrals to in-network providers based on clinical and geographic needs. If required, an authorization is generated, allowing the Member to see any USBHPC contracted clinician for routine outpatient psychotherapy services.

- Member calls the clinician directly to schedule an appointment. When applicable, the Optum Member brings a copy of the authorization to the initial appointment. To determine if a Member's plan requires authorization, go to the ***Provider Express*** "Eligibility & Benefits" section available in secure "Transactions", or call the number on the back of the Member's ID card. Failure to obtain a required authorization may result in denial of claim payment. To obtain a copy of an existing authorization or to initiate an authorization request:

  - If you are a registered user of *Provider Express*, you can access the authorization inquiry and authorization request functions in the secure "Transactions" area

  - If you are not registered, you may call the number on the back of the Member's ID card

- At the first session, you provide the one-page WA to each new Optum Member, or to the parent/guardian of a child or adolescent patient.

- You promptly return each completed WA to Optum as instructed on the form.

- A second WA is administered between 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.

- 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 participate in ALERT. 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. WA forms can be obtained from *Provider Express* or by calling the Forms Hotline at 1-800-888-2998 ext. 5759. You may go to *Provider Express* for detailed information about **completing and downloading WAs**.

Practice Management

Practice Management, a clinical team, in coordination with other Optum departments, works with network and out-of-network providers on the following key elements:

- Managing outliers, through the identification of practice patterns that appear to fall outside typical patterns, including the measurement of improvement over time

- Identifying and resolving potential practice patterns that may constitute Fraud, Waste and/or Abuse (see "Fraud, Waste and Abuse" chapter of this Manual).

- Evaluating compliance with Care Advocacy processes and contractual obligations

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

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

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

WorkLife

A Member who is actively engaged in an Employee Assistance Program (EAP) 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 or they may access **liveandworkwell.com**. Each Member can use an employer-specific access code to enter a tailored liveandworkwell website covering employer-specific benefit information. 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.

Employee Assistance Program (EAP) Benefit and Authorization

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

Authorizations for EAP services are required and must be initiated by Members or

network clinicians prior to the first appointment. The EAP authorization letter is sent to the Member and allows the Member to see any Optum EAP network clinician for the number of sessions authorized. When a Member presents for EAP services, you should inquire whether any of the authorized visits have already been used. 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 on ***Provider Express*** using the “Auth Inquiry” under the secure “Transactions”. You must be a registered user of *Provider Express* to use secure features.

Optum makes every effort to refer Members with EAP benefits to clinicians with an 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 EAP benefit in compliance with your Agreement.

With an EAP benefit, all pre-authorized sessions are paid by Optum at 100 percent of the Optum contracted rate of reimbursement. The Member has no financial responsibility (e.g., the Member does not have a deductible, co-payment, or coinsurance amount).

EAP benefits require specific pre-authorization. To obtain an EAP authorization, call the number on the back of the Member’s ID card or obtain the number from the Member. Most Members have a dedicated EAP or MH/SUD number. Members are able to request EAP authorization through **liveandworkwell.com** or by phone.

You must obtain a new EAP authorization when a new benefit year begins.

EAP Transition to MH/SUD Benefits

Some Members will have a managed behavioral health care benefit through Optum in addition to their EAP benefit. In some instances, an authorization or notification may be necessary for those Members who transition from EAP to MH/SUD benefits for routine psychotherapy services. To obtain an authorization or notification, use the “Auth Request” function through *Provider Express* or send the Benefit Transition Notification (BTN) form available online. Upon completion of the *Provider Express* “Auth Request” or receipt of the BTN form, Optum will generate an MH/SUD benefit authorization. The Member will receive a letter indicating that routine outpatient psychotherapy services are authorized. You will not receive a copy of this letter from Optum but can obtain a copy at *Provider Express*. Members will be instructed to bring this letter to their initial MH/SUD session with you. It is not necessary to wait for the Member to bring in the authorization letter before continuing services.

If a Member chooses not to continue treatment with the EAP provider, they can bring the authorization or notification, when required, to any in-network MH/SUD provider. The Member is instructed to bring a copy of the letter to the first MH/SUD session. If the Member does not bring this letter, you may check *Provider Express* to see whether or not the Member has an MH/SUD authorization or notification. You may also call the number on the back of the Member’s ID card. If an authorization or notification is not in place, you may request it online or by phone at the time of your initial inquiry.

Once a Member’s benefits have transitioned from EAP to MH/SUD 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 coinsurance amount

EAP and Medication Management

Medication management services are rarely covered under EAP services and those that do require prior authorization or notification.

EAP and ALERT

If the Member you are seeing has a combined EAP and MH/SUD benefit through Optum, administer the Wellness Assessment (WA) at the initial EAP session. If the Member eventually transitions to MH/SUD benefits, it is not necessary to have them complete another initial WA at the time of the transition; however, you should administer the second WA between sessions three and five of the MH/SUD benefits. For greater detail about ALERT, please see “Clinical Outcomes Model: ALERT” and “Wellness Assessments” in this chapter of the Manual.

Standard Behavioral Care

Standard Behavioral Care, a designated unit within Optum, provides MH/SUD care advocacy services to UnitedHealthcare Members enrolled in PPO Benefit Plans. You are contracted with us to provide MH/SUD services to members with these benefits. For Benefit Plans managed by Standard Behavioral Care, outpatient MH/SUD services do not require notification, whereas notification for inpatient services is required.

Members covered under these plans can receive referrals to network clinicians and facilities from Standard Behavioral Care staff. MH/SUD services for these Members are reimbursed at Optum contracted rates. In order to receive payment at the network benefit level, claims for these outpatient MH/SUD services should be submitted to the Optum Claims office listed on the Member’s health ID card.

Notification through Optum is required only for residential, partial hospitalization and inpatient services. Outpatient services, which include intensive outpatient programs and psychological testing, do not require notification.

MH/SUD Medication Management Services

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

Pharmaceutical Management

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.

Applied Behavior Analysis (ABA) Services

Coverage for ABA services requires prior authorization by an Optum Autism 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 to verify eligibility, review treatment plans and obtain authorization.

Authorization of Benefits for Non-Routine Outpatient Services

Non-routine outpatient services, including, but not limited to psychological testing or extended sessions, 53 minutes or more (90837/+90838 or successor codes), require ongoing authorization prior to providing services. To pursue this authorization, please call the number on the back of the Member's ID card. Authorizations for non-routine outpatient services are specific to the Provider. The Provider will receive a copy of this authorization. For an unforeseen crisis, for which there may be an unanticipated need for an extended office visit, you should use the new crisis code 90839 to bill for the first 30-74 minutes of psychotherapy. Prior authorization is not required for crisis sessions.

Authorization or Notification for Inpatient and Subacute Services

In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists. All inpatient and subacute level of care admissions require pre-authorization or notification by the network Provider or facility. This includes:

- Inpatient treatment
- Partial/day hospital
- Residential treatment
- Intensive outpatient program treatment
- Outpatient electro-convulsive treatment
- Psychological testing
- Methadone maintenance
- Extended outpatient treatment visits beyond 53 minutes or more in duration, with or without medication management
- Applied Behavior Analysis (ABA) for the treatment of autism

Note: Plan exclusions are applied where applicable.

Network Providers are solely responsible for prior notification or obtaining pre-authorization prior to providing these 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 Provider up to 100% of the Provider's reimbursement rate. Network Provider payment reductions for failure to make notification or obtain pre-authorization are solely the 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 impairment and risk factors. You can access our **guidelines/policies** at *Provider Express* from our Clinical Resources page. You may also request a paper copy of these guidelines from Network Management at (877) 614-0484.

Services provided to Members in an inpatient psychiatric or substance use disorder unit are reviewed initially and may be reviewed concurrently by licensed Optum clinicians. These reviews provide information regarding the patient's status and need for continued inpatient care. Optum reserves the right to require a direct conversation with the attending psychiatrist before authorizing benefits for any inpatient stay. For potential adverse determinations based on relevant Optum guidelines, Optum makes a peer reviewer available to you before the decision is made so that you may provide additional information about the case. If you do not contact Optum prior to the expiration of the decision time frame, the peer reviewer will still be available to discuss the basis of an adverse determination. In the case of urgent concurrent review, Optum will review and render a decision within no more than seventy-two (72) hours, taking into consideration the nature of the Member's condition, and will provide a response to you within twenty-four (24) hours of the decision. The Member's care shall not be discontinued until you have been notified of Optum's decision and you and Optum have agreed upon a care plan that is appropriate for the medical needs of the patient.

If you have received an authorization letter or an adverse determination letter and you wish to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, please call the toll-free number in the letter. In the event benefits are not authorized, Optum will support clinicians or facility staff to maximize benefits that are available.

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. The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission

or transfer to a psychiatric unit within a general acute care hospital. Optum should be notified of the emergency as soon as possible.

A medically necessary admission following stabilization in an emergency room may require authorization or notification prior to the admission. Depending on the Member's Benefit Plan and your facility Agreement, charges for emergency room services may be considered part of the facility inpatient per diem in the event the Member is admitted to the facility.

Upon claim submission, Optum reviews emergency services rendered to a Member. Payment for services may be denied if Optum has determined that the emergency services were never provided; in situations where the Member did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist; and/or post-stabilization services were rendered without notification or prior authorization by Optum.

Retrospective Review Process

A retrospective review occurs only on those rare 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. Retrospective review requests must be submitted within 180 calendar days following the date(s) of service unless otherwise mandated by applicable law. For all retrospective reviews, Optum will issue a determination within 30 calendar days of receipt of the request, unless otherwise required by applicable law. Any retrospective review requests received outside the established time frame will not be processed by Optum.

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 for both outpatient and inpatient services.

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 purely 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.

For more information regarding coverage for testing, interpretation and report writing, see the current Optum **"Psychological/Neuropsychological Testing Guidelines"** and the **"Neuropsychological Testing – Frequently Asked Questions"**. Both documents may be found at *Provider Express*: Home page > Guidelines/Policies > Psychological/Neuropsychological Testing.

Timely Access to Outpatient MH/SUD and EAP Care

As part of our Quality Management and 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. Optum requires that services be provided in a timely manner appropriate for the nature of the Member's condition consistent with good professional practice, and that the network has adequate capacity and availability to offer Members appointments within certain timeframes. Thus, Optum requires that the network adhere to specific access standards, which are outlined as follows:

- Respond verbally within twenty-four (24) hours to a Member or provider request for routine outpatient care
- An initial MH/SUD appointment must be offered within ten (10) business days of the request
- An initial appointment for routine EAP services must be offered within three (3) business days
- Urgent appointments must be offered within required timeframes (MH/SUD - 48 hours, EAP – 24 hours)
- Non-life-threatening emergencies must be offered an appointment within six (6) hours
- An immediate appointment must be offered for any life-threatening emergencies
- An MH/SUD outpatient appointment must be offered within seven (7) days of an

acute inpatient discharge

If more stringent time frames are required by applicable law, we require that the network adhere to the more stringent time frames.

Optum expects that Members will generally have no more than a fifteen (15) minute wait time for their appointment in your office. In addition, any rescheduling of an appointment must occur in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with good professional practice.

In cases where a Member is being discharged from acute inpatient care, Optum expects a follow-up outpatient appointment to occur within seven (7) days from the discharge date. This appointment should be included in the facility discharge plan.

If you are unable to take a referral, immediately direct the Member to the number on the back of his or her ID card so that he or she can obtain a new referral.

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. 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 (**800) 374-6060**. 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.

Continuation of Services after Termination

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

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

Please note that state-specific laws will be followed when they provide for a longer 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 Member's next appointment or prior to the effective termination date, in compliance with your Agreement.

Network facilities that withdraw from the Optum network are required to notify us, in writing, 120 calendar days prior to the effective date of the 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 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. In the event that a facility's participation is terminated due to quality-related issues, suspected fraud, waste or abuse, of 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 the Member to extend care beyond these timeframes. Optum will arrange to continue authorization for such care at the 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.

Treatment Philosophy

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 20 years of experience, we know it is the efforts of our clinical network that give our 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. You will find the following guidelines, including, but not limited to:

- Level of Care Guidelines
- Best Practice Guidelines
  - Supplemental and Measurable Guidelines
- Coverage Determination Guidelines
- Medicare Coverage Summaries
- Psychological/Neuropsychological Testing Guidelines

Optum participates with health plans in measuring performance on NCQA HEDIS® measures and incorporates these standards into our requirements and guidelines. *Provider Express*, which serves as a resource for policy updates of interest to the network, is available to you 24/7.

Level of Care Guidelines

Our **Level of Care Guidelines** are intended to promote optimal clinical outcomes and consistency in the authorization of benefits by Care Advocacy staff and Peer Reviewers. They are available at *Provider Express* or you may request a paper copy by contacting Network Management at **(877) 614-0484**.

Best Practice Guidelines

We have adopted **Best Practice Guidelines** from external nationally recognized organizations. The guidelines provide information about evidence-based treatment of common behavioral health conditions. In addition, we have created **Supplemental and Measurable Guidelines**. Two aspects of each Supplemental and Measurable Guideline are measured annually and the data is then used to identify opportunities for improvement. Links to these guidelines may be found at *Provider Express*.

Coverage Determination Guidelines

Our **Coverage Determination Guidelines** are intended to standardize the interpretation and application of terms of the Member's Benefit Plan, including terms of coverage, Benefit Plan exclusions and limitations. They are available on *Provider Express* or you may request a paper copy by contacting Network Management at **(877) 614-0484**.

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 and Local coverage Determinations. They are available at *Provider Express* or you may request a paper copy by contacting Network Management at **(877) 614-0484**

The Clinical Technology Assessment Committee (CTAC)

The CTAC meets quarterly to review current medical and scientific literature. An Optum Medical Director chairs this multidisciplinary committee that includes at least one external clinician on a standing basis. In addition, this Committee consults on an as-needed basis with professionals who are actively working with relevant technology and/or clinical issue(s) that may be impacted by the technology under review. This Committee examines the use of new technologies and new applications of existing technologies for the assessment and treatment of behavioral health conditions. The Committee also reviews existing technologies when questions arise as to their application. The Committee recommends as "proven" those treatments for which there is published scientific evidence of efficacy and safety. This evidence must consist of 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 treatment, enhance self-management, and support broader recovery goals.

We encourage you to discuss all treatment options and the associated risks and benefits and solicit Members' input about their treatment preferences, 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 is to 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 comprehensive treatment planning (see the “Benefit Plans, Authorization, EAP, and Access to Care” chapter of this Manual).

Treatment, Recovery & Resiliency, and Discharge Planning

The treatment plan stems from the Member’s presenting condition and is used to document realistic and measurable goals, as well as the evidence-based treatments that will be used to achieve the goals of treatment. Effective treatment planning should also take into account significant variables such as 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 might be directly expressed or documented in an advance directive or crisis plan. For some Members, treatment is part of a broader recovery & resiliency effort, so the recovery & resiliency goals which may be documented in a recovery plan should also be considered.

A change in the Member’s condition should prompt a reassessment of the treatment plan and selection of level of care. When his or her condition has improved, the reassessment should determine whether a less restrictive level of care may be adequate to treat the condition, or whether he or she no longer requires treatment. When a Member’s condition has not improved or has worsened, the reassessment should determine whether the diagnosis is accurate, the treatment plan should be modified, or the condition should be treated in another level of care.

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 with 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 his or her preferences. The final discharge plan should document the anticipated discharge date, the proposed post-discharge services, the plan to coordinate discharge with the Provider at the next level of care when indicated, and the plan to reduce the risk of relapse, such as by confirming that the Member understands and agrees with the discharge plan. The risk of relapse can also be mitigated by arranging a timely first post-discharge appointment.

As the Member transitions from one level of care to another, Optum expects that the first appointment at the next level of care will be scheduled commensurate with the Member’s needs. The first post-discharge appointment following inpatient care should occur no later than seven (7) days from the date of discharge. This timeframe is in accordance with the HEDIS® standard for follow-up treatment after discharge from inpatient care. Optum assesses the compliance of Network facilities in meeting this standard on an annual basis.

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

Optum expects that the Provider will collaborate with the Member during treatment, recovery and discharge planning whenever possible.

Communication with Primary Physicians & 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 in order to ensure that care is comprehensive, safe and effective. Optum expects Providers to make a "good faith" effort at coordinating care with other behavioral health clinicians or facilities and any medical care professionals who are treating the Member.

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

Optum believes that coordination of services improves the quality of care to Members in a number of 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/or 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

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 problems

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 at ***Provider Express***. You may request a paper copy by contacting Network Management at **(877) 614-0484** (see "Resource Guide"). 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

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

In order to perform required utilization management, practice management, 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.

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 without national accreditation such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF) or other agency approved by Optum
- Audits of services and programs, including, but not limited, to Applied Behavioral Analysis (ABA), Supervisory Protocol 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 related to a Member complaint regarding the physical environment of an office

The audits may focus on the physical environment (including safety issues), policies and procedures, 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 on-site audit. On-site audit or Treatment Record Review scores under 85% will require a written Corrective Action Plan (CAP). Scores under 80% require submission of a written CAP and a re-audit within six months of the implementation of the CAP. However, in some cases, a requesting committee may require a CAP and/or re-audit regardless of the scores on the audit tools.

Billing records should reflect all applicable fields as required for completion of the 1500 claim form or UB-04 claim form.

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
- 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
- The date of service, either start and stop time or total time in session (for time based services), Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS)/Revenue (REV) code billed, notation of session attendees, the rendering clinician's name, professional degree, license, and relevant identification number as applicable
- 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, 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

- Continue to list medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of mental health condition

- Treatment plan documentation needs to include the following elements:

  - Specify 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
  - 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 initiation of treatment
  - Throughout treatment as clinically indicated
  - At the time of transfer to another treating clinician, facility, or program
  - At the conclusion of treatment
- Documentation of referrals to other clinicians, services, community resources, and/or wellness and prevention programs
- Records related to billing must include all data elements required for submission of the claim

The **Fraud, Waste, Abuse, Error and Payment Integrity** information page 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 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.

Privacy Practices

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

Our operations are compliant with the required HIPAA privacy practices as well as other applicable law. Below are some of the highlights of these privacy practices.

Uses and Disclosures of PHI

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

Release of Information

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

Identification and Authentication

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

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

Internal Protection of Verbal, Written and Electronic PHI

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

Disclosure to Plan Sponsors or Employers

Summary health information may be released to a Plan Sponsor[2] without the authorization of the affected individual. This information may be used for the purpose of obtaining premium bids or modifying, amending, or terminating the Group Health Plan. It may also be used by employees of an employer or Plan Sponsor to carry out administrative duties of a Health Plan related to Treatment, Payment or Health Care Operations.

Members receive a Notice of Privacy Practices (NPP), as required under HIPAA, from their group health plan, which outlines the uses and disclosures of their PHI and their rights, as well as the legal duties of their health plan to ensure protection of their PHI. Information regarding a Member's NPP is posted on our Member-facing websites, such as **liveandworkwell.com**, and is available in paper copy by contacting the Member's health plan.

National Provider Identification

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

[2] "Plan Sponsor" as defined in the Employee Retirement Income Security Act (ERISA), means the employer in the case of a Group Health Plan maintained by a single employer, the employee organization in the case of a plan maintained by such organization, or the committee or similar group or representatives in the case of a plan maintained by two or more employers or jointly by one or more employers and employee organizations.

Quality Management and Improvement

Participation in the Optum Quality Management and Improvement Program

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

Compliance with the QMI 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.

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

- Ensuring that care is appropriately coordinated and managed between you and the Member's primary medical physician and other treating clinicians and/or 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)
- Cooperation with the performance programs including Achievements in Clinical Excellence Campaign for Excellence (CFE) and Facility Quality Measure (FQM) programs (please refer to the ACE, CFE and FQM chapters of this Manual for more information)
- Responding to inquiries by our Quality Management and Improvement staff
- Participation in Quality Management and 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
- Helping to ensure Members receive rapid follow-up upon discharge from an inpatient level of care

Upon request, Optum makes information available about the QMI Program, including a description of the QMI 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

A sentinel event is 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 the occurrence by calling the number on the back of the Member's ID card.

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. Both the survey results and action plans are shared as necessary and appropriate.

Clinician Satisfaction Surveys

We regularly conduct a satisfaction survey of a representative sample of clinicians delivering behavioral health services to Members. This survey obtains data on clinician satisfaction with Optum services including Care Advocacy, Network Services, and claims administration.

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

Preventive Behavioral Health Services

Our preventive behavioral health programs are selected and developed based on the demographic, linguistic, cultural, clinical, and risk characteristics of Members. You may be enlisted to participate in the design and implementation of preventive behavioral health programs. We encourage all clinicians and facility-based clinical staff to review the content and process of Optum preventive health programs. These programs are described on ***Provider Express***. If you would like a paper copy of these programs please contact Network Management. We periodically communicate additional information about these programs, including modifications in program process and

content, on *Provider Express* and in the newsletter, ***Network Notes***.

Practice Guidelines

Optum has adopted clinical guidelines from nationally recognized behavioral health organizations and groups. We also have Supplemental and Measurable Guidelines based on existing nationally recognized guidelines, additional literature review and clinician input. The development of these Supplemental and Measurable Guidelines is driven by quality initiatives aimed at improving clinical outcomes for Members. The adopted **Best Practice Guidelines** and the **Supplemental and Measurable Guidelines** are available through *Provider Express*: Home page > Quick Links > Guidelines/Policies. Your feedback is encouraged on all guidelines and any suggestions on new guidelines to be considered for adoption are welcome. If you would like a paper copy of these guidelines please contact Network Management.

Complaint Investigation and Resolution

You are required to cooperate with Optum in the complaint investigation and resolution process. If we request written records for the purpose of investigating a Member complaint, you must submit these to Optum within 10 business days, or sooner, as requested. 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.

QMI staff, in conjunction with Network Management staff, monitors complaints filed against all clinicians and facilities, and solicits information from them in order to properly address Member complaints. In general, resolution of most complaints is communicated to the Member when the complaint is received from, or on behalf of, the Member. Quality of Care complaints do not generally include notification of resolution except as required by applicable law or contractual agreement.

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

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

"unavailable" and/or reassigning Members to the care of another participating clinician or facility

- Terminate your participation status with Optum

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

Additionally, Optum has a Program and Network Integrity (PNI) program. Please refer to the **Anti – Fraud, Waste and Abuse** section of this Manual for additional PNI program requirements.

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 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.

Facilities and CMHCs 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 CMHCs 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 CMHC, 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.

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 (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 > **Site Audit Tools**.

Member Education

We offer a variety of health and wellness articles and resources for eligible Members on the members' website, **liveandworkwell.com**. Topics include general therapy issues, self-help, mood and anxiety disorders, and substance use disorders, and address child, adult and elderly populations. We encourage you to visit the site and direct Members, as appropriate, to take advantage of these resources.

Achievements in Clinical Excellence (ACE) Facility

Transitioning from FQM to ACE

Achievements in Clinical Excellence (ACE)

ACE is the next generation measurement program, replacing the previous measurement program known as Facility Quality Measure (FQM). ACE is a quality-first program designed to measure, recognize and reward facility performance based on ACE metrics.

This program provides facilities with a scorecard of their relative performance using industry-standard quality and efficiency metrics.

Metrics and Criteria for Inclusions

In-network facilities with 50 or more annual inpatient admissions are included in the ACE program. In order to achieve Platinum status, an inpatient facility must first meet quality standards (effectiveness) before efficiency metrics are included in overall evaluation. To achieve Platinum, a facility must meet three of the five effectiveness metrics, one of which must be Peer Review, and one of the two efficiency metrics.

	Ace Metrics
Effectiveness	Risk-adjusted 30 and 90-day Readmission Rates (must meet one of these for Platinum)
	7 and 30-day Follow-up Rates (must meet one of these for Platinum)
	Peer Review Rates (must meet this for Platinum)
Efficiency	Residual Inpatient Length of Stay
	Behavioral Health (BH) Spend per Inpatient Episode

Access to ACE Scorecards

ACE facility scorecards are accessible at ***Provider Express***. A user ID and password are required to perform online, self-service secure “Transactions”. If you have not yet registered for login credentials, please go to *Provider Express* and click on the “First-time User” link at the top of the page. Once you are registered, follow these steps to access your scorecard:

- Log on to secure “Transactions” on *Provider Express*

- Select the “Provider Reports” tab
- Select “ACE” scorecard will populate
- The scorecard can be printed

ACE Model

A facility’s effectiveness and efficiency metrics are calculated and compared against regional, case-mix adjusted benchmarks. The result of this measure determines the facility’s performance based on the ACE standards. The facility’s score is then stratified and assigned a tier designating the facility’s ACE status.

- **PLATINUM**
  Passed Effectiveness and Efficiency measures
- **GOLD**
  Passed Effectiveness measure only
- **SILVER**
  Passed the Peer Review and Efficiency measures only
- **BRONZE**
  Passed Efficiency, Readmission and Follow-up measures but not Peer Review
- **CRITERIA NOT MET**
  Did not meet Effectiveness or Efficiency measures

Achievements in Clinical Excellence (ACE) Clinicians

Transitioning from CFE to ACE

Achievements in Clinical Excellence (ACE)

The ACE program is a quality-focused measurement program that recognizes and rewards excellence from our network clinicians. ACE Clinicians replaced the Campaign for Excellence (CFE) program, which concluded in November, 2014.

Using nationally-based, regionally-adjusted metrics, ACE identifies clinicians and group providers who deliver both effective and efficient care for Members. The results of this data-driven system allow us to annually measure clinician performance and recognize and reward those Providers who meet or exceed ACE benchmarks.

Due to state regulatory requirements, California is currently excluded from Optum's clinician evaluation program. Since measurement relies upon data that is collected over a two year period, it is still very important that clinicians and groups in California continue to submit ALERT Wellness Assessments. Regulatory changes may occur allowing us to recognize you through the ACE program.

For more information, please visit ***Provider Express***.

Compensation and Claims Processing

Compensation

The network rate for eligible outpatient visits is reimbursed to you at the lesser of (1) your customary charge, less any applicable co-payments, coinsurance and deductibles due from the Member, or (2) the Optum fee maximum, less any applicable co-payments, coinsurance and deductibles due from the Member. Fee maximums can vary based on different insurance plans and are available upon request.

The contracted rate for facilities is referenced in the Payment Appendix of the facility Agreement and defines rates applicable to inpatient and/or outpatient care through that 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.

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 law, whichever is longer. Any termination of the Agreement has no bearing on this legal obligation.

Co-payments, Coinsurance and Deductibles

In most Benefit Plans, Members bear some of the cost of behavioral health services by paying a co-payment, coinsurance, 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 coinsurance 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, which 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, coinsurance or deductible amounts.

Billing for Non- Covered Services and “No Shows”

In the event that 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. The Member may be billed for such services only if a written statement is signed by the Member, subsequent to the non-coverage determination and in advance of receiving such services. Please note that a signed 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:

- 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; and
- That as a result, the Member has been denied coverage for such services under their Benefit Plan and will be financially responsible.

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 facility contracted rate for such services.

A **Sample Patient Financial Responsibility Form** may be found at *Provider Express*. We encourage you to use this or a similar form when billing Members for non-covered services.

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 (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.

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

Claims Submission

Unless otherwise directed by Optum, providers shall submit claims using current 1500 claim form (v 02/12) or UB-04 form (its equivalent or successor), whichever is appropriate, with applicable coding including, but not limited to, ICD-9 diagnosis code(s), CPT, Revenue and HCPCS coding. Please note that, effective October 1, 2014, Optum implemented use of the DSM-5 for assessment to include ICD-9 codes listed in the DSM-5 for billing. Effective October 1, 2015, in compliance with federal regulations, we will implement use of ICD-10 billing codes.

Providers shall include all data elements necessary to process a complete claim,

including: the Member number, Customary Charges for the MH/SUD services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number, National Provider Identifier (NPI), code modifiers, and/or other identifiers requested by Optum.

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

Although claims are reimbursed based on the network fee schedule or facility contracted rate, your claims should be billed with your customary charges indicated on the claim.

Claim Entry through *Provider Express*: You should file Optum claims at *Provider Express*. This secured, HIPAA-compliant transaction feature is designed to streamline the claim submission process. It performs well on all connection speeds, and submitting claims on *Provider Express* closely mirrors the process of completing a 1500 claim form. In order to use this feature you must be a network clinician or group practice and have a registered user ID and password for *Provider Express*. To obtain a user ID, call toll-free **(866) 209-9320**.

EAP claims are supported through this feature as well. We strongly encourage you to use this no-cost claims entry feature for claims submission at *Provider Express*, which allows claims to be paid quickly and accurately. EAP claims should be submitted through *Provider Express* or on a 1500 claim form using the standard "HJ" code in the modifier field of section 24 D. The table below reflects the most commonly used EAP service codes:

90832 HJ	90834 HJ	90846 HJ
90847 HJ	90853 HJ	

For more information about fast and efficient electronic claims submission, please see *Provider Express* "**Improve the Speed of Processing – Tips for Claims Filing**".

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

Clinician Claim Forms: Paper claims can be submitted to Optum using the 1500 claim form (v 02/12), the UB-04 claim form, or their successor forms, as based on your Agreement. The claims should include all itemized information such as diagnosis code (ICD code as listed in DSM), length of session, Member and subscriber names, Member and subscriber dates of birth, Member identification number, dates of service,

type and duration of service, name of clinician (i.e. individual who actually provided the service), credentials, Tax ID and NPI numbers.

Facility Claim Forms: Paper claims should be submitted to Optum using the UB-04 billing format, or its successor, which includes all itemized information such as diagnosis (ICD code as listed in DSM), Member name, Member date of birth, Member identification number, dates of service, procedure (CPT-4) and/or revenue codes, name of facility and Federal Tax ID number of the facility, and billed charges for the services rendered. After receipt of all of the above information, participating facilities are reimbursed according to the appropriate rates as set forth in the facility's Agreement. Facilities may file claims through an EDI vendor and can view claim status on ***Provider Express***.

Anti-Fraud, Waste and Abuse (FWA): Optum has an Anti-Fraud, Waste and Abuse Program in place. You agree to remain in compliance with Optum's FWA Program. Please review the "Anti-Fraud, Waste and Abuse" chapter of this Manual.

Online Claims Help

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

If your practice address changes, it is important that you notify us of the change. You may make changes to your practice address online. Go to *Provider Express* Home Page > secure Transactions > My Practice Info.

Customer Service Claims Help

Optum has dedicated customer service departments with staff available five days a week during regular business hours to assist our network with questions related to general information, eligibility verification or the status of a claim payment. The main Optum customer service phone numbers are listed below; however various Members may have account-specific customer service numbers. It is best to call the phone number listed on the Provider Remittance Advice.

Health Plan Groups	**(800) 557-5745**
Employer Groups & EAP	**(800) 333-8724**

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.

Processing and Payment of Claims

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 applicable law or specific Member Benefit Plans. Claims received after this time period may be rejected for payment at the discretion of Optum and/or the Payor. You may not bill the Member for claim submissions that fall outside these established timelines. Any corrections or additions to a claim should be made within 90 days of receipt of the initial claim.

Claims should be submitted as directed by Optum. We strongly recommend that you keep copies of all claims for your own records. You permit Optum, on behalf of the payer, to bill and process forms for third-party claims or for third-party payers, 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 payer, not the Member. You must agree to continue to provide services to Members through the period for which premiums have been paid. Any termination of the Agreement has no bearing on this requirement.

Generally, claims that contain all of the required information and match the authorization, if applicable, will be paid within 30 calendar days after receipt, or as required by applicable law. This may exclude claims that require Coordination of Benefits (COB) determinations. Benefits are payable provided coverage is in force at the time expenses are incurred, and are subject to all limitations, provisions and exclusions of the plan. You will be paid for covered services by Optum and must not under any circumstances seek payment through Optum for plans for which Optum is not the Payor or administrator.

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

The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable law.

Anti-Fraud, Waste and Abuse

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.

Federal law requires:

"…the establishment of "Special Investigations Units" or their equivalents and the "Effective System for Routine Monitoring, Auditing and Identification of…Risks" and to "carry out appropriate corrective action". (Centers for Medicare and Medicaid Services (CMS) requirement)

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 to 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 PNI interacts with you
- Building and sustaining trust in provider communities regarding FWA 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 FWA

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 both 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 clinicians, 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 peer-to-peer 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 attestation materials on the **Optum Forms** page on *Provider Express*: Home page > Forms > Optum Forms > Fraud, Waste & Abuse (FWA).

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

Prevention, Detection and 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 investigation, timely payment is made or, in the event that a claim denial is issued, the denial notification includes the Provider's standard appeal rights.

Findings of billing inconsistent with our policies by in-network Providers may result in such actions as

- Clarification of proper procedure
- A Corrective Action Plan (CAP)
- A change in network availability status, or
- May result in termination of 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 applicable 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 applicable 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.

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

Exclusion/Sanction/Debarment Checks

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

- Health and Human Services – Office of the Inspector General (HHS-OIG) List of Excluded Individuals / Entities: **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/portal/public/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, and
- Any summary of the following: diagnosis, functional status, treatment plan/goals, prognosis, and progress to date

Appeals and Provider Dispute Resolution

There are two distinct processes related to Non-Coverage (Adverse) Determinations (NCD) regarding requests for services or payment: (1) 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 Appeals process or Provider Dispute Resolution process depending on the nature of the NCD, Member liability and your Agreement. A final internal NCD is the upholding of an NCD at the conclusion of the Optum Appeals process.

Care advocacy decision-making is based on the appropriateness of care as defined by the Level of Care Guidelines, the Psychological and Neuropsychological Testing Guidelines, the Coverage Determination Guidelines, and the Medicare Coverage Summaries, as well as the existence of coverage for the requested service in the Member's plan.

The **Level of Care Guidelines,** the **Psychological and Neuropsychological Testing Guidelines,** the **Coverage Determination Guidelines** and the **Medicare Coverage Summaries** are available at *Provider Express*. To request a paper copy of these guidelines, please contact Network Management at **(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.

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 (adverse) Determination (NCD) based on medical necessity with an appropriate peer reviewer at OptumHealth Behavioral Solutions of California (OptumHealth) 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 OptumHealth 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 OptumHealth 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, OptumHealth 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 OptumHealth 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 OptumHealth upholds the NCD regarding the cessation of coverage for such care, you cannot collect reimbursement from the Member.

Optum Member Appeals Process

The Member Appeals process is available to Members, or their authorized representative, which may be their treating clinician at any level of care, in the event of a Non-Coverage (adverse) Determination (NCD) when the Member may incur financial liability beyond the normal cost share or may experience a reduction in

services requested. In the case of clinical reviews, Optum offers you the opportunity to discuss a request for services with an appropriately licensed peer reviewer. If Optum issues a denial, in whole or in part, then such determination will be subject to the applicable Member Appeals process. The procedures for the Member Appeals process, including any applicable requirements for the filing and handling of an appeal, will be detailed in the Member Rights enclosure which accompanies the NCD notice sent to you and the Member.

Member Appeals may be handled as urgent or non-urgent appeals. Urgent appeals apply in situations where, in your opinion, application of non-urgent procedures could seriously jeopardize the Member's life, health or ability to regain maximum functioning. For an urgent appeal, contact Optum immediately.   For an urgent appeal, Optum will make the review determination, notify you by telephone, and send written notice of the appeal outcome to you and the Member or authorized Member representative within 72 hours of the Member Appeal request or in accordance with applicable laws, whichever is sooner. By definition, urgent appeals are not available in situations where services have already been provided.

A non-urgent appeal must be requested within 180 calendar days from the Member's receipt of the NCD letter or in accordance with applicable laws, whichever is most beneficial to the Member. Optum will make a Member Appeal determination and notify you and the Member or the authorized Member representative. This notification will be provided in writing within 15 calendar days from receipt of the request, if services have not yet been received by the Member, or within 30 calendar days if services have already been received by the Member or in accordance with applicable laws, whichever is sooner.

If you have received an authorization letter or an NCD letter and you wish to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, please follow the instructions in the letter and call the toll-free number provided in the letter. Authorization is not a guarantee of payment (except as required by law), payment of benefits is still subject to all other terms and conditions of the Member's plan and your Agreement.

If you request a Member Appeal it will be reviewed by someone who was not previously involved in the NCD and who is not a subordinate of the person who made the initial NCD. The appeal reviewer will review all available information, including treatment records, in order to make a determination.

Appeals involving clinical determination

For an inpatient case involving a clinical determination, the appeal reviewer will be a board-certified psychiatrist (from the same or similar specialty area as the treating clinician) with an active, unrestricted license. For an outpatient case involving a clinical determination, the appeal reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted license. For non-clinical administrative appeals, the appeals reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted license.

Appeals involving non-clinical administrative determination

For non-clinical administrative appeals, the appeals reviewer will be an appropriately

qualified Optum professional who was not involved in the initial NCD and who is not a subordinate of any person involved in the initial adverse decision.

Appeals decisions

If the appeal decision is to uphold an NCD, Optum will notify you and the Member, or the Member representative, of the outcome and any additional levels of appeal that are available, as applicable.

When required by state law or Payor, the Member or you, as the authorized representative, may appeal the NCD a second time if you are dissatisfied with the outcome of the first level appeal. The second level request must be made in writing within 60 calendar days (or as indicated in the first level appeal notification) of the date you received notification of the outcome of your first level appeal from Optum. You may initiate a second level appeal by contacting Optum at the address listed on the first level appeal notification.

You may continue to provide service following an NCD, but the Member should be informed of the NCD by you in writing. The Member or the Member representative should be informed that the care will become the financial responsibility of the Member from the date of the NCD. 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 contracted fee for such services, although a lower fee may be charged. The consent of the Member to such care and responsibility will not impact the appeals determination, but 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 the terms of your Agreement.

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 **(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 **(800) 999-9585**.

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

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 (OptumHealth) 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.

The written dispute should 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: **(800) 999-9585**
Fax: (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 OptumHealth's action, inaction or incident causing dissatisfaction to submit a dispute. OptumHealth will send written acknowledgment to the provider within 15 working days of receiving the dispute. OptumHealth 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 OptumHealth'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 OptumHealth's final determination.

Optum Provider Dispute Resolution Process

The Provider Dispute Resolution process is available to you, or your authorized representative, in a situation where the Member is not financially liable for the Non-Coverage Determination (NCD) issued by Optum, beyond the Member's normal cost share. That is, the payment dispute is between you and Optum, and regulated by the Agreement, rather than the Member's Benefit Plan. You, or your authorized representative, have the right to dispute any NCD made by Optum when the benefit determination is adverse to you, rather than the Member.

The Provider Dispute Resolution process must be initiated in writing by contacting Optum at the address listed on the Provider Dispute Rights enclosure, which accompanies the NCD notice, and must include the following information:

- Member identifying information –
  - Name
  - Identification number
  - Date of birth
  - Address
- Each applicable date of service

- Provider identifying information
  - Name
  - Tax identification number
  - Contact information
- Dollar amount in dispute, if applicable
- Any additional information you would like to have considered as part of the Dispute process, including records relating to the current conditions of treatment, co-existent conditions, or any other relevant information
- Your explanation as to why the NCD should be overturned

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

In limited circumstances, when required by applicable law or Payor, you may dispute the NCD a second time if you are dissatisfied with the outcome of the first level dispute. The second level request must be made in writing within 60 calendar days (or as indicated in the first level appeal notification) of the date you received notification of the outcome of your first level dispute from Optum. You may initiate a second level dispute by contacting Optum at the address listed on the first level dispute notification.

Member Complaints/Grievances

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

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: **(800) 999-9585**
Fax: (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. Providers will be notified a minimum of forty-five (45) calendar days prior to any material change to the Manual unless otherwise required by applicable law, regulatory or accreditation bodies. 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 Network Management at **(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 (OptumHealth)
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 OptumHealth'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, religion, gender, 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 under-standing 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 OptumHealth, 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 OptumHealth 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 OptumHealth 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 (OptumHealth)
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 OptumHealth, 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 OptumHealth, 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 OptumHealth 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 OptumHealth 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 de tratamiento conjuntamente con su proveedor.

Appendix C

Optum Member Rights And Responsibilities

Optum Member Rights and Responsibilities

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

Member Rights

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

- Receive information about Optum's services, network practitioners, and Members' rights and responsibilities
- Be treated with respect and recognition of his or her dignity and right to privacy
- Participate with network practitioners in making decisions about his or her health care
- A candid discussion of appropriate or medically necessary treatment options for his or her condition regardless of cost or benefit coverage
- Voice complaints or appeals about Optum for the services provided by Optum
- Make recommendations regarding Optum's Members' rights and responsibilities policies
- Care that is considerate and that respects his or her personal values and belief system
- Personal privacy and confidentiality of information
- Reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability
- Have family members participate in treatment planning. Members over 12 years of age have the right to participate in such planning
- Individualized treatment, including:
  - Adequate and humane services regardless of the source(s) of financial support
  - Provision of services within the least restrictive environment possible
  - An individualized treatment or program plan
  - Periodic review of the treatment or program plan
  - An adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment or program plan
- Participate in the consideration of ethical issues that may arise in the provision of care and services, including:
  - Resolving conflict
  - Withholding resuscitative services
  - Forgoing or withdrawing life-sustaining treatment
  - Participating in investigational studies or clinical trials
- Designate a surrogate decision-maker if he or she is incapable of understanding a proposed treatment or procesure or is unable to communicate his or her wishes regarding care
- Be informed, along with his or her family, of his or her rights and responsibilities, in a language they understand
- Choose not to comply with recommended care, treatment, or procedures, and be informed of the potential consequences of not complying with the treatment recommendations
- Be informed of rules and regulations concerning his or her own conduct

- Be informed of the reason for any non-coverage determination, including the specific criteria or benefit provisions used in the determination
- Have decisions about the management of their behavioral health benefits made based on appropriateness of care. Optum does not reward network practitioners or other individuals for issuing non-coverage determinations
- Inspect and copy their protected health information (PHI) and, in addition:
  - Request to amend their PHI
  - Request an accounting of non-routine disclosures of PHI
  - Request limitations on the use or disclosure of PHI
  - Request confidential communications of PHI to be sent to an alternate address or by alternate means
  - Make a complaint regarding use or disclosure of PHI
  - Receive a *Privacy Notice*
- Receive information about Optum's clinical guidelines and Quality Management and Improvement (QMI) program

Member Responsibilities

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

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

Appendix D

Member Grievance Form and Notice

OPTUMHealth™
Behavioral Solutions of California

Member Grievance Form

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 www.liveandworkwell.com. To access OHBS-CA's online Grievance Form, enter your access code to log in and click on "Grievance/Complaint Form" in the Quick Links section.

Please see page 2 for important information regarding member grievance rights.

Member Grievance Form

Expedited Appeal. An expedited appeal may be requested in those cases where care is in progress, 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. 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-HMO-2219)** or **(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.hmohelp.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. These rights apply only under California law. However, these rights do not apply to all California residents. These rights do not apply to all languages.

You can get an interpreter to help you talk with your doctor or health plan. To get help in your language, please call your health plan at 1-800-985-2410 or call the number on your ID card.

Language services are at no cost to the enrollee. Written information may be available in some languages. If you need more help, call HMO Help Line at 1-888-466-2219.

Español

INFORMACIÓN IMPORTANTE SOBRE EL IDIOMA:
Usted puede tener derecho a los derechos y servicios que se indican a continuación. Estos derechos se aplican sólo bajo la ley de California. No obstante, estos derechos no se aplican a todos los residentes de California. Estos derechos no se aplican a todos los idiomas.

Puede obtener la ayuda de un intérprete para hablar con su médico o plan de salud. Para obtener ayuda en su idioma, llame a su plan de salud al 1-800-985-2410 o llame al número que se encuentra en su Tarjeta de Identificación (ID).

Los servicios en otros idiomas son gratuitos para el afiliado. Puede haber información escrita disponible en otros idiomas. Si necesita más ayuda, llame a la Línea de Ayuda de la HMO al 1-888-466-2219.
(Spanish)

中文

重要語言資訊：
您可能有權擁有下列權利並取得下列服務。這些權利僅按加州法律規定而適用。然而這些權利並不適用於所有加州居民。這些權利並不適用於所有語言。

您可以取得口譯員服務，協助您和醫師或健康計畫溝通。如需取得您的語言的協助，請撥打 1-800-985-2410 或會員卡背後的電話與您的健康計畫連絡。

計畫參加者不須支付語言服務費用。部分語言備有書面資訊。若您需要更多協助，請撥打 HMO 專線1-888-466-2219。
(Chinese)

PCA398451-000

Appendix E

DMHC Language Assistance Program Long Notice

English

IMPORTANT LANGUAGE INFORMATION:
You can get an interpreter to help you talk with your doctor or health plan. To get help in your language, please call your health plan at 1-**866-374-6060** or call the number on your ID card.

Language services are at no cost to the enrollee. Written information may be available in some languages. If you need more help, call HMO Help Line at 1-888-466-2219.

Español

INFORMACIÓN IMPORTANTE SOBRE EL IDIOMA:
Puede obtener la ayuda de un intérprete para hablar con su médico o plan de salud. Para obtener ayuda en su idioma, llame a su plan de salud al **1-866-374-6060** o llame al número que se encuentra en su Tarjeta de Identificación (ID).

Los servicios en otros idiomas son gratuitos para el afiliado. Puede haber información escrita disponible en otros idiomas. Si necesita más ayuda, llame a la Línea de Ayuda de la HMO al 1-888-466-2219.
(Spanish)

中文

重要語言資訊：
您可以取得口譯員服務，協助您和醫師或健康計畫溝通。如需取得您的語言的協助，請撥打 1-866-374-6060 或會員卡背後的電話與您的健康計畫連絡。

計畫參加者不須支付語言服務費用。部分語言備有書面資訊。若您需要更多協助，請撥打 HMO 專線1-888-466-2219。
(Chinese)

Tiếng Việt

THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:
Quý vị có thể được một thông dịch viên giúp giao tiếp với bác sĩ hay chương trình sức khỏe của quý vị. Để được giúp đỡ bằng ngôn ngữ của quý vị, xin gọi chương trình sức khỏe của quý vị tại số 1-866-374-6060 hoặc gọi số điện thoại ghi trên thẻ hội viên của quý vị.

Có dịch vụ trợ giúp ngôn ngữ miễn phí cho người tham gia. Có thể có các ấn bản tài liệu bằng một số ngôn ngữ khác. Nếu quý vị cần giúp đỡ thêm, xin gọi Đường Dây Trợ Giúp HMO tại số 1-888-466-2219.

Հայերեն

ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝
Դուք կարող եք ձեռք բերել մի թարգմանիչ, որը ձեզ կօգնի զրուցել ձեր բժշկի կամ առողջական ծրագրի հետ: Ձեր լեզվով օգնություն ստանալու համար խնդրվում է 1-866-374-6060 համարով զանգահարել ձեր առողջական ծրագրին կամ հավաքել ձեր ինքնության տոմսի (ID) վրա գտնվող համարը:

Լեզվական ծառայությունները անվճար են գրանցված անդամների համար: Հնարավոր է, որ գրավոր տեղեկությունը տրամադրելի լինի որոշ լեզուներով: Եթե ձեզ լրացուցիչ օգնություն է պետք, 1-888-466-2219 համարով զանգահարեք HMO -ի Օգնության Գծին:
(Armenian)

한국어

중요 언어 서비스 정보:
귀하가 의사나 의료보험사와 대화시 통역 서비스를 받으실 수 있습니다. 통역 서비스가 필요하신 분은 본인의 의료보험사, 1-866-374-6060 번으로 문의해 주시거나 혹은 본인의 ID 카드상의 안내번호로 연락해 주십시오.

통역 서비스는 가입자님께 무료로 제공됩니다. 일부 언어의 경우 번역 서비스가 제공될 수도 있습니다. 더 많은 도움이 필요하신 분은 HMO 헬프 라인(안내번호: 1-888-466-2219)으로 문의해 주십시오.
(Korean)

ភាសាខ្មែរ

ព័ត៌មានដ៏សំខាន់ខាងភាសា :
អ្នកអាចទទួលជំនួយពីអ្នកបកប្រែ ដើម្បីជួយអ្នកនិយាយទៅកាន់គ្រូពេទ្យ Éគំរោងសុខភាពរបស់អ្នក ។ ដើម្បីទទួលជំនួយជាភាសាខ្មែរ សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក តាមលេខ 1-866-374-6060 Éលេខទូរស័ព្ទនៅលើប័ណ្ណ ID របស់អ្នក ។

ជំនួយខាងភាសា គឺ²តអស់ថ្លៃសំរាប់អ្នកចុះឈ្មោះឡើយ ។ ព័ត៌áមានដែលសរសេរ អាចនឹងមានជាភាសាខ្លះ ។ បើសិនជាអ្នកត្រូវការ ជំនួយថែមទៀត សូមទូរស័ព្ទទៅខ្សែជំនួយ HMO តាមលេខ 1-888-466-2219 ។
(Khmer)

Appendix F

CDI Language Assistance Program Long Notice

English

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 أولا 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)

<u>Հայերեն</u>

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)

<u>ភាសាខ្មែរ</u>

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

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

(Khmer)

<u>فارسی</u>

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)

<u>Hmoob</u>

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)

한국어

중요 사항: 귀하가 의사나 의료보험회사와 대화시 무료 통역 서비스를 받으실 수 있습니다. 통역사 서비스 혹은 한국어로 번역된 서면 정보를 원하시는 분은 본인 보험회사의 다음 안내번호로 문의하십시오. 1-866-374-6060.

귀하가 원하는 언어로 도움을 받으실 수 있습니다. 도움이 더 필요하신 분은 보험 담당국 핫라인 1-800-927-4357번으로 전화하십시오.
(Korean)

ລາວ

ສຳຄັນ: ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າເພື່ອປຶກສາກັບທ່ານໝໍຫລືບໍລິສັດປະກັນໄພສຸກຂະພາບຂອງທ່ານ. ເພື່ອຈະໄດ້ຮັບບໍລິການແປພາສາ ຫລືເພື່ອຖາມເຖິງຂໍ້ມູນພາສາລາວເປັນລາຍລັກອັກສອນ, ໃຫ້ໂທຫາບໍລິສັດປະກັນໄພສຸກຂະພາບຂອງທ່ານກ່ອນ ຕາມໝາຍເລກ 1-866-374-6060.

ຄົນນຶ່ງຄົນໃດທີ່ເວົ້າພາສາລາວສາມາດຊ່ວຍທ່ານໄດ້. ຫາກວ່າທ່ານຕ້ອງການຄວາມ ຊ່ວຍເຫລືອເພີ່ມຕື່ມ, ໃຫ້ໂທຫາສາຍດ່ວນແຫ່ງກົມປະກັນໄພຕາມ 1-800-927-4357.
(Laotian)

Русский

ВАЖНО: Вы можете бесплатно воспользоваться услугами переводчика, чтобы поговорить с врачом или компанией, предоставляющей вам медицинскую страховку. Чтобы воспользоваться услугами переводчика или получить письменную информацию на русском языке, сначала позвоните в вашу страховую компанию по тел.: 1-866-374-6060.

Вам может помочь сотрудник, говорящий на русском языке. Если вам нужна дополнительная помощь, позвоните в Департамент страхования (Department of Insurance) по телефону горячей линии: 1-800-927-4357.
(Russian)

Tagalog

MAHALAGA: Maaari kang kumuha ng interpreter (tagasalin) nang libre upang makausap ang iyong doktor o kompanya ng health insurance. Upang makakuha ng isang interpreter o magtanong tungkol sa nakasulat na impormasyon sa Tagalog, tawagan muna ang telepono ng iyong insurance sa 1-866-374-6060.

May makakatulong sa iyo na nagsasalita ng Tagalog. Kung kailangan mo ng karagdagang tulong, tawagan ang Department of Insurance Hotline sa 1-800-927-4357.
(Tagalog)

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)

Behavioral Solutions of California

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