Network Notes

OptumHealth Behavioral Solutions of California News for Clinicians and Facilities Spring 2013

Maintaining High Quality of Treatment Record Documentation

Thorough, high-quality documentation and maintenance of medical records are key elements of member safety and continuity and coordination of care. In addition, your documentation supports the coding you use on the claims you submit.

We may review your records during a scheduled on-site audit or Treatment Record Review. These may occur for a number of reasons, including reviews of facilities without national accreditation, audits of high volume clinicians, routine random audits and audits related to a quality of care concern or member complaint. During an audit or review, we will check your documentation against our established standards, which include:

- All non-electronic treatment records are written legibly in blue or black ink, and include:
- 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
- An indication of whether or not the Member is of Limited English Proficiency (LEP); if determined to be LEP, the record indicates that the Member was offered language interpretation services and whether the Member accepted or declined those services
- Treatment record entries that include the date and start and stop time of service, CPT code billed, notation of session attendees, the responsible clinician's name, professional degree, license, and relevant identification number
- Treatment records should be made contemporaneously with treatment description and include the date of entry; if records are not contemporaneously made with treatment, then the date of service should be noted along with date of 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 known allergies, history of adverse reactions or relevant medical conditions, this should be prominently noted
- Clear and uniform medication tracking that provides a clear picture of all medications taken by the patient from the onset of care through discharge includes the following:
  - 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 and risks, side effects, and alternative of the medications
  - 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. 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
- 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 cigarettes or alcohol, as well as illicit, prescribed or over-the-counter medications
- Documentation of a DSM-IV-TR (or its successor) diagnosis, including all five axes, consistent with the presenting problem(s), history, mental status examination, and other assessment data
- Treatment plan documentation needs to include the following elements:
  - Specify symptoms and problems related to the Axis I diagnosis of the treatment episode
  - Critical problems that will be the focus of this episode of care are prioritized
  - 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
- Progress notes include:
  - Member strengths and limitations in achieving treatment plan goals and objectives
  - Treatment interventions that are consistent with those goals and objectives

Documenting Coordination of Care Activity in Treatment Records

One important component of treatment record documentation (see article **"Maintaining High Quality of Treatment Record Documentation"** in this newsletter) is the coordination of care between you and other professionals treating the patient. We expect all network providers to coordinate care with the member's Primary Care Physician (PCP), other behavioral health clinicians and, if applicable, hospital staff. This communication should be documented in the member's record.

Consistent and comprehensive information-sharing facilitates coordinated treatment efforts and decisions for members. Coordination of care can improve the overall quality of the member's care by:

- Confirming for a PCP that a member followed through with a referral to a behavioral health professional
- Minimizing potential adverse medication interactions
- Allowing for more effective treatment management for members with co-morbid behavioral and medical disorders
- Reducing the risk of relapse for patients with substance-use disorders

If the member refuses to allow the release of this information, this decision and the reason for the refusal should be documented in the record. Primary Care Physicians continue to express interest in receiving more frequent and comprehensive information about their patients who are receiving behavioral health services. This communication is essential to the successful coordination of medical and behavioral care.

To help facilitate timely and effective communication between you and the member's PCP and/or other treating behavioral clinicians, we have developed a Coordination of Care Checklist. The form is designed to assist in documenting coordination of care activities and can be found on Provider Express Quick Links under "Forms". Alternatively, your coordination of care activities may be documented in progress notes or through another system you have developed for your practice.

For additional tips and guidelines to facilitate effective communication, please refer to the "Communication with Primary Physicians and Other Health Care Professionals" section on page 56 of the OptumHealth Behavioral Solutions of California Network Manual, available on Provider Express. You can also request a paper copy of the Manual by contacting Network Management by email at bnswest@optum.com or by calling 1-877-614-0484.

We appreciate your efforts to coordinate care with other professionals in order to provide the best possible service to members.

  - Start and stop times for each session
  - Who is in attendance at each session
  - The CPT code that is billed for each session
  - Dates of follow-up visits
  - Documentation of missed appointments
- 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
- 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
  - 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
- When care involves more than one family member, separate treatment records must be maintained
- Billing records should reflect the Member who was treated and the modality of care

Below are Additional Guidelines for Maintaining and Storing Treatment Records

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

You can also find these standards in the OptumHealth Behavioral Solutions of California Network Manual, which is available at www.providerexpress.com. To request a paper copy of the Manual, please contact Network Management at bnswest@optum.com.

Billing for Non-Covered Services

For Members who are enrolled in a benefit plan which requires prior authorization for services, you are required to obtain the prior authorization on behalf of the Member. If you seek prior authorization of benefits for behavioral health services (or authorization for continued treatment) and OptumHealth does not authorize the requested services, you may bill the Member under certain limited circumstances.

The Member may be billed for these services only if a written statement is signed by the Member, following the adverse benefit determination and in advance of receiving the services for which you will bill the Member. Please note that a financial responsibility waiver signed by the Member at the onset of treatment or at the time of admission is not applicable and will not allow you to bill the Member.

The signed statement must include:

- That you have informed the Member that OptumHealth is unable to authorize such services for coverage under the Member's Benefit Plan;
- The reason given by OptumHealth 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.

To help you properly collect payments from Members, a Sample Patient Financial Responsibility Form may be found on Provider Express. We encourage you to use this or a similar form when billing Members for non-covered services. It is important to note, however, that this form is intended as a sample only. The use of this form does not ensure acceptance by state regulatory agencies in the event of a member grievance or appeal.

Ensuring Timely Access to Care

OptumHealth Behavioral Solutions of California (OptumHealth) has established the following standards to ensure that members are able to obtain treatment in a timely manner.

Standard	Criteria	Anticipated Compliance
Non-Life-Threatening Emergency	A situation in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm to self or others	100% of members must be offered an appointment within 6 hours of the request for the appointment
Urgent	A situation in which immediate care is not needed for stabilization but, if not addressed in a timely way, could escalate to an emergency situation	100% of members must be offered an appointment within 48 hours of the request for the appointment
Routine (non-urgent)	A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others	100% of members must be offered an appointment within 10 business days of the request for the appointment
Routine Office Visit Wait Time	In-office wait time will not exceed 15 minutes	90%
After-Hours Answering System & Messaging	Messaging must include instruction for obtaining emergency care	100%
Clinician's Timely Response to Enrollee Messages	Providers shall respond to member messages for routine issues within 24 hours	90%
Network Clinician Availability	Percentage of Network clinicians available to see new patients	90%

The time for a particular, non-emergency appointment may be extended if we have determined and documented that a longer waiting time will not have a detrimental impact on the member's health. Rescheduling of appointments, when necessary, needs to be consistent with good professional care and must ensure there is no detriment to the member.

Putting it into Perspective

The most recent measure of the OptumHealth Network for Access to Care Standards shows high performance marks for the following standards:

- Non-Life-Threatening Emergency Situations
- Urgent
- After-Hours Answering System & Messaging
- Network Clinician Availability

After-Hours Answering System and Messaging: Please take a few minutes to review your answering machine message to ensure that it includes instructions to members regarding what they should do in an emergency situation. If you change your message due to vacation or leave of absence, remember to include the instructions in your new message, too. Even if you have provided written instructions to your clients, consider that they may not have those instructions close at hand in a crisis situation. The guidance you provide through your phone message could be critical to aiding a member in crisis.

Clinician's Timely Response to Enrollee Messages: This measure continues to fall well short of our goal. In a recent survey, less than 50% of the clinicians contacted responded within 24 hours. This lack of response leaves members uncertain about what to do next. Please make it a basic part of your business practice to return member calls within 24 hours. If you are going to be away from the office and unable to access your messages, please be sure that your out-going message reflects that information in addition to instructing the members regarding emergency situations.

If you are unable to see new members due to a full practice or leave of absence, please let us know. You have the ability to designate yourself as temporarily unavailable for new referrals. This reduces inappropriate referrals and frustration for members. You may remain unavailable for up to six months. Changes to your availability status can be made through Provider Express, emailed to us at bnswest@optum.com, or faxed to Network Management at **619-641-6322**.

We know you share our commitment to offering clinically appropriate and timely access to care. Thank you for making these standards a part of the quality care provided by the OptumHealth Network.

Members Highly Satisfied with Treatment and Services

The most recent annual findings of member satisfaction show high marks. Members who were surveyed received services from an OptumHealth network clinician in 2011.

The survey assessed member satisfaction along multiple domains including:

- Obtaining referrals or authorizations
- Accessibility and acceptability of the clinician network
- Customer service
- Treatment/quality of care
- Overall satisfaction

Results of the survey indicate that members experience high overall satisfaction with treatment received and services rendered. High levels of satisfaction are also associated with obtaining referrals and authorizations. Members reported 91.8% overall satisfaction with their experience of finding an available clinician. Over 92% of the members surveyed are reporting that the treatment they received from their clinician helped them better manage their problems and their health. Overall member satisfaction with services received from OptumHealth was 92%.

SB 946 — California Autism Mandate

As of July 1, 2012, U.S. Behavioral Health Plan, California ("USBHPC" or the "Plan") doing business as OptumHealth Behavioral Solutions of California, has met the requirements mandated by SB 946 to provide coverage for evidence-based behavioral health treatment and evidenced-based intervention programs, including applied behavior analysis ("ABA"), for pervasive developmental disorder or autism (collectively referred to as "autism"). Through collaboration with the Plan's parent organization, United Behavioral Health (Optum) ("UBH"), an Autism Program has been designed to meet the needs of families with autistic children. The needs of California enrollees are managed from the Plan's Care Advocacy Center ("CAC") in San Francisco, California with a consistent, standard approach focused on ensuring the best care. Our Autism Care Advocates, who have training and experience working with individuals diagnosed with autism and their families and are familiar with current treatments including Applied Behavior Analysis and other evidence-based behavior intervention programs are available to coordinate care with the family and autism treatment team.

Our contracted network of Qualified Autism Service Providers has been established to serve the health plans' membership across all California counties. We are committed to meeting availability and accessibility standards when arranging care for enrollees with Pervasive Developmental Disorders or autism throughout the Plan's service area.

For additional information regarding the OptumHealth Behavioral Solutions of California Autism Program, please contact customer service at 1-800-999-9585, and you will be directed to an Autism Care Advocate.

Quality Achievements

The Quality Improvement (QI) Program monitors access to care and availability of clinicians, quality of care and services, patient safety, and appropriate utilization of resources. Each year, an in-depth evaluation of the QI Program is performed. This includes a review of the processes that support these components of care along with OptumHealth's overall structure. The findings of the most recent evaluation conducted in 2011 include:

- Outstanding performance in the areas of network availability and accessibility
- High performance for customer service call response time, and turn-around times for member appeals and complaints, resolution of provider disputes, and adverse determinations
- Appointment for emergent care (non-life threatening) offered within 6 hours was at 100%
- Appointment for urgent care offered within 48 hours was at 100%
- Member complaints remain well below the performance threshold

An Executive Summary of the most recent QI performance evaluation is available by calling toll-free (866) 243-4044.

Timely Filing and Correct Submission of Claims

Your Agreement and the Network Manual state that claims must be received by OptumHealth within 90 days from the date of service. Claims received more than 90 calendar days after the date of service may be rejected for payment. If your claims are not received within 90 calendar days, members may not be billed for more than the applicable co-payment or coinsurance amounts.

If a claim is denied for timely filing and you feel that you have acceptable proof that it was filed in a timely manner, you must file a Provider Dispute with OptumHealth at the following address for reconsideration. Simply submitting the claims again to our standard claims address will not result in reconsideration.

OptumHealth Provider Disputes
P.O. Box 2839
San Francisco, CA 94126
Phone: 800-505-8826
Fax: 800-984-7584

What Constitutes Proof of Timely Filing?

Acceptable as proof of timely filing:

- Confirmation from providerexpress.com claims submission
- Certified mail receipt
- Proof of submission to a claims Electronic Data Interchange (EDI) Clearinghouse

Unacceptable as proof of timely filing:

- Call logs or office ledger entries showing claims mailing dates do not constitute proof of mailing
- Statement that the claim was mailed within 90 calendar days of the date of service with no supporting documentation

Other possible scenerios:

- Proof of submission to an incorrect carrier – 90 calendar days to restart on date of proof that the provider was advised by the incorrect carrier that they were not the insurer or the health plan (i.e., an EOB or PRA). If the claim is received within 90 calendar days of that date, the dispute can be overturned.
- OptumHealth is the secondary carrier – 90 calendar days to restart on the date the primary carrier denies or partially denies the claim for payment. If the claim is received within 90 calendar days of that date, the dispute can be overturned.

The most efficient and effective way to submit claims properly and timely is to submit them electronically on our website, Provider Express. However, in the event that you must submit your claim on paper, it is important that the proper address is used. Below are the most common claim addresses used for OptumHealth and Optum members.

If you have questions about these requirements, please contact Network Management at bnswest@optum.com.

Please note that claims are not to be faxed. They must be submitted electronically through Provider Express or through an EDI clearinghouse, or submitted on paper via the U. S. Postal Service.

University of California & Wells Fargo Members	OptumHealth Members
P.O. Box 30760 Salt Lake City, UT 84130-0760	P.O. Box 30755 Salt Lake City, UT 84130-0755
UnitedHealthCare (UHC) Members	
UHC OPTIONS PPO	**UHC (all other)**
Mail to the address listed on the back of members ID card or call 1-877-842-3210	P.O. Box 30757 Salt Lake City, UT 84130-0757

Revised Network Manual Available

The latest edition of the Network Manual for California providers was posted to Provider Express in November. Reflecting the change of our branding from U. S. Behavioral Health Plan, California to OptumHealth Behavioral Solutions of California, the new Manual includes the most up-to-date information regarding the Network.

You'll find updates to:

- California Contact List
- Frequently Asked Questions
- Campaign for Excellence
- Board Certified Behavior Analyst and Applied Behavior Analysis Agency network requirements
- Authorization/notification requirements for inpatient and subacute services
- Appeals and grievance contact information

Please be sure to review the new Manual at Provider Express. Under "Guidelines/Policies", select "Network Manuals" and look for the OHBSC Network Manual. If you would prefer to receive a paper copy of the Manual, please contact Network Services at bnswest@optum.com.

Monitoring Network Availability

We have developed standards to ensure that members have appropriate availability of behavioral health clinicians and facilities within a defined geographic distance.

The most recent results are in for the compliance measurement of the standards for geographic availability for the OptumHealth Network. Clinicians and facilities are in geographic positions of availability to provide services to membership in all urban and suburban areas of California. In rural areas, M.D. availability shows improvement but continues to fall slightly short of our goal. We continue to monitor rural areas to identify new psychiatrists with whom we can contract.

Standard (within number of miles from member)				
Clinician Type	**Urban**	**Suburban**	**Rural**	**Performance Goal**
Physician (M.D./D.O.)	10 miles	20 miles	30 miles	95%
Ph.D./Master's Level	10 miles	20 miles	30 miles	95%
Child/Adolescent Clinician	10 miles	20 miles	30 miles	95%
Acute Inpatient Care	15 miles	30 miles	60 miles	90%
Intermediate Care/Partial Hospitalization	15 miles	30 miles	60 miles	90%
Intensive Outpatient Care	15 miles	30 miles	60 miles	90%

Public Policy Committee

In accordance with California law, OptumHealth Behavioral Solutions of California (OptumHealth) has a Public Policy Committee to provide a formal structure for the comments and participation of covered members, and employer and health plan representatives. This committee consists of at least three subscriber enrollees of OptumHealth, one contracted clinician and one member of our Board of Directors.

Responsibilities of the Public Policy Committee include:

- Evaluating care and service proposals
- Defining public policy in accordance with the state's Knox-Keene Act
- Reviewing and discussing member grievance data
- Examining member and provider satisfaction survey results
- Reviewing the company's financial condition
- Making recommendations to the OptumHealth Board of Directors regarding quality of care and service

The Public Policy Committee meets quarterly, and reports to our Board of Directors. For more information regarding committee membership, please contact Eileen Innecken, Sr. Director of Regulatory Affairs & Compliance, at (619) 641-6907.

Listening to Your Feedback

In 2011, we invited over 4,500 Network clinicians to participate in a web-based survey to measure clinician satisfaction with areas of service including the authorization process, the credentialing process, Network Services staff and Claims/ Customer Service. Overall satisfaction was very consistent with the prior year. Satisfaction with the authorization process and claims/customer service showed improvement over the prior year, while overall satisfaction with Network Services staff was unchanged.

For the first time, we assessed clinicians' satisfaction with the credentialing process and were pleased to see a high level of satisfaction with all aspects of credentialing.

The information you provide through the survey helps us identify what we are doing well, and where we need to improve our service. This year, we have offered providers a single point of contact for Network Services and improved ability to reach a representative. In addition, a new documentation system has enabled us to more effectively capture and route your issues to the appropriate team for faster and more efficient resolution.

Thank you to all of the clinicians who took the time to participate in the survey and provide us with valuable feedback.

OptumHealth Behavioral Solutions of California Important Reminders

Affirmative Incentive Statement

Care advocate decision-making is based only on the appropriateness of care as defined by the Level of Care Guidelines, Coverage Determination Guidelines, the Psychological and Neuropsychological Testing Guidelines, the Member's Benefit Plan, and applicable state and federal laws.

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

You will find the Level of Care Guidelines, along with the Best Practice Guidelines, Coverage Determination Guidelines and the Supplemental and Measurable Guidelines, at Provider Express or you can receive a paper copy from Network Management.

Care Advocacy Process Provides Peer Review Discussion

OptumHealth's care advocacy process offers every clinician the opportunity to discuss a potential adverse benefit determination based on medical necessity with an appropriate peer reviewer at OptumHealth before a final determination is made. You may request a discussion with a peer reviewer at any time during the decision process or after the decision has been made. You may reach a peer reviewer by calling the number shown in the certification letter or an adverse

determination letter or by calling the number on the back of the member's identification card and requesting to speak with a peer reviewer.

University of California Employee Claims

We encourage all clinicians to submit claims electronically, either through our secure website, www.providerexpress.com or via Electronic Data Interchange (EDI). However, if you do not submit your claims electronically, please remember that claims for employees of the University of California should be submitted to their designated claims address:

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

If you submit your claims electronically, no special handling is required.

Information regarding electronic submission of claims can be found on Provider Express.

Is Your Practice Information Current?

Members may be referred to you by our intake services or they may self-refer based on an online provider directory available on the member web site. Referrals and the ability for member's to obtain timely access to appropriate services rely on the contact and service information you provide. Clinician searches may specify a certain demographic area, clinical expertise, and/or particular language needs.

As a network clinician, it is your contractual responsibility to notify us when there is a demographic change pertaining to your practice, when your practice is full, or when you are not able to accept new OptumHealth patients for any reason. It is also important to confirm that your Medicare, Medicaid and National Provider Identifier (NPI) information is current and accurate. You may check your current information and make updates:

- Through secure Transactions on our website, www.providerexpress.com
- By fax to (619) 641-6322
- By email to bnswest@optum.com

Notifying OptumHealth of changes to your practice information ensures new patient referrals can reach you and helps to prevent potential claims payment issues.