Network Notes

OptumHealth News and Updates for USBHPC-Contracted Clinicians and Facilities Fall 2014

Update Your Practice Information

OptumHealth Behavioral Solutions of California (OptumHealth) members may be referred to you by our intake services or through self-referral based on a review of information available on the member website. Referrals, timely access to appropriate services, and your receipt of claim payments rely on the information you provide. It is critical that this information be kept current and accurate.

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. You may initiate these changes in our system by:

- Submitting the change directly on **Provider Express** through "My Practice Info" using the secure "Transactions" available only to registered users. Through **providerexpress.com**, you can update:
  - Changes in practice location, billing/remit address, telephone or fax number
  - Your Tax Identification Number (TIN) used for claims filing
  - The programs you offer (services you provide must continue to meet our credentialing criteria)
  - The hours you are available
  - Languages you speak
  - Your areas of expertise
- Selecting "Contact Us" from the right side of the horizontal menu bar on *Provider Express*, select "Provider Record Maintenance – Demographic and Tax Identification Number (TIN) Changes and Updates" then complete and fax the Clinician Add/Change Application to Network Management at **(855) 833-3724**
- Submitting an email to: **bnswest@optum.com** (if specific forms are required, we will email them back to you with instructions)

Please notify us immediately of any changes to your practice information.

Have We Called You, Yet?

By March 31 of each year, all full service and mental health plans in California are required to submit reports to the Department of Managed Health Care (DMHC) regarding their timely access compliance pursuant to California Health and Safety Code section 1367.03(f)(2). The ultimate goal of the DMHC is to ensure that reliable data is easily accessible to consumers to help them compare the relative compliance of behavioral health plan networks with the state-required timely access standards.

Beginning in 2014, our reporting includes the results of a telephone survey of the provider network regarding routine appointment availability. Opportunities for improvement will be determined based on our analysis of the survey results. If we identify the need for corrective action, we will provide advance written notice to any impacted providers.

OptumHealth calls a sampling of the provider network for the survey and this could include you! The survey is very brief and should only take a few minutes. If you are contacted for the survey, we appreciate your cooperation and prompt response.

Ensuring Timely Access to Care

OptumHealth has established the following standards to ensure that members are able to obtain treatment in a timely manner. We rely on you to make compliance with these standards a part of your business practice.

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%
Network Clinician Availability	Percentage of network clinicians available to see new patients	90%
Clinician Timely Response to Enrollee Messages	Clinicians shall provide live answer or respond to enrollee messages for routine issues within 24 hours	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.

The most recent measure of the network for Access to Care Standards shows high performance marks for all of the standards.

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. 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 Timely Response to Enrollee Messages: We expect all network providers to make it a basic part of your business practice to return member calls within 24 hours.

If you are unable to see new members due to a full practice or leave of absence, it is extremely important that you let us know. You have the ability to designate yourself as temporarily unavailable for new referrals. This way, we won't refer members to you. 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*, e-mailed to us at **bnswest@optum.com**, or faxed to Network Management at **(855) 833-3724**.

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.

OptumHealth Language Assistance Program

The OptumHealth Language Assistance Program was implemented in January 2009 to meet the regulatory requirements promulgated by 2003 California Senate Bill 853 (SB853). This Program offers language assistance services to enrollees with Limited English Proficiency (LEP).

Our Language Assistance Program includes the following services at no charge to the enrollee or the provider:

- Informing enrollees and providers about the available language services
- Providing information to enrollees about bilingual clinicians through the online provider directory
- Oral interpretation services in the caller's language of choice via the Language Line to any enrollee who requires language assistance
- Oral interpretation of relevant written OptumHealth English-version documents via the Language Line, per the regulations
- Written translation into threshold languages of relevant written OptumHealth English-version documents, per the regulations

What is Required of Clinicians and Facilities?

- Offer any LEP enrollee oral interpretation services, at no charge, through OptumHealth, even when accompanied by a family member or friend who is able to interpret
- Document the acceptance or declining of interpreter services in the enrollee's chart
- Post a one-page notice in your waiting room/facility of the availability of language assistance (Notice). The Notice is available to you via providerexpress.com and in the OptumHealth Behavioral Solutions of California Network Manual, which can be found on *Provider Express*
- Make available to enrollees, upon request, a pre-translated version of the DMHC grievance process and Independent Medical Review (IMR) application and instructions. Providers may access the DMHC grievance instructions and IMR application on the Department's website at **www.dmhc.ca.gov** or by clicking on the link on **providerexpress.com**
- Go to *Provider Express* to obtain pre-translated versions of the OptumHealth Grievance Form as well as the English version accompanied by the notice of availability of language assistance
- If language assistance is required, contact OptumHealth at the number provided on the back of the enrollee's ID card so we can assist you by using the Language Line to provide telephonic oral interpretation

OptumHealth monitors provider compliance with the Language Assistance Program through site visits and treatment record reviews.

For additional information about the Language Assistance Program, visit *Provider Express*, select "Admin Resources", then select "California Language Assistance Program".

Clinician Satisfaction Survey Provides Valuable Feedback

In 2013, OptumHealth invited over 5,000 Network clinicians to participate in a web-based survey to measure clinician satisfaction with areas of service including the authorization process, Network Services staff, the Authorization Process, Claims/Customer Service, Credentialing and website usage.

Overall satisfaction with OptumHealth declined somewhat over the prior year. Satisfaction with the Authorization Process and Network Services declined slightly and Claims/Customer Service remained consistent with the prior year. Credentialing continued to show a high level of satisfaction.

The information you provide through the web-based survey helps us identify what we are doing well, and where we need to improve our service. Thank you to all of you who took the time to participate in the survey and provide us with valuable feedback.

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.

	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%

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, suburban and rural areas of California.

OptumHealth's Complex Case Management Program

OptumHealth offers a Complex Case Management program for members who could be helped through more intensive coordination of services. This program is intended to help members with complex behavioral health conditions connect with needed services and resources. Care Coordinators work intensely with individuals in the development of a comprehensive plan of care which coordinates the following:

- Therapeutic services (therapy, medication management, case management, etc.)
- Community and Psychosocial supports (education/support regarding illness, coordination with support system, other supportive services)
- Coordination of care between medical and behavioral physicians and clinicians
- Recovery and Resiliency Services (peer support, development of a crisis/recovery plan, life planning activities)
- Other services as appropriate (legal, shelter, basic needs, etc.)

Program Goals:

- Movement toward recovery
- Enhanced wellness
- Building resiliency through empowerment and self-care

Criteria for acceptance into the program include:

- Presence of complex behavioral health condition(s) which require intensive coordination of services
- History of intensive behavioral health service utilization over the past 12 months
- Member willingness to actively participate in the program for at least 90 days

If an individual with whom you are working meets these criteria and may benefit from OptumHealth's Complex Case Management program, please contact us at the toll-free number on the back of your patient's/client's insurance card to make the referral. OptumHealth looks forward to collaborating with you to assist your patient/client on the path to recovery and wellness.

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, the OptumHealth 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 ID 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, 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 must be submitted to their designated claims address:

Optum
PO 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**.

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 2014 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 QMI performance evaluation is available by calling toll-free **(877) 614-0484**.

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 2014.

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. 91% of members were satisfied overall with their experience of finding an available clinician. 93.5% of the members surveyed are reporting that the treatment they received from their clinician helped them better manage their problems. Overall member satisfaction with services received from OptumHealth was 93%.

Public Policy Committee

In accordance with California law, U.S. Behavioral Health Plan, California ("USBHPC") doing business as 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 satisfactions survey results
- Reviewing the company's financial condition
- Making recommendations to the USBHPC 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**.