Network Notes

OptumHealth News and Updates for USBHPC-Contracted Clinicians and Facilities Fall 2015

Record Requests for Grievance Review or Independent Medical Reviews with the DMHC

OptumHealth Behavioral Solutions of California ("OHBS-CA") enrollees have the right to request a grievance review and/or Independent Medical Review (IMR) with the California Department of Managed Health Care (DMHC) when the enrollee is unsatisfied with the services received or decisions made about requested services. When the DMHC notifies us that an enrollee has requested a grievance review or IMR, the DMHC requires that all requested information, which may include medical records maintained by the treating provider, regarding the services in question be submitted to the DMHC and/or IMR organization. By law, these records must be provided to the DMHC and/or the IMR organization within 24 hours, 3 business days, or 5 calendar days of the request, depending on the nature and urgency of the request.

We may reach out to the treating provider in order to facilitate DMHC requests for records. According to sections 3.5, 7.2, and 7.3 of the Participation Agreement, providers are required to maintain adequate records and those records must be made immediately available to OHBS-CA for purposes of utilization management and quality improvement activities and upon request by government and accreditation organizations, including the DMHC. To meet the required due date for the grievance review or IMR, we expect contracted providers to submit the requested information immediately. If the records are not immediately available for an unforeseeable reason, the provider must inform OHBS-CA of the delay, the reason for the delay, and the date on which the records will be available.

We appreciate your cooperation with these requests. If you have questions about this information, please contact Network Services at:

Optum – Behavioral Network Services
PO Box 880609
San Diego, CA 92168-0609

Phone: (877) 614-0484
Fax: (855) 833-3724
Email: bnswest@optum.com

Notice of Updated Definition: Medical Necessity

U.S. Behavioral Health Plan, California ("USBHPC") doing business as OptumHealth Behavioral Solutions of California ("OHBS-CA") adheres to the following definition of medical necessity, and as such herein advises its contracted provider network accordingly. USBHPC is aware that this definition varies for some full-service plan customers. In such situations, USBHPC will support the customer's definition. These full-service plan customers include Central California Alliance for Health; Ventura County Health Care Plan; and Sutter Health Plan.

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

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A service or item will be covered under the USBHPC 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.

If you have questions or need additional information about this definition, please contact us at bnswest@optum.com or call (877) 614-0484.

Clinicians Provide Valuable Feedback

In 2014, we invited over 5,000 Network clinicians in California 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 web site usage.

Overall satisfaction with OHBS-CA improved slightly over the prior year. Satisfaction with the Authorization Process, Network Services, and Claims/Customer Service and Credentialing all showed improvement over 2013 results.

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	15 miles	15 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 OHBS-CA network. Clinicians and facilities are in geographic positions of availability to provide services to membership in all urban, suburban and rural areas of California with the exception of acute care facilities. There is an overall scarcity of behavioral health facility programs throughout California, especially in rural areas. We continue to monitor these areas for new programs that are willing and able to contract with us to enhance the availability of services for the members we serve.

Coordinating Care for Healthier Lives

As a specialty, behavioral healthcare has an obligation to foster overall healthier lives. At OHBS-CA, our mission is to help people live their lives to the fullest. One of the important ways in which we work toward that goal is by promoting ongoing coordination of care for patients. We take an active role in this process and expect our network providers to do so as well.

For members who are hospitalized, our Care Advocates request that hospital staff collaborate in obtaining a Release of Information (ROI) for us that will enable us to connect with the patient's primary caregiver and support system. This allows us to more effectively support patients and caregivers in accessing benefits, resources, and in remaining engaged in follow-up treatment. Additionally, within our various clinical programs, our Care Advocates facilitate coordination of care with medical and other treating providers to promote optimal treatment for patients.

Another important aspect of care coordination is ensuring that treating clinicians connect directly with one another. Even the best work to address behavioral health and substance use issues can be jeopardized by underlying medical conditions. A recent survey of the network reveals that a significant portion of clinicians do not coordinate care with the member's Primary Care Physician (PCP) on a routine basis and many clinicians report they do not believe it is even necessary.

PCPs continue to express interest in receiving more frequent and comprehensive information about their patients who are receiving behavioral health services. A behavioral health condition, including those considered "routine" or uncomplicated from a behavioral health professional's perspective, could be regarded as a significant complication of the patient's medical condition by the PCP.

All OHBS-CA network providers are expected to coordinate care with a member's PCP, other behavioral health clinicians and, when applicable, hospital staff. This communication should be documented in the member's record. Treatment records are subject to review. Verification of Coordination of Care with a member's PCP can occur as part of audits for high-volume clinicians, routine random audits, reviews of facilities and audits concerning quality of care issues.

The collaboration achieved through your coordination of care with a patient's PCP and other treating providers can make a big difference in your patient's quality of care, healthy outcomes and overall quality of life.

OHBS-CA Language Assistance Program

The OHBS-CA 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 OHBS-CA English-version documents via the Language Line, per the regulations
- Written translation into threshold languages of relevant written OHBS-CA English-version documents, per the regulations

What is Required of Clinicians and Facilities?

- Offer any LEP enrollee oral interpretation services, at no charge, through OHBS-CA, 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 OHBS-CA 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 web site 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 OHBS-CA Grievance Form as well as the English version accompanied by the notice of availability of language assistance
- If language assistance is required, contact us 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

We monitor 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".

Update Your Practice Information

OHBS-CA members may be referred to you by our intake services or through self-referral based on a review of information available on the member web site. 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 OHBS-CA 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.

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 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 OHBS-CA must be outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. OHBS-CA 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

Our 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 OHBS-CA 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, 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.

The Survey Says…

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 2015, OHBS-CA reporting includes the results of telephone and online surveys of the 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.

We call or email the provider network to take part in the survey and this could include you! The surveys are 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
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 OHBS-CA network.

UnitedHealthcare Joins Covered California

The Affordable Care Act (ACA) introduced a new option for consumers to access health insurance using a Health Insurance Marketplace, also known as an Exchange. Covered California, the health insurance marketplace in the state of California, lets consumers research, compare and enroll for health insurance plans offered by health insurers.

Effective January 1, 2016, UnitedHealthcare will join Covered California offering the following commercial benefit plans on the Individual Exchange for 2016:

- Core
- Core Essential

The open enrollment period runs from Nov. 1, 2015, through Jan. 31, 2016 with coverage beginning as soon as Jan. 1, 2016.

Here are a couple of things you should know about your participation and plan requirements:

- Under your U.S. Behavioral Health Plan, California Participation Agreement, OHBS-CA providers contracted in the service areas below already participate for both benefit plans offered on the Exchange.
- Participating providers agree to give UnitedHealthcare members equal access to the treatment they need. This includes delivery of service or treatment for any Exchange member covered through plans with which a provider participates.

The 2016 UnitedHealthcare Core and Core Essential Individual Exchange benefit plans include the following counties in California: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Frenso, Glenn, Humbolt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Mendocino, Modoc, Mono, Montery, Neveda, Plumas, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumme, Ventura, and Yuma.

Source: diymaps.com

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 OHBS-CA overall structure. The findings of the most recent evaluation conducted in 2014 include:

- Outstanding performance in the areas of network availability and accessibility
- Continued high performance in the areas of customer service call response time, turn-around times for clinician re-credentialing, retrospective reviews, 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 (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 OHBS-CA network clinician in 2015.

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. 89.7% of members were satisfied overall with their experience of finding an available clinician. Over 90% 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 OHBS-CA was over 88.2%.

Public Policy Committee

In accordance with California law, U.S. Behavioral Health Plan, California ("USBHPC") dba OptumHealth Behavioral Solutions of California ("OHBS-CA") 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 OHBS-CA, 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 1-619-641-6907.

The information herein offers informational resources and tools and is intended for educational purposes only. All treatment and level of care decisions are at the discretion of the clinician. Nothing herein is intended as legal advice or opinions. Please consult your legal advisor related to your particular practice.