Optum

Quick Reference Guide

Resources and Services for California Providers

This reference guide includes all of the annual required behavioral health articles for 2025. New 2026 articles will be included in monthly Top of Mind West region editions throughout the coming year.

Optum remains dedicated to providing you with the best tools and the most efficient resources and will continue to seek ways to improve service for you, our providers.

Surveys

Provider Satisfaction Survey Results

In 2024, **522** network clinicians in California responded to our California Provider Satisfaction survey which measures **clinician satisfaction** with areas of service including the authorization process, Network Services staff, claims/customer service, credentialing, website usage and Net Promoter Score (NPS).

Areas where improvement was noted:

- NPS has been rising from a score of 1 in 2022 to 13 for 2023 and 17 for 2024. (Key positive drivers include clarification of the authorization process, assistance with resolving claims issues, and provider reimbursement rates)
- Cultural Competency education/training satisfaction improved favorably and continues to remain strong, climbing from 87% in 2023 to 93% in 2024

Areas where satisfaction rate remains high:

- Provider Express website - 86%
- Commercial provider reimbursement satisfaction increased from 47% to 51%

Areas for Improvement:

- Overall satisfaction with Network Services decreased from 65% to 62%
- Satisfaction in reaching Network Services in a timely manner decreased from 59% to 57%
- Awareness of the Linguistic Assistance Program remains high, and referring members to the program rose from 10 to 16%, though this service is infrequently used

Thank you to all who took the time to participate in the survey. And thank you for your continued partnership to meet the behavioral health needs of our members.

Members Highly Satisfied with Treatment and Services

Optum administers the Member Satisfaction Survey to a sample of members who receive services from an Optum network clinician or facility. Results are analyzed annually.

The 2025 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

Survey results indicate members experience high overall satisfaction with treatment received: The findings from the survey are used to identify opportunities to improve the member experience

- 88% of surveyed members indicated that they would use Optum services again
- 92% of members indicated that they were able to find care that was respectful of language, cultural, and ethnic needs
- 88% of those surveyed reported that the treatment they received from their clinician

helped them better manage their problems
- 90% were satisfied with their overall experience with their behavioral health clinician
- Overall member satisfaction with services received was 87%

Member Resources

California Language Assistance Program

The California Language Assistance Program includes provisions for the provider network to ensure that members with limited English proficiency can obtain free language assistance when needed:

- Requirements for clinicians and facilities
- Tips for working with interpreters
- Tips for working with members with limited English proficiency
- Grievance forms and notices of language assistance

Free services to help work with members

- Interpreter services are available at no cost to members or providers: **1-800-999-9585**
- Assistance for those with hearing and/or speech impairment is available: **1-800-842-9489**

Provider Responsibilities

After-Hour Member Access

- **Timely response to member messages**: Please return all member calls within 24 hours.
- **After-hours messaging**: Your voicemail or answering service must include instructions to members regarding what they should do in an emergency.

Verifying Enrollee Eligibility

It's important to always verify enrollee eligibility before providing services, either by checking eligibility through the Provider Express secure portal or by calling Optum at **1-800-333-8724**. In addition, you are encouraged to check member insurance information at every visit and discuss all treatment options and their related risks and benefits with the enrollee, regardless of whether the treatment is covered under their benefit plan.

Guidelines

Optum uses Clinical Criteria and Guidelines established by leading industry organizations and nationally recognized associations to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency and well-being.

Optum expects all member treatment to be outcome-driven, clinically necessary, evidence-based and provided in the least restrictive environment possible. Decisions for prior authorization and utilization management are based only on the appropriateness of care/service and coverage requirements and limitations. Optum does not reward its staff, practitioners or other individuals for issuing denials of coverage/services. Utilization Management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

For more information, review:

- Clinical criteria and guidelines
- Practice guidelines

Coordination of Care

Our mission is to help people live their lives to the fullest. One of the important ways 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.

Resources are available about the importance of coordination of care as well as tools to make it easier for you to document it:

- Overview on the Providerexpress.com website
- Coordination of care checklist
- Coordination of care flyer
- Other coordination of care tips

Enrollee Rights and Responsibilities

Optum requests that you display the Enrollee Rights and Responsibilities in your waiting room or have some other means of documenting that these standards have been communicated to Optum members. All enrollees benefit from reviewing these standards in the treatment setting.

A copy of the Enrollee Rights and Responsibilities, in English and in Spanish, can be found in the Appendices of the California Behavioral Health Network Manual.

Quality Achievements

The Quality Improvement 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 Quality Improvement Program is performed. This includes a review of the processes that support these components of care along with the Optum overall structure.

The findings of the most recent evaluation conducted in 2023 include:

- Outstanding performance in the areas of network availability and accessibility
- High performance in the areas of customer service call response time and claims payment accuracy, as well as in turnaround times for claims processing, appeals, provider disputes and non-coverage determinations
- Appointments for emergent care (non-life threatening) offered within 6 hours was 100%
- Appointments for urgent care offered within 48 hours was 100%
- Member complaints remain below the performance threshold, with 100% of complaints resolved within 30 days of receipt

To request a copy of the Executive Summary of the most recent Quality Improvement performance evaluation, please call **1-877-614-0484**.

Resources for Providers

You have 24/7 access to a wide variety of resources and information through the Provider Express website:

California-specific resources

- Welcome page
- Network management contacts
- Mobile crisis resources
- Behavioral Health Network Manual

General resources

- Credentialing plan
- Reimbursement policies
- Provider training
- Optum Pay™ information

Timely Access to Care

Updating Your Appointment Availability Status

If you're unable to see new members, please update your availability status online in the Provider Express secure portal. You may remain unavailable for up to 6 months.

California regulations require you update your information within 5 days of changes to your availability, and within 10 days for any other demographic change to your practice (e.g., new phone #, hours of operation, etc.).

Appointment Availability Standards

Improving and expanding member access to care continues to be a priority and a challenge throughout the healthcare industry. Section 1367.03 of the California Health and Safety Code outlines the timelines within which members should be able to schedule appointments. Please be aware of and comply with the appointment availability standards noted below.

The California Department of Managed Health Care (DMHC) Help Center may be contacted at **1-888-466-2219** to file a complaint if the member is unable to obtain a timely referral to an appropriate provider.

For the 2023 California Provider Appointment Availability Surveys (PAAS) measurement year, Optum met the DMHC Rate of Compliance thresholds for Urgent, Non-Urgent and Non-Physician mental health follow-up appointments.

Standard	Criteria	Compliance Target
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 where immediate care isn't needed for stabilization but, if the situation is not addressed in a timely way, could escalate to an emergency	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
Follow-up care Mental health or substance use disorder follow-up appointment with non-physician	10 business days from prior appointment	100%
After-hours answering system and messaging	Messaging must include instructions for obtaining emergency care	100%
Network clinician availability	Percentage of network clinicians available to see new patients	90%
Clinician timely response to enrollee messages	Clinician 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 it is determined and documented that a longer waiting time will not have a detrimental impact on the member's health. Rescheduling appointments, when necessary, must be consistent with good professional care and ensure there is no detriment to the member. An extension to the time for a non-emergency appointment may be determined by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and is consistent with professionally recognized standards of practice.

Provider Availability Standards by Location

We have updated our standards to ensure that members have appropriate availability of behavioral health clinicians and facilities within a defined geographic distance. California network availability is reviewed quarterly to verify that clinicians and facilities are in geographic positions of availability to provide services to membership in all large metro, metro, micro, rural and counties with extreme access consideration (CEAC) areas of California. Our standards have been updated to reflect the new DMHC requirements from **APL-23-023**.

Note: A provider's region is based on county classification. The county classification for large metro, metro, micro, rural, and CEAC is based on county and the population size/density. It is also defined by Centers for Medicare (CMS) and Medicaid Services (CMS) in its published Medicare Advantage Network Adequacy Criteria, set forth in **42 CFR 422.116(c)** available at **cms.gov**.

Geographic Standards											
U.S. Behavioral Health Plan, California	**Large Metro counties**		**Metro counties**		**Micro counties**		**Rural counties**		**CEAC counties**		**Compliance Threshold for Geographic Access Standards**
Provider Types	**Miles**	**Min**	**Miles**	**Min**	**Miles**	**Min**	**Miles**	**Min**	**Miles**	**Min**	
Child/Adolescent clinician (Prescriber, PhD, master's-level)	10	20	30	45	45	60	60	75	100	110	90%
Applied Behavior Analysis (ABA)	15	30	45	70	75	100	75	90	140	155	90%
Intermediate care / Partial hospitalization / Residential (Mental health and substance use disorder)	15	30	45	70	75	100	75	90	140	155	90%
Intensive outpatient care (Mental health and substance use disorder)	15	30	45	70	75	100	75	90	140	155	90%
Medication assisted Treatment (MAT) Prescribers with expertise in naltrexone injectable or buprenorphine, methadone clinics)	15	30	45	70	75	100	75	90	140	155	90%

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Geographic Standards						
Provider Type	Distance in Miles					
	Large Metro counties	Metro counties	Micro counties	Rural counties	CEAC counties	Compliance Threshold for Geographic Access Standards
Specialist physicians / Psychiatry	15	20	55	55	100	90%
Counseling non-physician mental health professional or Counseling mental health professional (Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, Psychologist)	15	15	35	35	65	90%
Mental health facilities (Acute psychiatric hospital, psychiatric health facility, or chemical dependency recovery hospital and/or residential detoxification facility. "Inpatient mental health facilities" also includes those facilities categorized as a general acute care hospital, where such hospital maintains an inpatient psychiatric unit)	15	45	90	90	120	90%

Provider Ratio Standards

Provider-to-enrollee ratio measurement is based on the number of providers per 1,000 members, determined overall and by county, in counties with greater than 500 members.

Provider Type	Standard
Child/Adolescent clinician (MD, PhD, master's level)	1 per 1,000 enrollees
Acute inpatient care (mental health and substance use)	1 per 20,000 enrollees
Intermediate care/Partial hospitalization/Residential (mental health and substance use)	1 per 20,000 enrollees
Intensive outpatient care (mental health and substance use)	1 per 20,000 enrollees
Medication Assisted Treatment (MAT)	1 per 20,000 enrollees

Provider-to-enrollee ratio for Specialist Physicians-Psychiatry and Counseling non-physician mental health professional or Counseling mental health professional.

Provider Type	Standard
Specialist Physicians / Psychiatry	1 full-time equivalent per 5,500 enrollees
Counseling non-physician mental health professional (MHP) or Counseling MHP (Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Professional Clinical Counselor, Psychologist)	1 full-time equivalent counseling MHP per 1,000 enrollees