IDAHO PROVIDER MANUAL UPDATES – January 2024 Edition

(Note: The change index does not include minor changes to content or formatting)

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The Clinical Technology Assessment Committee (CTAC) /Technology Review	44	**The Clinical Technology Assessment Committee (CTAC)** The CTAC meets quarterly to review current medical and scientific literature. An Optum Medical Director chairs this multidisciplinary committee that includes at least one external clinician on a standing basis. In addition, this committee consults on an as-needed basis with professionals who are actively working with the technology under review and/or clinical issue(s) that may be impacted by the technology under review. This committee examines the use of new technologies and new applications of existing technologies for the assessment and treatment of behavioral health conditions. The committee also reviews existing technologies when questions arise as to their application. The committee recommends as proven those treatments for which there is published scientific evidence of efficacy and safety. This evidence includes controlled studies of adequate sample size, published in established peer-reviewed journals, as well as guidance from state and federal agencies. If you have a technology that you would like to have reviewed by this committee, make your request to the Medical Director and he or she will notify the committee chair of your interest.	**Technology Review** Technology is reviewed on an as-needed basis with professionals who are actively working with the technology under review and/or clinical issue(s) that may be impacted by the technology under review.
Provider Dispute Process	51 & 52	**Provider Dispute Process** A dispute or request for reconsideration of a claim (or group of claims) that has been denied, adjusted or contested	**Provider Dispute Process** You may dispute or request for reconsideration of a claims (or group of claims) that has been denied,

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		may be requested by you or your authorized representative. Members cannot be held financially liable for services received and therefore, you cannot bill the member for these services beyond the applicable co-payments or deductibles. The Provider Dispute process must be initiated by contacting Optum via one of the methods listed below and must include the following information: • Member identifying information: » Name » Medicaid Identification number (MID) » Date of birth » Address • The type of service • Each applicable date of service and units • Your identifying information: » Name » Tax identification number » Contact information • Dollar amount in dispute, if applicable • Any additional information you would like to have considered as part of the dispute process, including records relating to the current conditions of treatment, co-occurring conditions or any other relevant information • Your explanation as to why the adverse decision should be overturned Where to submit a Provider Dispute: • Mail: Optum Idaho, 322 E. Front Street, 4th Floor, Boise, ID 83702 • Fax: 1-888-950-1182 •Email:optum.idaho.provider.dispute@optum.com • Online: providerexpress.com For questions or assistance, call 1-855-202-0983 and press prompt 4. The Provider Dispute process is available for post-service requests. Disputes related to pre-service and other concurrent service requests are subject to the member appeal process previously described. To initiate a Provider Dispute, Optum must receive your request within 180 calendar days	adjusted or contested. Members cannot be held financially liable for services received and therefore, you cannot bill the member for these services beyond the applicable co-payments or deductibles. For all services requiring a prior authorization, a request must be made and approved prior to providing the requested service and submitted a claim. The Provider Dispute process must be initiated by contacting Optum via one of the methods listed below and must include the following information: • Member identifying information: » Name » Medicaid Identification number (MID) » Date of birth » Address • The type of service • Each applicable date of service and units • Your identifying information: » Name » Tax identification number » Contact information • Dollar amount in dispute, if applicable • Any additional information you would like to have considered as part of the dispute process, including but not limited to, administrative records which dispute the reason for the denial of the claim, such as explanation of benefits from other insurance showing a trial of attempted claim submitted, proof of claim acceptance from Provider Express, prior authorization approval letter from Optum (where applicable). • Your explanation as to why the adverse decision should be overturned Where to submit a Provider Dispute: • Mail: Optum Idaho, 322 E. Front Street, 4th Floor, Boise, ID 83702 • Fax: 1-888-950-1182 •Email:optum.idaho.provider.dispute@optum.com • Online: providerexpress.com

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		from the date you received the Provider Remittance Advice (PRA) from Optum. Disputes received outside of this timeframe will not be processed. Optum will notify you or your authorized representative of the dispute resolution in writing within 30 calendar days of the receipt of your request.	For questions or assistance, call 1-855-202-0983 and press prompt 4. The Provider Dispute process is available for post-service requests for which a claim has already been submitted. Disputes related to pre-service and other concurrent service requests are subject to the member appeal process previously described. Disputes related to post-service requests that, due to extenuating circumstances failed to obtain prior authorization, and no claim filed, are subject to the retrospective review process. To initiate a Provider Dispute, Optum must receive your request within 180 calendar days from the date you received the Provider Remittance Advice (PRA) from Optum. Disputes received outside of this timeframe will not be processed. Optum will notify you or your authorized representative of the dispute resolution in writing within 30 calendar days of the receipt of your request.
Family Psychoeducation	94 & 95	**Family Psychoeducation** **Description** Family Psychoeducation (FPE) is an approach for partnering with families and members with Serious and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED). FPE is based on a core set of practice principles as outlined by Substance Abuse and Mental Health Services Administration (SAMHSA) at SAMHSA.com. These principles form the foundation of the evidence-based practice and guide practitioners in delivering effective FPE services. Family Psychoeducation gives members and families information about mental illnesses, helps them build social supports, and enhances problem-	**Family Psychoeducation** **Description** Family Psychoeducation (FPE) is an approach for partnering with families and members with Serious and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED). Family Psychoeducation gives members and families information about mental illnesses, helps them build social supports, and enhances problem-solving, communication, and coping skills. Since Family Psychoeducation is a unique approach to mental health intervention, specialized sessions (joining sessions and an educational workshop) should be completed before beginning ongoing sessions and provider should

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		solving, communication, and coping skills. Since Family Psychoeducation is a unique approach to mental health intervention, specialized sessions (joining sessions and an educational workshop) should be completed before beginning ongoing sessions. These sessions are components of the evidence-based protocol as defined in the SAMHSA Evidence-Based Practice KIT for Family Psychoeducation. Providers may follow a different Evidence-Based Practice (EBP) from the one defined by SAMHSA for Family Psychoeducation as fits the needs of the member, including EBPs where the member is not present with the family. **Payment Methodology** *Note: Hours per member are guidelines. Optum will analyze claims information to identify outlier cases that may benefit from a clinical review when utilization exceeds the guidelines. These guidelines do not indicate there is a hard limit and there is no requirement for an authorization to exceed the indicated hours. **Note: Please refer to the SAMHSA Family Psychoeducation Evidence-Based Practices (EBP) Kit on SAMHSA.gov for guidance on the provision of this service, including session duration. ***Note: Family Psychoeducation may be completed as part of the Therapeutic After School and Summer Programs (TASSP). The UC modifier is used to indicate that the service was rendered as a TASSP service as related to the clinical treatment plan goals.	ensure they are utilizing an Evidence-Based Practice. Providers may follow a different Evidence-Based Practice (EBP) Family Psychoeducation as fits the needs of the member, including EBPs where the member is not present with the family. **Payment Methodology** *Note: Hours per member are guidelines. Optum will analyze claims information to identify outlier cases that may benefit from a clinical review when utilization exceeds the guidelines. These guidelines do not indicate there is a hard limit and there is no requirement for an authorization to exceed the indicated hours. ***Note: Family Psychoeducation may be completed as part of the Therapeutic After School and Summer Programs (TASSP). The UC modifier is used to indicate that the service was rendered as a TASSP service as related to the clinical treatment plan goals.
Skills Building/Community -Based Rehabilitation Services (CBRS)	100	**Additional Information** • Providers should rely on the policies and procedures established by their agency and any code of professional conduct that guides their certification or licensure to ensure appropriate boundaries are	**Additional Information** • Providers should rely on the policies and procedures established by their agency and any code of professional conduct that guides their certification or licensure to ensure appropriate boundaries are

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		maintained with the member if providing other direct services. • Skills Building/CBRS is not: » Provision of transportation, Respite, Case Management, or any other support or treatment service. » Daycare or a substitute for supervision. » Provided without involvement, communication and coordination with the family. • Skills Building/CBRS Service Request Form » Providers should complete the Skills Building/CBRS service request form with information that demonstrates the member's current condition and how the member meets medical necessity criteria established by the Idaho Medicaid Supplemental Clinical Criteria (Optum Idaho Level of Care Guidelines). » The Identified Functional Needs and Goals Section (8) of the Skills Building/CBRS service request form should contain the following: › A brief description of the functional need. › Goals that address the described functional needs. › Goals that have a connection with the member's presenting issues/diagnoses. › Goals that are skills-specific. › Goals should follow the SMART Principles: Specific, Measurable, Achievable, Relevant and Timely. › Specific interventions that indicate what the Skill Building/CBRS provider is doing to assist the member in reaching their goal(s). • Providers are responsible to submit service request forms for continued services: » When submitting a continued services request, providers should document the progress related to what the member was	maintained with the member if providing other direct services. • Skills Building/CBRS is not: » Provision of transportation, Respite, Case Management, or any other support or treatment service. » Daycare or a substitute for supervision. » Provided without involvement, communication and coordination with the family of Member's under the age of 18. • Skills Building/CBRS Service Request Form » Providers should complete the Skills Building/CBRS service request form with information that demonstrates the member's current condition and how the member meets medical necessity criteria established by the Idaho Medicaid Supplemental Clinical Criteria (Optum Idaho Level of Care Guidelines). » Service request forms are only to be submitted when all 308 threshold units have been utilized for the year. Providers are responsible for tracking of units used and to only request services when additional units are needed.

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		working on over the past 180 days or since the previous request. » Progress should be specific and related to goals (usually noted in the previous service request form). » If goals aren't met or progress has not been made, then it is appropriate to document setbacks that the member experiences. » If goals are not met or progress is not made, provider should consider different interventions and/or modifying the goal. » Any changes to goals and/or interventions should be documented in their respective sections on the service request form.	
Intensive Outpatient Program (IOP)	128	**IOP Programming Requirements** **Required** IOP components included in the per diem rate: • Assessment and Treatment Planning • 24-hour Crisis Services • Psychiatric Evaluation • Medication Management • Skill-Building activities • Substance Use Screening and Monitoring • Drug Testing provided in the amounts, frequencies and intensities as appropriate to the members treatment needs. • Care Coordination/Transition Management/Discharge Planning • Physical exam within the first week of treatment to address the member's whole health and ensure this level of care is appropriate. • A psychiatrist is available to consult with the program during and after normal program hours • Health assessment and monitoring (Eating Disorder) • Dietary and nutrition services (Eating Disorder) Additionally, the following services are provided in the amounts, frequencies	**IOP Programming Requirements** **Required** IOP components included in the per diem rate: • Assessment and Treatment Planning • 24-hour Crisis Services • Clinical Diagnostic Assessment (Also Referred to as a Psychiatric Evaluation or Exam) • Skill-Building activities • Substance Use Screening and Monitoring • Drug Testing provided in the amounts, frequencies and intensities as appropriate to the members treatment needs. • Care Coordination/Transition Management/Discharge Planning • Physical exam within the first week of treatment to address the member's whole health and ensure this level of care is appropriate. • Health assessment and monitoring (Eating Disorder) • Dietary and nutrition services (Eating Disorder) Additionally, the following services are provided in the amounts, frequencies and intensities as appropriate to the member's treatment needs. • Individual Therapy

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		and intensities as appropriate to the member's treatment needs. • Individual Therapy • Group Therapy • Family Therapy • Psychoeducation **Required** program components that can be billed outside of bundled rate: • Psychiatric Evaluation (that can be completed by psychiatrist, MD, NP) • Medication Management **Optional** services that can be billed outside of bundled rate: • Case Management/TCC • Respite • Peer Support • Youth Support • Family Support • Recovery Coaching • CFT • Psych/Neuropsychological Testing Members cannot receive other outpatient services while engaged in the program except for the ones listed above and Opioid Treatment Services. This means a member could participate in a MH IOP while also participating in an OTP if medically necessary and meets the requirements for both programs. Please refer to the Continuum of Care Grid.	• Group Therapy • Family Therapy • Psychoeducation **Required** program components that can be billed outside of bundled rate: • Medication Management **Optional** services that can be billed outside of bundled rate: • Case Management/TCC • Respite • Peer Support • Youth Support • Family Support • Recovery Coaching • CFT • Psych/Neuropsychological Testing Members cannot receive other outpatient services while engaged in the program except for the ones listed above and Opioid Treatment Services. This means a member could participate in a MH IOP while also participating in an OTP if medically necessary and meets the requirements for both programs. Please refer to the Continuum of Care Grid.
Partial Hospitalization Program (PHP)	131-136	**Partial Hospitalization Program (PHP)** **Description** Partial Hospitalization programs can be used to treat mental health conditions, including eating disorders, or substance use disorders, or both; i.e., co-occurring conditions. Partial Hospitalization is a facility-based, structured bundle of services for members whose symptoms result in severe personal distress and/or significant psychosocial and environmental issues. The required program components of PHP listed	**Partial Hospitalization Program (PHP)** **Description** Partial Hospitalization Programs (PHP) are structured, intensive, and time limited services provided by a hospital, free-standing facility, or provider group utilizing evidenced based medical and clinical practices which are provided under the direction of a Medical Director. Partial Hospitalization Programs may serve Members due to mental health, substance abuse, or eating disorders,

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		below and are separated out by services that can be billed under the per diem bundled rate and those that can be billed outside of the per diem bundled rate. All services to members will be individualized in the amounts, frequencies and intensities based on the member's treatment needs and preferences within the program guidelines. Partial Hospitalization programs are appropriate for members who are experiencing symptoms that can be addressed and managed in a level of care that is less intensive than psychiatric hospitalization but who require a higher level of care than routine outpatient or other intensive services. Partial Hospitalization provides not only behavioral health treatment, but also the opportunity to practice new skills. Services for adolescents are offered separately from services for adults. Services must be delivered under the supervision of a licensed physician, MD/DO. Oversight of the program must be by a licensed physician, but day-to-day activity can be done by a designee. IOP and PHP have different requirements, please see chart at the end of the PHP section for more information. **PHP Programming Requirements** PHP Services are delivered a minimum of 20 hours per week and no less than four days per week (may include evening or weekend) for adults or children/adolescents. Common Treatment duration is four to six weeks for PHP. Services are expected to be maintained at this level throughout the member's participation in the program. Services are provided by an interdisciplinary team. PHP consists of a scheduled series of sessions consistent with the treatment plan of the member served. The treatment plan should	and may serve co-occurring needs when appropriately meeting the programmatic requirements for each service type provided. PHP treatment should resemble a highly structured, short-term inpatient program, and is a more intense level of care than routine outpatient or an intensive outpatient program (please see chart following this section). PHP treatment must proactively address the Member's needs through individualized treatment planning, coordination of care, comprehensive discharge planning, and structured, evidence based, clinical and medical interventions. Admission to a Partial Hospitalization shall not be for the purpose of social engagement, recreation, custodial care, respite care, or to maintain psychiatric wellness in the absence of acuity that would require a higher level of care. Partial Hospitalization is not for the purpose of housing or to alleviate homelessness. Legal mandates to attend Partial Hospitalization do not supersede the requirement that medical necessity be met in accordance with the Optum Idaho Supplemental Clinical Criteria. **PHP Programming Requirements** PHP services are to be delivered a minimum of 20 hours per week, no less than 4 days per week (may include evenings and weekends), for adults, adolescents, and children. A full day of PHP is considered to be 6 or more hours of structured treatment, comprised of the services approved to be a part of the PHP bundle (see below). The goal of PHP treatment shall be to avert admission or readmission to a higher level of care by addressing significant functional impairments experienced by the Member such as acute decompensation of psychiatric

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		include evidence-informed practices, such as group therapy, cognitive behavioral therapy (CBT), and motivational interviewing to enhance motivation and support member's recovery, resiliency, and well-being. Plan must include duration and frequency of treatment and must be reassessed and updated at least every 14 days, as member's condition improves, worsens, or member does not respond. Initial and ongoing risk assessments are required to be administered and documented throughout the course of treatment. Initial Clinical Diagnostic Assessment conducted by master's level therapist or higher completed within one program day of admission. Initial treatment plan is developed within five program days of admission. Treatment plans are reviewed and updated at least once every 14 days. **Required** PHP components included in the per diem rate: • Assessment and Treatment Planning • 24-hour Crisis Services • Initial Psychiatric Evaluation followed by weekly Psychiatric Reviews done by either an MD/DO or medical director's designee (NP, PA, or Prescribing Psychologist) • Medication Management • Skill-Building activities • Substance Use Screening and Monitoring • Drug Testing • Care Coordination/Transition Management/Discharge Planning • Physical Exam: If stepping up or entering a PHP program, a new exam within three days (or one program day if SUD or ED). If stepping down within seven days of discharge, previous exam done by behavioral health provider (inpatient or residential level of care) is accepted. • Health Assessment and Monitoring (eating disorder)	symptoms and/or significant regression in daily functioning and will be provided with the goal of stabilization so that the Member may safely return to a less intensive level of care. PHP services are defined by medical necessity and are not a "default" level of care from a higher level of service. All services are provided in a manner that is strengths-based, culturally competent, and responsive to each Member's individual psychosocial, developmental, and treatment needs. <u>Medical Director</u> PHP services must be provided under the supervision of a MD/DO. It is preferrable that the services are supervised by a psychiatrist or MD/DO with additional certifications/fellowships related to the specialty of the PHP. The Medical Director is required to: •At least annually, provide written attestation to the review of all PHP policies and procedures •Attend at least two interdisciplinary team meetings for each physical PHP location supervised per month. A licensed medical professional must be present at all interdisciplinary team meetings for each physical PHP location •Provide coverage of equal licensure to ensure medical supervision of the PHP, should the Medical Director be on a leave of absence •Supervise any medical designee in accordance with the appropriate Idaho licensing boarding and Optum Idaho's supervisory protocol <u>Medical Designee</u> The day-to-day operations of a PHP (i.e. medication management, medical evaluations of members, and sign-off on the member's PHP treatment plan) may be delegated by the Medical

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		• Dietary and Nutrition Services (eating disorder) • Registered nurse or higher is available 24 hours as part of program Additionally, the following services are provided in the amounts, frequencies and intensities as appropriate to the members treatment needs. • Individual Therapy • Group Therapy • Family Therapy • Psychoeducation **Required** program components that can be billed outside of bundled rate: • Medication Management • Psychiatric Evaluation **Optional** services that can be billed outside of bundled rate: • Case Management/TCC • Respite • Peer Support • Youth Support • Family Support • Recovery Coaching • CFT • Psych/Neuropsychological Testing Members cannot receive other outpatient services while engaged in the program except for the ones listed above and Opioid Treatment Services. This means a member could participate in a MH PHP while also participating in an OTP if medically necessary and meets the requirements for both programs. Please refer to the Continuum of Care Grid **Provider Qualifications** Partial Hospitalization programs may be provided by the following contracted professionals within the scope of their practice, under the supervision of a licensed physician, MD/DO: • Licensed physician, Advanced Practice Registered Nurse, Physician Assistant,	Director to a prescribing professional (PA, NP, Prescribing Psychologist, MD/DO). The Medical Director shall establish appropriate policy, procedure, organizational charts, etc. to ensure effective and ongoing medical supervision of the PHP. •The MD/DO may not delegate medical director responsibilities to a non-prescribing professional. •Independently licensed medical designees must be supervised by a person of equal licensure, at peer level or higher. •Non-independently licensed medical designees must be directly supervised by the Medical Director of the program. Registered Nurse At minimum, a Registered Nurse will be available 24 hours a day. Staffing The PHP will be sufficiently staffed, per the staffing description below, to provide intensive, structured, 20 hour per week treatment that is not for the purpose of recreation, socializing, respite, housing, etc. Staffing of PHP component services must be consistent with the guidance presented in the **Provider Manual Appendix.** Admission Requirements Admission to a PHP requires the following components be completed within 24 hours of entry to the program: •An initial Clinical Diagnostic Assessment (CDA) conducted by a master's level clinician or higher which shall also include the functional assessment (CANS for under 18, adults per LOCGs), risk assessment, and ASAM 6-dimensional assessment (for Substance Abuse). A GAIN I Core is also

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		Licensed Social Worker, Licensed Counselor, Licensed Marriage and Family Therapist, Licensed Psychologist, Psychologist Extender (Registered with the Idaho Division of Occupational and Professional Licenses), Registered Nurse, Paraprofessionals and/or bachelor's level practicing within their scope of practice/training/education and meeting supervisory protocol requirements. • SUD Providers will be licensed clinicians and paraprofessionals as defined per licensure by the Idaho Division of Occupational and Professional Licenses, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), Northwest Indian Alcohol/Drug Certification Board (NWIADCB) and practicing under the Optum Idaho supervisory protocol. Paraprofessionals (defined as individuals who are not independently licensed) providing outpatient substance use disorder treatment services within the IBHP are required to have the appropriate license and/or certification for the services provided. • Substance use disorder providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable. • It is important to ensure that services provided are within the scope of practice based on education/training and certification/designation of the substance use disorder provider. State-approved certification/designation entities are IBADCC, NWIADCB, DBH per IDAPA.	acceptable in place of an ASAM assessment. •Admission order to admit to partial hospital services (PHP) by the MD/DO or medical designee. The medical assessment and plan should include evidence to support need for PHP and without PHP services, the member would require inpatient behavioral hospitalization or ASAM Level 3.7 or higher. •Physical Exam by MD/DO or medical designee if stepping up or entering into a Substance Abuse Partial Hospitalization or when an interruption to services has occurred after stepping down from a higher level of care (i.e. there was a greater than 24 hour period unsupervised where relapse may have occurred). •Withdrawal screening to include basic vitals and applicable withdraw evaluation such as CIWA, COWS, or CINA. •Physical Exam by MD/DO or medical designed for any Member admitted to an Eating Disorder Partial Hospitalization. •Health Assessment and Monitoring by MD/DO or medical designee if stepping up or entering into an Eating Disorder Partial Hospitalization •Dietary and Nutrition Services if stepping up or entering into an Eating Disorder Partial Hospitalization <u>Within the first 72 hours of admission:</u> •Physical Exam by MD/DO or medical designee for Mental Health and Eating Disorder Partial Hospitalization or for Substance Abuse PHP Member's that have stepped down from a higher level of care with no interrupt to services •Initial Clinical Diagnostic Assessment by MD/DO or medical designee for all Partial Hospitalization programs. This may occur via telehealth if the member is onsite at the physical PHP location. If clinically indicated, there

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		Provider Responsibilities Services must be delivered under the supervision of a licensed physician, MD/DO. Oversight of the program must be by a licensed physician, but day to day activity can be done by a designee. All services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs. **Treatment Plan** An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and objectives designed to achieve those goals must also be completed and signed by a licensed network provider within five program days of first day of treatment of PHP. This member-centered plan should be developed in collaboration with the member. All participating staff working within the member's treatment plan should have integrated treatment goals that are coordinated across modalities. The treatment plan is to be reviewed and updated in collaboration with the member every 14 days. Discharge criteria and planning for aftercare options must begin upon admission and are included in the treatment plan. The member's transition out of PHP services should be clinically smooth and safe. Providers must assist the member in his/her transition to other services as needed. If the member is discharged from PHP services to another provider and/or facility document that communication and/or collaboration occurred for a clinically safe transition along with obtaining the proper releases of information. The discharge plan, at a minimum, should include the following:	shall be another provider on the member's treatment team physically present with the member. •An individualized crisis plan <u>Within 5 days of admission:</u> •An initial, individualized, interdisciplinary treatment plan utilizing evidenced based practices for the management of the Members mental health, substance abuse, eating disorder, or co-occurring needs. <u>Ongoing Requirements</u> At least every 7 days: •Psychiatric Review by MD/DO or medical designee. This may occur via telehealth if the member is onsite at the physical PHP location. If clinically indicated, there shall be another provider on the member's treatment team physically present with the member. At least every 14 days: •Treatment plan review and update As medically and/or clinically indicated: •Evaluation and re-evaluation of the Member's presentation •Risk assessment •Evaluation and re-evaluation of the Member's withdrawal with appropriate re-administration of CIWA, COWS, CINA, etc. <u>Treatment Plan Requirement</u> An individualized, interdisciplinary treatment plan will be completed within 5 days of admission to a PHP. The plan will be developed with the oversight of, and signed off by, the Medical Director or designee. A treatment plan may not consist of generic, programmatic goals, or be developed with the goal of completing a predetermined length of program (i.e. 30, 60, 90 days).

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		• The reason for discharge is clearly identified. • The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met. • The discharge/aftercare plan describes specific follow up activities. • Treatment records are completed within 30 days following discharge. • The member has a safety plan that, at minimum, address current and expected stressors, risk level, and resources. **Per Diem Rate** Except for psychiatric services and medication management, all services, as referenced above, are included in the per diem rate and should be addressed for the member by the PHP provider. **Additional Information** • Providers of SUD PHP must follow the ASAM Criteria® and administer a GAIN-I Core or a six-dimension ASAM assessment with the outcomes and recommendations documented in the medical record. • The Level of Care Utilization System (LOCUS), the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and the Early Childhood Service Intensity Instrument (ECSII) are nationally recognized tools that the Optum Idaho Utilization Management (UM) Team will be using when evaluating clinical criteria decisions and determining medical necessity for ONLY mental health Intensive Outpatient Program (IOP) and the mental health Partial Hospitalization Program (PHP). These tools are strictly being utilized as UM tools for IOP and PHP as these two services have national standards rather than state-specific standards. These tools will not be used to determine a diagnosis or functional impairment for	The treatment plan shall, at minimum, be: •Individualized treatment goals that are Member-centered and developed with the Member and full interdisciplinary team including MD/DO or medical designee, nursing, clinical, nutrition, and paraprofessional services. •Integrated across the interdisciplinary team. •Specific, time limited, measurable, and include anticipated discharge date. Treatment goals shall be achievable during the PHP stay and shall focus on management of acute symptoms that require structured, medical oversight, and could not be reasonably provided at a lower level of care. Long term goals will be identified for referral to appropriate professional follow up and included in discharge planning. •Inclusive of criteria for successful discharge. •Updated to reflect adjustment of goals to reflect the Member's ongoing needs at a minimum of every 14 days. <u>Discharge</u> Discharge planning should begin at the time of admission and be incorporated into the treatment plan. Discharge planning shall be robust and to include: •Identification of basic needs and assistance with obtaining services that provide shelter, food, etc. in accordance with Member's identified needs. •Ensuring that follow up appointments are scheduled within 7 days of discharge for IOP/OP and medication management. •Referral to a primary care physician. •Releases of information to ensure coordination of care. •Coordination of care with the Member's sources of support and care. Coordination of care shall include coordinating with the Member's

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		any member; they are only being utilized for UM purposes. • Providers are not expected to use these tools but are welcome to review the training and guidance being provided to the Optum UM team if they would like to understand the process and tools for utilization management. For additional information, please visit Provider Express > Clinical Resources > Guidelines and Policies > Adoption of LOCUS CALOCUS-CASII ECSII. • Discharge and Coordination of Care: The Partial Hospitalization provider is responsible for coordination of care with the participant's primary care provider (PCP), school, and other behavioral health provider (Optum LoC guidelines). •Treatment goals written in a time-limited manner with goals that can be accomplished within PHP length of stay (four to six weeks). • Crisis plan developed with member by program day three. • Additional information on PHP best practice can be obtained from the Commission on Accreditation of Rehabilitation Facilities (CARF). • For guidance on Supervisory Protocol, please see the Provider Manual Appendix. • This service may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.	school, legal team, probation/parole, primary care physician, outpatient treatment team, residential care, inpatient hospital, detox, etc. •When the member is discharged from PHP, for planned or unplanned reasons, to services from another provider and/or facility the PHP will document that communication and/or collaboration occurred to ensure a clinically safe transition. •If a Member requires admission to a higher level of care, such as a hospital admission, withdrawal management/detox admission, or otherwise is away from the Partial Hospitalization for greater than overnight to another facility or provider, it is appropriate to discharge the Member. When the Member returns to the program, they shall be re-evaluated for appropriateness and be considered a new admission. •If a Member is unable or unwilling to attend the required 20 hours per week of PHP treatment, the PHP will discharge the Member and facilitate engagement in a more appropriate level of care that is the least restrictive environment to meet the Member's treatment needs. The discharge summary, at a minimum, should include the following: •The reason for discharge is clearly identified. •Documentation of follow up appointments including provider, time and date of appointment, and contact information. •A summary of the reason(s) for treatment and the extent to which treatment goals were met. •The discharge/aftercare plan which will include specific referrals and follow up activities. •A Member-specific safety plan that, at minimum, addresses current and

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			expected stressors, risk level, and resources. All treatment records must be completed within 30 days of discharge from the PHP. <u>Required Services</u> Partial Hospitalization is an intensive, structured, program that will at minimum include the following services that are individualized to the Member through the interdisciplinary treatment plan: Bundled (included in the per diem rate) •Assessment and Treatment Planning •24 Hour Crisis Services •Nursing Services •Medication Management •Skills-Building Activities •Physical Exam •Clinical Diagnostic Assessment (also known as a Psychiatric Exam) •Health Assessment/Monitoring •Individual, Group, and Family Therapy •Case Management •Coordination of Care •Discharge Planning •Psychoeducation •Substance Use Screening and Monitoring (only required for substance use programs) •Drug Testing (only required for substance use programs) •Dietary/Nutrition Services (only required for eating disorder programs) Optional, Unbundled Services A Member may receive these services while participating in a PHP. Member's may not receive any other outpatient services while in a PHP. The PHP is expected to provide complete care to the Member. •Opioid Treatment Program (OTP) •Targeted Case Coordination •SOAR Case Management

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			•Respite •Peer, Youth, Family, or Recovery Support •CFT •Psychological/Neuropsychological Testing **Provider Qualifications** Partial Hospitalization programs may be provided by the following contracted professionals within the scope of their practice, under the supervision of an Idaho licensed, Optum Idaho network approved, MD/DO: •Licensed physician, Advanced Practice Registered Nurse, Licensed Prescribing Psychologist, Physician Assistant, Licensed Social Worker, Licensed Counselor, Licensed Marriage and Family Therapist, Licensed Psychologist, Registered Psychologist Extender, Registered Nurse, Paraprofessionals and/or Bachelor's level practicing within their scope of practice/training/education and meeting supervisory protocol requirements. •SUD Providers will be licensed clinicians and paraprofessionals as defined per licensure by the Idaho Division of Occupational and Professional Licenses, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), Northwest Indian Alcohol/Drug Certification Board (NWIADCB) and practicing under the Optum Idaho supervisory protocol. Paraprofessionals (defined as individuals who are not independently licensed) providing outpatient substance use disorder treatment services within the IBHP are required to have the appropriate license and/or certification for the services provided. •Substance use disorder providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through

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			certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable. •It is important to ensure that services provided are within the scope of practice based on education/training and certification/designation of the substance use disorder provider. State-approved certification/designation entities are IBADCC, NWIADCB, DBH per IDAPA. **Per Diem Rate** The per diem rate includes all services as described above and the services shall be addressed for the Member by the PHP provider. Exceptions to the per diem rate are also noted above. Please note the 0912, half day PHP, does not supersede the requirement that a Member attend 20 hours per week.
Member Appeal Process	176	**Member Appeal Process** The Appeal process is available to members, or their authorized representative with their written permission, which may be their legal guardian or provider at any level of care, in the event of an Adverse Benefit Determination when the member may incur financial liability for the services. If Optum issues an Adverse Benefit Determination, in whole or in part, then such determination will be subject to the applicable appeal process concurrently, if specifically requested, providers may ask to discuss the determination with an appropriately licensed peer reviewer. The procedures for the appeal process, i.e. how to file an appeal and where to send it, are listed below. It is important	**Member Appeal Process** The Appeal process is available to members, or their authorized representative with their written permission, which may be their legal guardian, other person of their choice, or provider at any level of care, in the event of an Adverse Benefit Determination when a claim for the appealed dates of service have not been filed. If Optum issues an Adverse Benefit Determination, in whole or in part, then such determination will be subject to the applicable appeal process concurrently, if specifically requested, providers may ask to discuss the determination with an appropriately licensed peer reviewer. For all services requiring a prior authorization, a request must be made and approved prior to providing the

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		to note that during this process the member or their representative has the right to submit any additional or new information to the medical reviewer for their reconsideration of the original determination made. Appeals may be handled as urgent or non-urgent. Urgent timeframes apply in situations where, in your opinion, application of non-urgent procedures could seriously jeopardize the member's life, health or ability to regain maximum functioning. To initiate an urgent appeal, contact Optum immediately at 1-855-202-0983 and press prompt 4. Provider-initiated urgent appeals by phone must be followed up with a written request. For an urgent appeal, Optum will make the review determination, notify you by telephone, and send written notification of the outcome to you and the member or authorized member representative within 72 hours after receipt of the request. By definition, urgent appeals are not available in situations where services have already been provided. A non-urgent appeal must be requested within 60 calendar days from the date the Notice of Adverse Benefit Determination is mailed. Optum will make a determination and notify you and the member or the authorized member representative. This notification will be provided as expeditiously as the enrollee's health condition requires in writing and sent within 30 calendar days from receipt of the request. If you have received an authorization letter or a Notice of Adverse Benefit Determination and you wish to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, please follow the instructions in the letter and call the	requested service and submitting a claim. If a member appeal is filed after a claim is submitted, the request will be subject to the provider dispute process. The procedures for the member appeal process, i.e. how to file a member appeal and where to send it, are listed below. It is important to note that during this process the member or their representative has the right to submit any additional or new information to the medical reviewer for their reconsideration of the original determination made. The provider or authorized representative must have the written member consent to file an appeal. This must be made available to Optum upon request. Member appeals may be handled as urgent or non-urgent. Urgent timeframes apply in situations where, in your opinion, application of non-urgent procedures could seriously jeopardize the member's life, health or ability to regain maximum functioning. To initiate an urgent appeal, contact Optum immediately at 1-855-202-0983 and press prompt 4. Provider-initiated urgent appeals by phone must be followed up with a written request. For an urgent appeal, Optum will make the review determination, notify you by telephone, and send written notification of the outcome to you and the member or authorized member representative within 72 hours after receipt of the request. By definition, urgent appeals are not available in situations where services have already been provided. A non-urgent appeal must be requested within 60 calendar days from the date the Notice of Adverse Benefit Determination is mailed. Optum will make a determination and

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		toll-free number provided in the letter. For additional assistance, contact Network Management to help you identify and contact the Care Advocate or peer reviewer for your specific case. Authorization is not a guarantee of payment (except as required by law), payment of benefits is still subject to all other terms and conditions of the member's plan and your Agreement. A clinical peer reviewer who has not previously been involved in the Notice of Adverse Benefit Determination and is not a subordinate of the person who made the initial decision will review a clinical appeal request. The reviewer will review all available information, including treatment records, in order to make a determination. For a case involving a clinical determination, the reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted license. For non-clinical administrative appeals, the reviewer will be an appropriately qualified Optum professional who was not involved in the initial Notice of Adverse Benefit Determination and who is not a subordinate of any person involved in the initial decision. If the decision is to uphold a Notice of Adverse Benefit Determination, Optum will notify you and the member, or the member representative, of the outcome and any additional levels of review that are available, as applicable. Members only have one appeal option with Optum and must exhaust that appeal option before being eligible to file a State Fair Hearing (see State Fair Hearing section below). If Optum fails to adhere to the notice and timing requirements, the member is deemed to have exhausted Optum's appeal process	notify you and the member or the authorized member representative. This notification will be provided as expeditiously as the enrollee's health condition requires in writing and sent within 30 calendar days from receipt of the request. If you have received an authorization letter or a Notice of Adverse Benefit Determination and you wish to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, please follow the instructions in the letter and call the toll-free number provided in the letter. Authorization is not a guarantee of payment (except as required by law), payment of benefits is still subject to all other terms and conditions of the member's plan and your Agreement. A clinical peer reviewer who has not previously been involved in the Notice of Adverse Benefit Determination and is not a subordinate of the person who made the initial decision will review the appeal request. The reviewer will review all available information, including treatment records to make a determination. For a case involving a clinical determination, the reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted license. For non-clinical administrative appeals, the reviewer will be an appropriately qualified Optum professional who was not involved in the initial Notice of Adverse Benefit Determination and who is not a subordinate of any person involved in the initial decision. If the decision is to uphold a Notice of Adverse Benefit Determination, Optum will notify you and the member, or the member representative, of the outcome and any additional levels of review that are available, as applicable.

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			Members only have one appeal option with Optum and must exhaust that appeal option before being eligible to file a State Fair Hearing (see State Fair Hearing section below). If Optum fails to adhere to the notice and timing requirements, the member is deemed to have exhausted Optum's appeal process
Retrospective Review Process	178	**Retrospective Review Process** A retrospective review may be requested when extenuating clinical circumstances (e.g. member eligibility, coordination of benefits) prevent the provider's ability to obtain a required pre-service review and prior authorization, and a claim has not been filed. Retrospective review requests must be submitted within 365 calendar days following the date(s) of service. For all retrospective reviews, Optum will issue a written determination within 30 calendar days of receipt of the request. The Retrospective Review request process must be initiated in writing by contacting Optum at the address listed below and must include the following information: • Member identifying information: » Name » Identification number » Date of birth » Address • Service type • Dates and units of service requested retrospectively • Your identifying information: » Name » Tax identification number » Contact information • Any additional information you would like to have considered as part of the retrospective review, including records relating to the current conditions of treatment, co-existent conditions, or any other relevant clinical information which may justify the medical necessity of the service requested per the Optum Idaho Level of Care Guidelines	**Retrospective Review Process** A retrospective review may be requested when extenuating clinical circumstances (e.g. member eligibility, coordination of benefits) prevent the provider's ability to obtain a required pre-service review and prior authorization, and a claim has not been filed. If a retrospective review is filed after a claim is submitted, the request will be subject to the provider dispute process. Retrospective review requests must be submitted within 365 calendar days following the date(s) of service. For all retrospective reviews, Optum will issue a written determination within 30 calendar days of receipt of the request. The Retrospective Review request process must be initiated in writing by contacting Optum at the address listed below and must include the following information: • Member identifying information: » Name » Identification number » Date of birth » Address • Service type • Dates and units of service requested retrospectively • Your identifying information: » Name » Tax identification number » Contact information • Any additional information you would like to have considered as part of the retrospective review, including records relating to the current conditions of treatment, co-existent conditions, or

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		• Your explanation as to why a prior authorization was not requested in advance of the provision of the service Where to Submit a Retrospective Review • Mail: Optum Idaho Attention: Retrospective Review 322 E. Front Street, 4th Floor Boise, ID 83702 • Fax: 1-888-950-1182 •Email:optum.idaho.provider.dispute@optum.com For questions or assistance, call 1-855-202-0983 and press prompt 4. A clinical review process will be initiated upon receipt of all information necessary to process a timely filed retrospective review request and will result in a determination that is noticed to the provider. The provider's right to dispute this determination then applies.	any other relevant clinical information which may justify the medical necessity of the service requested per the Optum Idaho Level of Care Guidelines • Your explanation as to why a prior authorization was not requested in advance of the provision of the service Where to Submit a Retrospective Review • Mail: Optum Idaho Attention: Retrospective Review 322 E. Front Street, 4th Floor Boise, ID 83702 • Fax: 1-888-950-1182 •Email:optum.idaho.provider.dispute@optum.com For questions or assistance, call 1-855-202-0983 and press prompt 4. A clinical review process will be initiated upon receipt of all information necessary to process a timely filed retrospective review request and will result in a determination that is noticed to the provider and member. The provider's right to dispute this determination then applies and will be subject to the member appeal process, or, if a claim was submitted, to the provider dispute process.

