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Welcome to Optum UT Medicaid

New Provider Orientation

08/02/2022

Agenda

1. Recovery and Peer Support Services
2. Care Advocacy and Coordination, Levels of Care
3. Quality: Audit Preparation, Outcome Measures (OQ®/Y-OQ®), Sentinel Event Reporting
4. Compliance: Crossing the T’s and Dotting the I’s
5. Member Access: Timely Access, SUD Screening and Referral, Telehealth
6. Due Diligence: Exclusions Search, Member Eligibility Check ProviderConnect Review
7. Take Care Utah and Other Resources

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Clinical Support

Care Advocacy and Coordination

Care Team

Utilization Management and Care Coordination

Our clinically licensed utilization management team is available 8 am to 5 pm for care coordination for all levels of care for providers and members. (after hours is 5 pm to 8 am, Monday thru Friday and on weekends. This team supports prior authorization requests for an inpatient level of care)

The care coordination team can support coordination and collaboration for outpatient referrals, discharge planning from all levels of care, transitions to higher levels of care, psychological testing, SUD treatment, and answer questions about benefits

It is expected that contracted providers will accommodate seeing their existing or new members discharging from inpatient within 7 days for better outcomes and prevent rapid re-admission.

Part of care coordination is supporting integrated needs.

Care advocates notify member's medical plans of inpatient admissions and coordinate otherwise when needed to support their whole recovery.

Screening and Referral for Substance Use Disorder (SUD)

Why?

Mental health assessments should be comprehensive and include SUD screening

- Substance use impacts physical, mental and spiritual health, relationships and daily functioning

Intoxication and withdrawal can present like symptoms of other mental health diagnoses

- Misdiagnosis can result in ineffective treatment and poor quality of care

Risk assessment is crucial

- Suicide risk can be exacerbated by substance use
- Members with SUD may engage in risky behavior, posing ongoing safety concerns for themselves and others (including children)

SUD Assessment Basics

Questions to include

1. Drug of choice
2. First use and details of first use
3. Peak use: dates, frequency and volume
4. Route(s) of administration
5. Last use
6. Periods of sobriety: how long and circumstances
7. Other substances and circumstances related to use of each
8. High risk behaviors resulting from substance use
9. Challenges in life domains

TIP: If you don't understand what the member says, ask for clarification. Don't be intimidated by drug lingo. Drugs can have several names and terms associated with use, handling, etc.

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Conversations about Substance Use and Treatment

Proceed mindfully and recommend SUD treatment as indicated

- Be **cautious** about your responses (both verbal and non-verbal) to the member
- Maintain a supportive attitude; avoid judgment
- Be prepared for resistance when asking about substance use or recommending treatment
- Use Motivational Interviewing or other techniques that promote meeting the member “where they are”

If the member’s primary diagnosis is SUD and your practice is not contracted with Optum to provide those services, you can coordinate a referral by contacting Optum’s Care Advocacy Team at **1-800-640-5349 (Tooele)**, or **877-370-8953 (SLCo).**

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Quality Assurance & Performance Improvement

Tips for Preparing for Chart Audits – cont.
Initial assessments

Assessments are expected to be complete including a diagnosis with adequate justification, history, presenting problem, cultural variables, and a clinical case formulation, which demonstrates medical necessity for the prescribed disposition.

Full requirements for documentation may be found in the State Medicaid Manual, as well as the Optum Provider Manual.

Members that are seeking Mental Health Services must be screened for their use of substances including nicotine use with referrals given, as appropriate.

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Tips for Preparing for Chart Audits

Suicide risk assessments

Members five years of age and older must be screened for suicidal risk.

The Suicide Risk Assessment is expected to be completed upon admission and any subsequent time the member demonstrates suicide risk.

When risk is confirmed, a safety plan needs to be created or updated on the same day.

Tips for Preparing for Chart Audits - cont.
Member voice and strength-based care

- The assessment is expected to include member's strengths related to characteristics which can be incorporated into the treatment plan.
- The member's voice is to be clear in the treatment plan goals, responses to treatment in the progress notes, and reflected in the discharge plan.
- Member centered care includes using motivational strategies, individualized interventions, addressing cultural barriers, and providing referrals to supportive resources as appropriate.

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Tips for Preparing for Chart Audits - cont.
Release of information

- A complete release of information (ROI) includes what type of information and who can share and receive the information and for what purpose.
- An expiration date or the event after which the agreement would expire is to be included in the ROI.
- It is recommended to reference 45 CFR.

Tips for Preparing for Chart Audits - cont.
Fee agreements

Per Utah Medicaid regulations and your contract with Optum Medicaid, members may not be billed for Medicaid covered services.

Tips for Preparing for Chart Audits - cont.
Timely access

Purpose

Timely Access is achieved by adherence to Medicaid Timely Access Standards.

Establishes guidelines for faster service delivery when a consumer's needs are more urgent.

To ensure that all consumers have access to services as needed.

Response Time

The initial response to the consumer for routine outpatient care should always be within 24 hours, whether for MH or SUD services.

Timely Access Standards are considered when offering when offering appointment times.

Once seen for an initial assessment by an LMHT, a consumer may be placed on a waitlist for non-urgent services for no more than 20 days if the consumer agrees.

Can't meet the standard?

Call Optum at 1-877-370-8953. Our Care Advocacy Team can help you and the consumer find a provider who can see the consumer within the required timeframes.

Tips for Preparing for Chart Audits - cont.
Timely access

Anytime a new client requests services, a timely access entry is to be completed.

Providers are required to have a standardized method for tracking timely access information for each member.

Providers must be able to demonstrate, for a given client whether timely access was offered and met.

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Tips for Preparing for Chart Audits - cont.
Eligibility, Roster and ProviderConnect (PCONN)

- Monthly eligibility checks included in the member record are required.
- Providers are expected to maintain evidence of this verification and prepared to provide the documentation upon request.
- Guidance can be found in the ProviderConnect User Guide

Tips for Preparing for Chart Audits - cont.
OQ®/YOQ

- Per the DSAMH/OSUMH Mandate, a questionnaire must be offered to members upon admission, every 30 days and at discharge.
- The questionnaire needs to be entered into the OQ® Analyst
- The results of the Clinician Report must be incorporated into treatment planning.

OQ® Analyst Questionnaires

Although many different tools are offered on the OQ® Analyst, the following tools may be used to fulfill the mandate.

Instrument NOTE: Each instrument is licensed separately	Number of Items	Completed By	Sub scales	Change Metrics	Treatment Failure Alerts	Reliable Change Index (RCI)	Community Normative Score Range	Clinical Score Range
OQ® 45.2 – adult outcome measure (ages 18+)	45	Self	3	√	√	14	0 to 63	64 to 180
Y-OQ® 2.01 – youth outcome measure (ages 4-17)	64	Parent	6	√	√	13	-16 to 46	47 to 240
Y-OQ® 2.0 SR – youth outcome measure (ages 12-18)	64	Self	6	√		18	-16 to 46	47 to 240
OQ® 30.2 – adult outcome measure (ages 18+)	30	Self	0	√	√	10	0 to 43	44 to 120
Y-OQ® 30.2 – omni-form youth outcome measure (ages 4-17)	30	Parent	7	√	√	10	0 to 29	30 to 120
Y-OQ® 30.2 SR – omni-form youth outcome measure (ages 12-18)	30	Self	7	√		10	0 to 30	31 to 120
S-OQ® 2.0 – outcome measure for clients with serious mental illness (SMI or SPMI)	45	Self or Clinician	2	√		11	0 to 59	60 to 180

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Sentinel Events

A Sentinel Event is defined as a serious, unexpected occurrence involving a member
that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services,
which has, or may have, deleterious effects on the member,
including death or serious disability, that occurs during the course of a member receiving behavioral health treatment.

The Sentinel Event Review Process is intended to be a collaborative effort between Optum and providers to identify and address issues or barriers in treatment or service delivery, in an effort to protect and support consumers and providers.

*Deleterious: causing harm or damage

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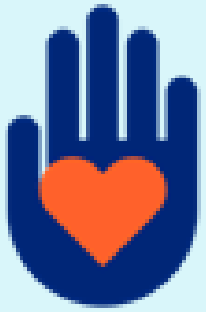
Types of Sentinel Events

Please see the Optum Provider Manual for full definitions of the categories below.

- Completed suicide
- Serious suicide attempt
- Unexpected death
- Completed homicide (perpetrator)
- Serious physical injury
- Physical assault OF a member
- Physical assault BY a member
- Sexual assault OF a member
- Sexual assault BY a member
- Abduction
- Impersonation



Sentinel Event Reporting

The official Sentinel Event Report Form includes:

- ✓ Member information
- ✓ Date and time of incident
- ✓ Date and time incident known to provider
- ✓ Type of event
- ✓ Other notifications
- ✓ Diagnoses
- ✓ Recent services
- ✓ Description of incident
- ✓ Description of actions to protect others

Timely Access Reporting

Medicaid outlines expectations for timely care delivery based on the member's presentation when requesting services. This information must be tracked by the provider and input into ProviderConnect (PCONN) for members who are:

- new to your practice, or
- requesting services after they have previously discharged from your care.

Please refer to the ProviderConnect User Guide for details on PCONN entry and the OTC Provider Manual for details on Timely Access Standards.

Note: If the time standards set forth are not met and the member is not satisfied with waiting beyond the established time frame, this constitutes an Adverse Benefit Decision (ABD) and requires a Notice of Adverse Benefit Decision (NABD). This can be avoided by coordinating care to find the member a timelier placement.

Compliance

Fraud, Waste and Abuse (FWA)

Pages 42-46 Provider Manual

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices resulting in unnecessary Medicaid costs. Ex. Providing services that are not medically necessary. Criminal intent need NOT be alleged to establish abuse.

Medicaid Fraud – Knowingly, recklessly, or intentionally presenting false information to the Medicaid agency with the intent to receive some Medicaid benefit for any person or entity.

Utah False Claims Act – The law designed as a mechanism to combat fraud and abuse in government health care programs in Utah.

Waste – Over-use of services or other practices that result in unnecessary costs.

Please know and understand all False Claims Act laws and provisions. Please see the Optum website for the FWA provisions. You can be held liable for violating FWA laws even if you are unaware you are doing so!

Fraud, Waste and Abuse (FWA) – cont.
What do I do if I suspect Fraud, Waste and Abuse (FWA)?

Everyone has the right and responsibility to report potential fraud, waste, or abuse. If you suspect FWA, you may contact any of the following:

Optum Compliance Manager

1-800-640-5349-Tooele
877-370-8953-Salt Lake
slcoquality@optum.com
Your call may be anonymous, but even if you give your name, your information will be kept confidential.

Bureau of Managed Health Care in the Division of Medicaid and Health Financing

Karen Ford
kford@utah.gov

Utah Program Integrity

1-855-403-7283
http://oig.utah.gov/report-fraud/

Adverse Benefit Determinations

Notice of Adverse Benefit Determinations (NABD)

Adverse Benefit Determination means:

The reduction, suspension, or termination of a previously authorized service; or the failure to provide services in a timely manner, as defined as failure to meet performance standards for provision of appointment waiting times when due to a Provider's limitations.

Provider Notice of Adverse Benefit Determination (NABD)

Written notification by the Provider to a Medicaid Member (client) of an adverse determination that will be taken by the Provider.

When should you send a Notice of Adverse Benefit Determination?

Scenario #1

The Provider terminates, suspends or reduces previously authorized services

AND

the Member informs the Provider that they disagree with the change

AND

the Provider affirms the decision.

Scenario #2

The Provider fails to offer services in a timely manner as defined by failure to meet performance standards for Timely Access when due to a Provider's limitations

AND

the Member is dissatisfied with this.

Attachments and the NABD

The following documents (found on optumhealthsIco.com) must be sent:

NABD Letter	Provider Notice of Adverse Benefit Determination letter
Appeal Request Form	Form that the Member fills out and send to Optum if they wish to appeal the decision
Instructions for Filing an Appeal	Form explaining the steps for filing an appeal

Retrospective Reviews

Retrospective Review Definition

A Retrospective Review is defined as a review to determine approval, in whole or in part, of services that the member has already received.

Exceptions to Prior Auth Requirement

- A member is unable to provide insurance information in an emergency situation.
- The member's Optum SLCo Medicaid eligibility is retrospectively activated after covered services have been delivered.
  - In these situations, the provider must submit the request for retrospective review to Optum as soon as they become aware of the retro eligibility, and no later than 365 days from the date of service.
- In cases where Optum is the secondary payor to another insurance plan.

Retrospective Auth Data Requirements

- DOS, the name of the practitioner/facility, and/or treating physician/clinician
- Information about any extenuating circumstances that prevented obtaining authorization at the time of service
- Contact information of the requestor
- Clinical information sufficient to make a determination to authorize requested services such as:
  - The precipitating factors, level of functioning, complications, risk assessment and relevant information about the home environment;
  - The member's diagnoses;
  - Co-occurring behavioral health or medical conditions;
  - The member's date of birth and Medicaid ID number;
  - Any relevant bio-psychosocial history and current family involvement;
  - The history of treatment;
  - The treatment plan.

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Retrospective Reviews- Salt Lake County

Submitting a Retrospective Review Request

3 options for submission

slcoreviews@optum.com

Salt Lake: 1-855-718-6743

12921 S. Vista Station Boulevard, #200
Draper, UT 84020

Retrospective Reviews- Tooele County

Submitting a Retrospective Review Request

3 options for submission

Tooele.Reviews@optum.com

Tooele: 1-877-331-0272

12921 S. Vista Station Boulevard, #200
Draper, UT 84020

Complaints (Grievances)
Complaint Types

Complaints about Optum

Members may file a complaint with Optum about Optum employees, practices, etc.

Complaints about a Provider

If a member has a complaint about their provider, and they cannot resolve it with their provider, they may file a complaint with Optum.

Providers may also file complaints on behalf of a member, with the member's written consent.

Exclusion Search

Identify parties excluded from participation in federal programs (e.g., Medicaid)

Organization

Required searches on a monthly basis

Search applies to anyone who "touches" Medicaid (usually staff but can include people such as board members, IT consultants)

Individuals and the practice itself must be searched

Results are saved for future reference, either on paper or electronically; auditors may ask for this information at any time

Searches

There are two sites to search:

- SAM website
- LEIE website

There are two methods for searching:

- By Individual name
- By downloadable file

A second level search must be completed if an entity's name appears on either site in order to confirm or rule out a match.

Reporting

Notice of attestation is sent to Optum (slcoquality@optum.com) by the 5th day of each month with search results indicated.

If a match is found, please contact Optum immediately. We will gather details and report , as required, to the applicable county and/ or Utah Medicaid.

Failure to report a match can result in recoupment of funds, which may extend beyond those involving the excluded party.

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Network Services, etc.

Improved Access with Telehealth

Optum is supportive of continued telehealth capability for our members.

While telehealth services will continue after the COVID-19 Emergency Period ends, telephonic services* will be discontinued with the end of the Emergency Period. We do not have an exact date as to when this will occur, but we anticipate that the Centers for Medicare and Medicaid (CMS) will provide a 30 to 60-day notice before that date.

**Telephonic services are those that are offered via telephone only.*

Member Eligibility Check

Must be done at admission and every month for all Medicaid members

Optum does not manage **all** behavioral health services for Tooele County Medicaid and Salt Lake County recipients.

It is important to review the details shown in the **Medicaid Eligibility Lookup Tool** (ELT).

Please keep these things in mind as you are checking the ELT:

- Verify the county where the member's eligibility is active
- Pay attention to the eligibility type and ensure that Optum Health is the listed provider for the type of service (MH or SUD) and level of care (e.g., outpatient) that you offer

Reminder: You must maintain evidence of this verification and be prepared to provide this documentation if requested.

Please refer to the **ProviderConnect User Guide** for further guidance.

ProviderConnect

Reminders

Optum now offers **training** on PCONN every month. This is recommended for new users and those needing a refresher. Please contact the Network Team if you are interested in attending.

Please note that PCONN **passwords expire** after 45 days of system inactivity. If you don't log in frequently, we recommend that you do so at least every 45 days in order to avoid the need for a password reset.

More Resources

Quick reference links Salt Lake County:

- OTC Home Page: www.optumhealthslco.com
- OTC Provider Manual: navigate to address above, select For Network Providers tab, scroll down to Manuals section and select it, see OTC Provider Manual listed

Quick reference links Tooele County:

- OTC Home Page: https://tooele.optum.com
- OTC Provider Manual: navigate to address above, select For Network Providers tab, scroll down to Manuals section and select it, see OTC Provider Manual listed

Documents to be sent separately

- Training slide deck
- Outpatient provider list
- Sentinel Event Reporting Form
- False Claims Act Provisions Policy
- Updated instructions for SAM exclusion search process
- Take Care Utah flyer