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Welcome to Optum Utah Medicaid

New Provider Orientation

2023

Recovery and Resiliency

Peer Support Services

Recovery from a member's perspective

- Your services are vital – It only takes one person to make all the difference.
- Assessments and coordination of care – Peer Support is a billable service
- Person-Centered care and planning – Be mindful to be supportive and nonjudgmental
- Mental illness and SUD often co-occur - Watch out for both, even after the initial assessment

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Clinical Support

Utilization Management, Care Advocacy and Coordination, Substance Use Disorder

Care Team

Utilization management, care advocacy and coordination

Our clinically licensed utilization management/care advocate team is available 8am to 5pm MT, Monday - Friday for care coordination for all levels of care for providers and members. (After hours staff support authorization requests for the inpatient level of care is available from 5pm to 8am MT, Monday - Friday and on weekends.)

The care advocate and care coordination team can support coordination and collaboration for:

- outpatient referrals
- discharge planning from all levels of care
- transitions and referrals to higher levels of care
- psychological testing
- SUD treatment

The care advocate and care coordination team can also answer questions about benefits for youth and adults.

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

Part of care coordination is supporting integrated needs.

Care advocates notify members' medical plans of inpatient discharges 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 treatment offered in the network

- ASAM LOC 1.0, 2.1, 2.5, 3.1, 3.3 and 3.5
- MAT, Social detox (medical detox is covered under the medical plan)

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 the Optum Care Advocacy Team at **1-800-640-5349 (Tooele)**, or **1-877-370-8953 (SLCo).**

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Quality Assurance and Performance Improvement

Tips for preparing for chart audits
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.

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

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

Tips for preparing for chart audits - cont.
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.

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Tips for preparing for chart audits - cont.
Treatment plan goals, objectives, and reviews

The treatment plan links goals with treatment recommendations and member needs, guides the treatment process using treatment goals, and prescribes frequency, duration and types of interventions.

SMART

Treatment objectives are expected to be SMART (specific, measurable, actionable, realistic, time specific).

Changes in the treatment plan are expected if a member is not progressing.

The treatment plan and reviews are expected to reflect treatment progress and discharge planning.

The discharge planning information and treatment progress should be evident in the Discharge Summary.

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

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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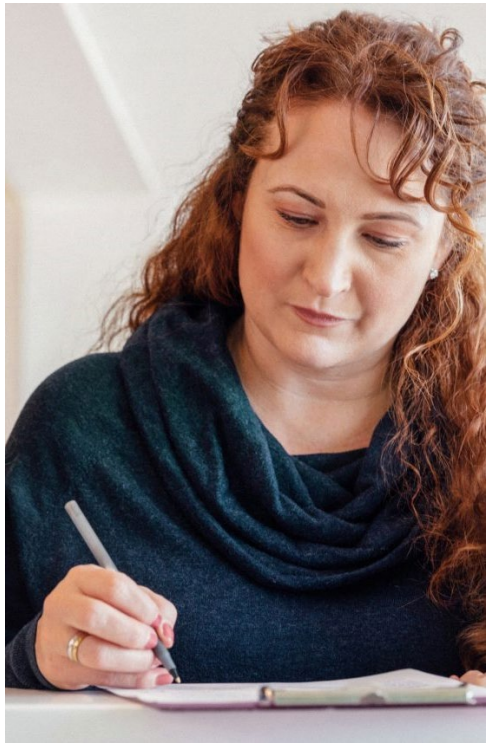
Tips for preparing for chart audits - cont.
Release of information



- 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.

It establishes guidelines for faster service delivery when a member's needs are more urgent.

It ensures that all members have access to services as needed.

Response Time

Timely Access Standards are considered when offering appointment times.

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

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

Can't meet the standard?

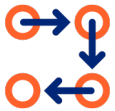
Call Optum at 1-877-370-8953. Our Care Advocacy Team can help you and the member find a provider who can see the member within the required timeframes.

Tips for preparing for chart audits - cont.
Timely access documentation and reporting

A timely access entry is to be completed in the following instances.

(1) Anytime a new member requests services.

(2) Anytime a member requests services after they have previously discharged from your care.



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

The tracked timely access information must be entered in PCONN.

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

Please refer to the ProviderConnect User Guide for details on PCONN entry and the Optum Provider Manual for Medicaid Services 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 Determination (ABD) and requires a Notice of Adverse Benefit Determination (NABD). This can be avoided by coordinating care to find the member a timelier placement.

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®/Y-OQ®

- Per the Utah Office of Substance Use and Mental Health (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.
- There should be evidence in the record that the scores from the OQ®/Y-OQ® are shared with the member or their parent/guardian.

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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

Types of Sentinel Events

- 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

* Please see the Optum Provider Manual for Medicaid Services for full definitions of the categories above.

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

Please use the Optum Sentinel Event Reporting Form.

Compliance

Fraud, Waste and Abuse (FWA)

From the Optum Provider Manual for Medicaid Services

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary, or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Medicaid Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes Fraud under applicable federal or State law. Under Utah Code Ann. § 63J-41-102(5), Fraud means intentional or knowing:
(1) deception, misrepresentation, or upcoding in relation to Medicaid or CHIP funds, costs, a Claim, reimbursement, or services; and
(2) a violation of a provision of Utah Code Ann. § 26-20-3 through § 26-20-7.

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

Waste – Overutilization of resources or inappropriate payment.

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
1-877-370-8953-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
oig.utah.gov/report-fraud/

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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 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

These documents can be found at optumhealthslco.com/ or tooele.optum.com/

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.

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

For Salt Lake County providers, Notice of attestation is sent to Optum (slcoquality@optum.com) by the 5th day of each month with search results indicated. Tooele County providers send to TooeleReviews@optum.com.

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.

Network Services, etc.

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.

Any PCONN users that need to be created for your agency will need to be requested by sending in a PCONN user request form to the Network Box.

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.

If an employee at your agency leaves, please notify the network department within 24 hours.

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MHER/TEDS

MHER

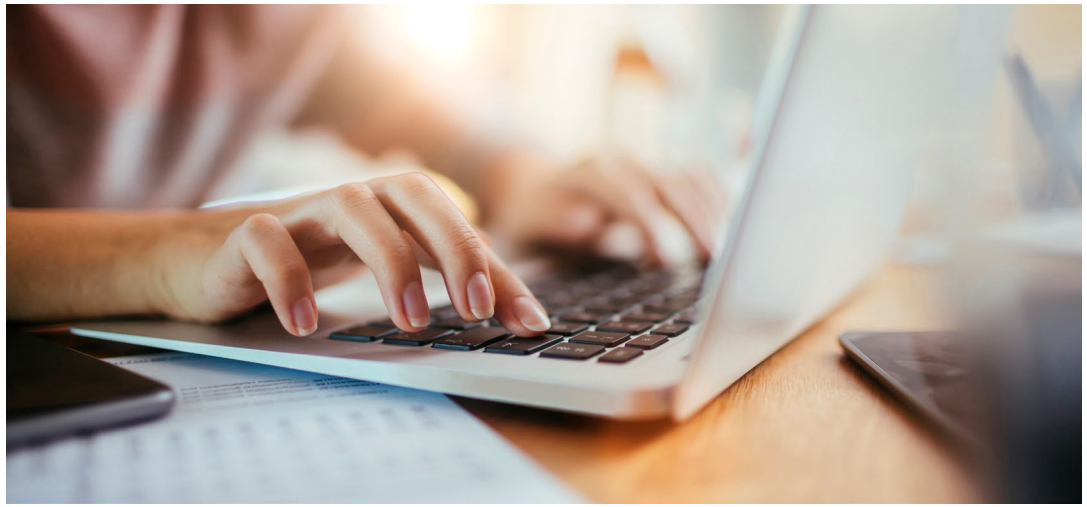
Providers are required to complete submission of the information that supports reporting to the State of Utah for each new episode of care or level of care change, including discharge. This data collection occurs through PCONN. All Mental Health services must have a Mental Health Event Record completed in PCONN upon admission and every 90 days thereafter.

TEDS

Treatment Episode Data Set (TEDS) for members receiving treatment for Substance Use Disorders (SUD) is collected through the 48 UWITS system. All information must be completed monthly.

Optum Roster Process

- Prior to performing services, every performing provider needs to be registered with State Medicaid via PRISM
- Once Approved in PRISM, a roster update form must be filled out and sent to the Network Box so that the provider can be loaded into Provider Connect.
- Once a provider leaves your agency, please send a roster update so we can enter their termination date in the system.



More Resources

State Medicaid Manual: medicaid.utah.gov/utah-medicaid-official-publications/

Quick reference links Salt Lake County:

- Optum Salt Lake County Home Page: optumhealthslco.com
- Optum Provider Manual for Medicaid Services: optumhealthslco.com/content/dam/ops-optslcty/slc/docs/provider-page/manuals,-guidelines,-policies/Optum%20SLCo%20Provider%20Manual_Jan2023_Final.pdf
- Optum Tooele County Behavioral Health Services Medicaid Member Handbook: optumhealthslco.com/content/dam/ops-optslcty/slc/docs/member-page/member-handbook/PDF-UA_SLCo_English_Member_Handbook_FINAL_update%2010.2022_a11y.pdf

Quick reference links Tooele County:

- Optum Tooele County Home Page: tooele.optum.com
- Optum Provider Manual for Medicaid Services: tooele.optum.com/content/dam/ops-tooele/docs/provider-page/manuals,-guidelines-and-policies/Optum%20TCo%20Provider%20Manual_Jan2023_Final.pdf
- Optum Tooele County Behavioral Health Services Medicaid Member Handbook: tooele.optum.com/content/dam/ops-tooele/docs/member-page/member-handbook/PDF-UA_Tooele_English_Member_Handbook_FINAL_update%2010.2022_a11y.pdf

Documents to be sent separately

- Training slide deck
- Link to Online Provider Directory
- False Claims Act Provisions Policy
- Updated instructions for SAM exclusion search process
- Take Care Utah flyer