Optum Salt Lake County

Quality Assurance and Performance Improvement Bulletin

January 31, 2022

Dear Providers,

The following information has been gathered to guide you in your efforts to meet Utah Medicaid regulations, DSAMH mandates and contractual requirements as you complete required documentation. Implementing these tips into your practice will also improve your audit performance and scores. Please reach out to our team with any questions regarding the guidelines provided.

-The Optum Salt Lake County QAPI Team

Administrative Updates

Medicaid Member Handbook and Member Acknowledgement Form

Members will initially receive the Behavioral Health Services Optum Salt Lake County Medicaid Member Handbook (Member Handbook) from the state of Utah when they become eligible for Optum Salt Lake County (SLCo) Medicaid. In addition, providers are required to offer new clients a Member Handbook as they seek services. This may be a printed copy or members can be directed to the Optum SLCo homepage (optumhealthslco.com), and then direct the member to look under the section *Medicaid Member Handbook*. As part of this process, providers are encouraged to have the member sign the Member Acknowledgement Form, indicating the provider has offered the handbook and answered any questions. This form is available at optumhealthslco.com/memberacknowledgementform and should be saved in the member's medical record once completed.

Each time a member seeks services with a new contracted provider, a Member Handbook must be offered. Even if a copy of the handbook is declined, providers must discuss with new clients the following areas: access to emergency services; transportation; choosing a network provider; grievance and appeal procedures. If the provider chooses not to utilize the Member Acknowledgement Form, the process described above must be followed and thoroughly documented in the clinical record.

If a member began treatment while with a different payor, the handbook must be offered, and the items listed above must be reviewed when the individual becomes eligible for Salt Lake County Medicaid.

Please contact the Optum SLCo Network Service Team at 1-877-370-8953 if you need printed copies of the current Member Handbook (September 2021). It is available in English and Spanish.

Member eligibility verification

Member eligibility must be verified and recorded monthly. Providers should have a standardized method for tracking eligibility that can be demonstrated during monitoring visits. A screenshot verifying the member's eligibility was checked is to be included in the record. Providers are responsible to check the eligibility of a qualified beneficiary prior to services being rendered.

To check eligibility for Optum Medicaid members, providers may utilize the Medicaid Eligibility Look-up Tool, found at medicaid.utah.gov/eligibility.

Tip: If you are treating a member who loses Optum SLCo Medicaid eligibility, you may support the individual in contacting their worker through the Division of Workforce Services. You may also contact Take Care Utah with the Utah Health Policy Project and request help from an "assistor" who can access the member's Medicaid record and research the case. They may also be able to help with the steps necessary to reinstate the member's eligibility. Spanish speaking assistors are available.

Take Care Utah: 1-801-433-2299

Clinical Updates

Initial treatment plans

Salt Lake County Division of Behavioral Health Services (DBHS) requires the provider of services to agree that at the time of admission, a licensed mental health therapist (LMHT) will establish a formal, individualized, person-centered treatment plan for every member. The plan shall be consistent with standards for individual treatment/recovery plans, incorporate the goals of the member and include the involvement of family and natural supports, respect the wishes and needs of the member within funding limitations, and follow clinical best practice standards. The treatment plan will be written in the following format:

- **Goal:** The goal is a statement that summarizes the individual's or family's desires for change and resolution to a problem or need, captured in their own words. Goals are identified throughout the assessment. They are not necessarily measurable but are reasonably attainable or recognized within an episode of continuing care.
- **Objectives:** Objectives will be established that address the member's aspirations as stated in the goal statements. Objectives are short term goals/steps that help the individual reach their goal. They describe desired changes in status, abilities, skills, or behaviors. Objectives will be measurable and will describe the progress anticipated in the near future, i.e., SMART goals:
    - Specific
    - Measurable
    - Attainable
    - Realistic and
    - Timely
- **Methods:** Methods are the strategies, interventions and tasks the member, family, peers, community support and/or staff will provide to reach the goal

and objectives. Methods will be short-term. The intensity, frequency and duration must be specified. Methods must be behaviorally measurable and use action verbs. Identifiable outcomes such as what, who, when, where and why must be stated.

The treatment plan must reflect the member's diagnoses and the information gathered in the assessment. It must be evident the member was included in the planning process and the plan addresses the member's individual needs and aspirations for the future, in their own words (without clinical jargon). The Utah Division of Substance Abuse and Mental Health (DSAMH) also requires providers to apply information gleaned from the OQ®/Y-OQ® in treatment planning. Additionally, discharge planning is a critical component of care. Providers are expected to incorporate discharge criteria and planning into the overall treatment plan, beginning at admission. A LMHT will be responsible for any clinical action and will sign off the treatment plan in the clinical record. A copy of the treatment plan will be made available to the member.

Treatment planning and the discharge plan are expected to evolve throughout treatment. Ongoing discharge and care planning is to be documented in the treatment plan reviews and throughout the treatment episode.

Treatment plan review(s)

DBHS requires treatment plan reviews be conducted by a LMHT in an individual, face-to-face interview with the member to review medical necessity, appropriateness of treatment interventions, and progress on the treatment plan. Reviews must be documented in the clinical record, and include the following:

- Date, time and duration of the service
- Evidence of member involvement
- Update of progress towards established treatment goals
- Appropriateness of services being offered
- Explanation of the need for continued participation and
- Signature and credentials of the individual rendering the service.

Rather than conducting treatment plan reviews in specified time intervals, plans should be updated whenever the member has achieved a goal or objective, is not progressing toward specific goals or when there is a change in priorities. At a minimum, treatment plan reviews must be conducted for members receiving mental health services every three months for all members who do not meet SMI criteria (non-SMI) and every six months for all members with severe mental illness (SMI). The review is to be completed during the calendar month in which it is due. For those receiving substance use specific treatment, continuing stay/treatment plan reviews are required on the following schedule, based on ASAM level of care.

- ASAM 3.5 = every 15 days
- ASAM 3.1 and 2.5 = every 30 days
- ASAM 2.1 and 1.0 = every 60 days

For members receiving mental health services, OQ®/Y-OQ® data is to be incorporated in order to support the current treatment plan or to guide changes made to the plan.

Client-Centered Care (Recovery-Oriented)

Assessing for substance use

Inquiring about substance use is an essential part of the initial and ongoing assessment. Because substance use disorders may coexist with other conditions, therapists shall continually assess for substance use and encourage appropriate treatment /recovery supports as needed. All referrals to substance use treatment and/or referrals shall be included in the member record. This applies to inpatient providers, as well as other levels of care. When appropriate, Mental health treatment providers are expected to refer members to an in-network substance use treatment provider for further evaluation and an ASAM assessment to determine if the member meets criteria for substance use specific treatment. These providers are listed in the Provider Directory. You may also contact Optum directly for referrals. Coordination of services improves the quality of care to members including reducing the risk of relapse.

Referrals

All providers are expected to document referrals to other clinicians, services, community resources, and/or wellness and prevention programs**.** Additionally, if the member has dependent children, an appropriate referral for evaluation or services for the youth shall be made when appropriate.

Interpreter services

Optum SLCo has also arranged an agreement with InterWest Interpreting for American Sign Language (ASL) support. Please call InterWest Interpreting at 1-801-224-7683 to schedule an ASL interpreter. More information is available on their website interwestinterpreting.com.

All other interpretive services will be arranged by providers on an individualized basis and at no cost to the member. **Family members should not be called upon, nor be allowed to volunteer, to act as an interpreter for a member.** Arrangements can be made through local interpretive service organizations. To pay for the service, all providers will make financial arrangements with the interpretive services agency. All providers may then bill Optum SLCo for the use of these services via CPT code T1013.

Discharge

Discharge planning

Effective discharge planning enables the member's safe and timely transition from one level of care to another and documents the services they will receive after discharge. Discharge planning begins at the onset of treatment when the provider anticipates the discharge date and forms an initial impression of the member's post-discharge needs. Discharge and continuing care planning are to be documented throughout treatment.

Discharge summary

At the time of discharge, a Discharge Summary document will be completed. This document incorporates information about the member's level of engagement, including examples, current DSM-5 or ICD-10 diagnoses, the extent to which the treatment plan goal, objectives and methods

were achieved, and services provided. It also documents the reason for discharge, member's response to treatment, and referrals and recommendations for additional services. The MHER should be updated at discharge for all members who receive mental health services. In addition, a final OQ®/Y-OQ® questionnaire is required to be administered at discharge. A LMHT will be involved in the discharge process and is responsible for any clinical action.

The provider of services agrees that members will be discharged, and the case closed in the EHR no later than 90 days after the last contact for non-SMI members and 180 days from date of last contact for members with SMI or non-SMI members receiving only medication management services. Prior to discharge, the provider of services agrees to demonstrate outreach attempts when a member fails to attend prescribed services. Providers who treat those with SUD are required to discharge a member no later than 30 days after the last contact, with the case closed in UWITS no later than 60 days after the last contact with the member.