Optum

Provider Manual for Medicaid Services

Tooele County

tooele.optum.com/

United Behavioral Health branded as Optum®

November 2024

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Introduction

Welcome to Optum Tooele County (Optum TCo) a brand of United Behavioral Health.

We are a mission driven organization, committed to promoting recovery and resiliency (see the Recovery & Resiliency Overview) and to strengthening community mental health and substance abuse systems. Optum TCo has embraced a commitment to member-centered and recovery-oriented programs. We value peer support as an integral part of this process and encourage continued innovation in the resources available to our members.

Optum TCo believes we are engaged in a partnership with our network clinicians, facilities, and the community at large. We strongly encourage dialogue and are open to your ideas. Thank you for participating.

Anni Butterfield,
Chief Executive Officer
Optum Tooele County

Important notice

Optum TCo maintains the Optum Provider Manual for Medicaid Services as a supplement to, not a replacement for, the Utah Department of Health and Human Services Medicaid Provider Manual (medicaid.utah.gov) and the Optum National Network Manual (providerexpress.com/).

We strongly encourage network participants to become familiar with all aspects of the Optum National Network Manual and the Optum Provider Manual for Medicaid, as these guide your overall contract with Optum.

Optum TCo regularly monitors providers via record reviews and onsite audits to evaluate for compliance with your contract, Medicaid regulations, Office of Substance Use and Mental Health (OSUMH) mandates, and the information in this manual.

Optum TCo expects all treatment provided to Optum TCo members be clinically necessary, outcome driven, evidence-based, and provided in the least restrictive environment possible. Optum TCo does not reward its staff, practitioners, or other individuals for issuing denials of coverage or service care. Utilization management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

Optum TCo resources

Website: tooele.optum.com
Includes key forms, reference guides, training opportunities and important updates.

Optum TCo Network Services Team contact information:
12921 South Vista Station Boulevard #200
Draper, Utah 84020
Phone: 1-800-64-5349
Fax Number: 1-855-466-3117
Email: saltlakecounty.networkbox@optum.com
Staff can answer questions or assist with the following:

- Joining the network, network status updates
- Making changes to practice/program information
- Billing or system related questions

Optum Provider Express provider portal: providerexpress.com

- Online clinical and administrative content to providers and practitioners
- Online clinical and administrative content is available to all visitors to the provider portal

Benefit plans

Benefit plans used in authorizations for Optum Tooele County Medicaid members include:

- Mental Health
- Substance Use
- Foster Care (Optum TCo ONLY manages the inpatient, BH services for these members.)
- Adult Medicaid Expansion

Please refer to the State's website medicaid.utah.gov for more detailed information about the Utah Medicaid Program.

1915(b)(3) Services

Definitions:

Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED): SMI and SED are classifications that help to identify the support members may need for stabilization of their symptoms. Completed upon admission and reviewed annually, these documents are to be included in the member record. Documents are located at tooele.optum.com under the Provider tab.

1915(b)(3) Services

1915(b)(3) Services are additional Covered Services only for Medicaid Members with:

- Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED)

- Members who receive treatment solely for substance use disorders are also eligible for 1915(b)(3) services.

If a member meets the above criteria, the following additional Covered Services are available:

- Psychoeducational Services
- Personal Services
- Supportive Living
- Respite Services (for SED only)
  If a child or youth needs Respite, please contact Optum TCo Clinical Team at 1-800-640-5349 to discuss how to access these services.

Online registrations

National Provider Identification (NPI)

The NPI is a unique, 10-digit, intelligence-free numeric identifier. This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. It is used in the administrative and financial transactions adopted under Health Insurance Portability and Accountability Act (HIPAA) and to improve the efficiency and effectiveness of the electronic transmission of health information. Optum TCo requires the billing clinician to include the NPI number and taxonomy code on all claims.

All rendering providers (see pg. 51) participating in the Optum TCo network are required to comply with Center for Medicare and Medicaid Services (CMS) rules regarding the use of NPI on the submission of claims. For a full overview on the use of NPI, please visit the NPI section of the CMS web site at cms.gov/Regulations-and-Guidance.

Getting an NPI

Getting an NPI is easy and free. For instructions on how to apply for an NPI, log onto the CMS website listed above and follow the links to the National Plan and Provider Enumeration System (NPPES) under the "How to Apply" section of the web page.

When applying for an NPI, you will be asked to select a "**Healthcare Provider Taxonomy Code**." The Healthcare Provider Taxonomy codes are a HIPAA standard code set that may be required by a healthcare payor to properly pay or process a claim and/or encounter information transactions. The Healthcare Provider Taxonomy code set divides health care providers into hierarchical groupings by type, classification, and specialization, and assigns a code to each grouping. These codes are not assigned to providers; rather, healthcare providers select the taxonomy code(s) that most closely represents their education, license, or certification.

Please note that if a healthcare provider has more than one taxonomy code associated with it, we may ask you to use one over another when submitting claims for certain services to properly process your claim.

There is a an individual NPI and an agency or group NPI for your practice. We do require both. For more information please visit cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/npi-what-you-need-to-know.pdf.

ProviderConnect NX™

ProviderConnect NX™ is our provider portal and is your primary tool for managing secure transactions including, admission, Timely Access data entry, Mental Health Event Record data entry, TEDS data entry, claim submission, and self-generated reports. ProviderConnect NX™ may also be referred to as PCNX™.

PCNX™ requires Multi-Factor Authentication (MFA), an added layer of security when accessing third party applications and helping to ensure PHI/PII is secure.

Providers shall request access to PCNX™ by contacting saltlakecounty.networkbox@optum.com. Optum shall configure a user-specific id in PCNX™ and the user will be notified via an automatic email with instructions to complete MFA setup.

After the user has completed MFA setup, PCNX™ may be accessed using the web browser of Chrome or Edge. No other software installation is required at the provider facility.

Benefits of ProviderConnect NX™

- Web-based user interface, focusing on user experience through a responsive design and workflows
- Access member demographics
- Self-service report generation
- Claim submission
- Minimizes paper-based communication, eliminating redundant data
- Reduces errors at time of entry through edit checks that ensure data validity

Training: Please contact saltlakecounty.networkbox@optum.com to request access to proprietary recorded training materials and the Open Office Hours schedules for both PCNX™ and MFA. Users are expected to review all PCNX™ training materials prior to requesting access to PCNX™.

Through ProviderConnect NX™ secure online transactions for the provider network include:

- Simplifying the collection of state required data
- Online claim submission – Supports the direct submission electronically of your claims
- Reporting – Provides reports which may be generated by the end-user
- Electronic Payments (EPS) – Provides access to claim payment details processed via electronic funds transfer.

Outcomes Questionnaire (OQ®) and Youth Outcomes Questionnaire (Y-OQ®)

The Utah OSUMH requires all providers serving Medicaid members to utilize the OQ®/Y-OQ® outcome measures, as outlined below in the Division Directives.

Further providers must track outcomes data utilizing the OQ®/Y-OQ® and maintain a record of member OQ®/Y-OQ® scores within the clinical record. OQ®/Y-OQ® questionnaires will be given to members at intake, every thirty days, or every visit (whichever is less frequent), and at discharge. The same instrument is to be completed throughout treatment by the member or by the parent/guardian for members under the age of 12. Youth between the age of 12 and 17 may complete a self-report (Y-OQ®- SR) and a guardian can complete the Y-OQ®.

The questionnaires must be entered into the OQ® Analyst and the data in the Clinician Report is to be used to inform treatment planning. Documentation is expected in the clinical record that the result of the questionnaire is shared with the member. Optum offers annual training for providers to learn how to use administer the questionnaires, understand the Clinician Reports and incorporate the information into treatment planning with the member and the guardians for youth.

OQ® Analyst client identification number

You will see **TOO** in front of the data field for the Identification Number. OSUMH uses the **TOO** to recognize the member from **Tooele County (TCo)**. This number is used to match your encounter to the member listed. You must follow the formula below when creating and updating Identification Numbers in the Client Profile within the OQ Analyst®.

Format: TOO[OQ Analyst Clinic ID#]_[PCONN# or Optum Member ID#]

Example: TOO222222_1234

TOO will auto-populate when you create a new client profile. Please DO NOT type "TOO". The only time you will need to type ""TOO is:

- if you are adding the Identification Number (missing)
- if you are updating the field **after** the profile has already been created

TOO should only appear once, **not** twice

Correct format: TOO_1234

Incorrect format: TOOTOO_1234

Your OQ Analyst® Clinic ID# can be found by clicking on the "Preferences" tab in the OQ Analyst®. You will see your Personal Information as listed in your Employee Profile. The last field on this list is "Assigned Clinics". Use the number assigned to your agency listed here.

The Optum Member ID# is the Provider Connect (PCONN) ID# or the Optum ID# used to identify the member on a claim. Do not use the Medicaid ID#.

Working with Medicaid members

Eligibility inquiry

You are responsible to determine the eligibility of a qualified beneficiary prior to services being rendered. Eligibility is not a guarantee of payment but is a key component of initiating services

and payment processing. Payment is based on contracted rates for eligible services for which prior authorization has been obtained. You are also responsible to verify Medicaid eligibility monthly, maintain evidence of this verification, and be prepared to provide this documentation if requested.

As a Utah State Medicaid Provider, you can access the online Medicaid Eligibility Lookup Tool or contact Utah Medicaid by phone at 1-801-538-6155 to determine the status of a member covered by Medicaid. To use the Medicaid Eligibility Lookup Tool, you will need to register online at medicaid.utah.gov/eligibility.

Utah Medicaid information:
1-801-538-6155
1-800-662-9651 # 3

Health Program Representative (HPR)
866-608-9422

Interpreter services

Optum TCo has also arranged an agreement with InterWest Interpreting for American Sign Language (ASL). The same eligibility rules and guidelines for accessing this service apply as they for non-English language services. 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 TCo for the use of these services via CPT code T1013.

Family members should not be called upon, nor be allowed to volunteer, to act as an interpreter for a member.

Member rights

You will find a copy of the Optum TCo Member Rights at the end of this manual and on the For Network Providers page on the Optum TCo website. You may request a paper copy by contacting Network Services or downloading it from the website. These rights are in keeping with industry standards and Medicaid Regulations. All members benefit from reviewing these standards in the treatment setting. Optum TCo requires that you display the Member Rights in your waiting room and complete the Member Acknowledgment Form which documents that these standards have been communicated to Optum TCo members.

Member responsibilities

- Keep scheduled appointments.
- Cancel appointments 24 hours in advance.
- Be on time for their appointments.

- Participate with their therapist in their treatment plan and care.
- Call Medicaid at 1-801-538-6155 about changes to their address,
  phone number or insurance.
- Tell medical staff about all medications they are taking, including medical and mental health prescriptions, over-the-counter medications, herbs and others.
- Complete any surveys that Optum TCo providers give them, including member satisfaction surveys and treatment progress surveys.
- Respect the property, comfort and confidentiality of other members and providers.
- Notify their treatment provider when they want to stop getting services.

Member Acknowledgment Form

Members will have access to the Optum TCo Member Handbook on the TCo Website (Optum TCo-For Medicaid Members). Providers are expected to also offer the handbook to new members as they seek services. The member my request a printed copy by copying Optum TCo via email (optum_utah_bh_communications@optum.com) or telephone (1-800-640-5349). The Member Acknowledgement Form can be found on the TCo website at For Network Providers under the *Member Materials* tab. Providers may have members sign the Member Acknowledgement Form indicating that the provider has offered them a Handbook and answered any questions they may have. This form is expected to be maintained in the member's medical record. If the provider chooses not to use this form, the provider must document in the member record the Member Handbook has been offered and the items above have been reviewed with the member.

Document when you discuss:

- How to access emergency services
- How to access transportation
- How to choose a provider
- How to file a grievance or appeal
- How to find the Optum Notice of Privacy Practices.

Each time a member seeks services at a new facility, a Member Handbook must be offered. In addition, even if the member chooses not to review the handbook, the Providers must discuss with the Member the following sections: Grievances/Complaints, Member Rights, Transportation, Emergency Services and Choice of Therapist.

If a member-initiated treatment with a different payor, the handbook must be offered, and the items listed above must be reviewed when the individual becomes eligible for Tooele County Medicaid.

Psychiatric Advance Directives

A mental health or psychiatric advance directive (PAD) is a legal document designed to preserve the autonomy of an individual with mental illness during times when the mental illness temporarily compromises the individual's ability to make or communicate mental health treatment decisions.

The Mental Health Care Treatment Decisions Act gives all individuals 18 years of age or older the right to have a PAD. It provides direction on the completion of a PAD and how organizations and providers must utilize and honor a PAD. A PAD allows an individual to give instructions about their treatment, including refusal of treatment, unless they are unable to do so because of illness or incapacitation. A PAD also lets a member assign an "agent" to make decision for the member if the member is unable to make their own decisions. The agent is required to make decisions in the best interest of and in accordance with the wishes of the member. Both the member and the agent must sign the PAD, and it must be signed by a witness. An appropriately executed PAD has no expiration date and is valid until rescinded by the member. The law includes a standard PAD form which a member may use.

Optum TCo provider responsibilities related to PADs

Optum TCo requires all providers to do the following concerning PADs:

- Provide adult members with written information on advance directive policies. This information shall include a description of applicable state law and regulation, member's rights under state law and regulation, Optum TCo's policies respecting the implementation of the right to have an advance directive, and direction that complaints concerning noncompliance with advance directive requirements may be filed with the state Survey and Certification Agency (currently Department of Health). This information shall reflect changes in Utah State law and regulation as soon as possible, but no later than ninety (90) calendar days after the effective date of such change.
- Document in the member's medical record whether or not the member has executed an advance directive.
- Honor advance directives within its Utilization Management protocols.
- Educate its staff and the community regarding advance directives and comply with applicable state and federal laws and regulations.
- Ensure that members are offered the opportunity to prepare an advance request and are provided assistance in the process, upon request.
- Do not discriminate against a member in the provision of care or in any other manner based on whether the member has executed a psychiatric advance directive.

Obligation to report/duty to warn

Providers are expected to follow state and federal laws governing the reporting of potential or suspected child or elder neglect/abuse as well those governing the duty to warn. If you are faced with a potential need to report to state protection agencies or to warn a potential victim but are uncertain about your obligations, it is incumbent upon you to seek appropriate and immediate clinical and/or legal counsel. In addition, information regarding reports to the appropriate

authorities must be documented in the clinical record. If a youth or family member shares reportable information and indicates it has already been reported and/or investigated, it is the provider's responsibility to verify this has been completed, unless confirming information is available (i.e., child/adult is referred by the court or DCFS/APS for treatment related to reported abuse and/or neglect).

Additionally, providers and staff are expected to be knowledgeable about methods to detect domestic violence, about the mandatory reporting laws when domestic violence is suspected and about resources in the community to which members can be referred.

Be in the know….

- ✓ Know how to report suspected child or elder abuse.
- ✓ Know how to contact state protection agencies.
- ✓ Know when to warn a potential victim of harm.
- ✓ Know who to ask for counsel when needed.

On-call and after-hours coverage

You must provide or arrange for the provision of assistance to members in emergency situations 24 hours a day, seven days a week. You are expected to inform members about your hours of operation and how to reach you after-hours in case of an emergency. In addition, any after-hours message or answering service is expected to provide instructions to the members regarding what to do in an emergency. When you are not available, it is expected coverage for emergencies be arranged with another participating clinician. Because certification of benefits may be required, Optum TCo must be contacted. If you are going to be unavailable for a known period, consider if members you are treating need a new or updated safety plan to identify additional/alternative supports.

Members transitioning to Medicaid from another payor source

If a member is currently receiving services paid by another source and transitions to Medicaid as the payor, the provider must review the sections of the provider manual as indicated below, and assure the following items are documented in the member's record:

1. Consent for treatment or informed consent
2. Medicaid Member Handbook - offered with confirmation attention was drawn to emergency services, transportation, choosing a subcontractor, filing grievances and appeals (Member acknowledgement form – pg. 7)
3. Medicaid eligibility checks (Eligibility Inquiry – pg. 5)
4. Member rights/Right to refuse treatment (Member rights and responsibilities – pg. 6-7)
5. Release of information, if applicable (Care Coordination Expectations – pg. 17)
6. Inpatient specific financial agreements that are required for the member to pay for services (Co-Pays – pg. 41)
7. Advance Directive brochure (Psychiatric Advance Directives – pg. 8)
8. SMI/SED Form (1915(b)(3) Services-pg. 2)

Additionally, review the documentation requirements as contained in the Documentation: Records of person served section on page 19 to confirm all necessary documentation is included.

In these circumstances a timely access entry is not required, and the following are needed only if clinically appropriate:

1. Suicide risk assessment
2. OQ®/YOQ® assessment

Optum Clinical Criteria

Optum Clinical Criteria provide objective and evidence-based admission and continuing stay criteria for mental health and substance use services offered by the provider network in support of the member's recovery. They are intended to standardize care advocacy decisions regarding the most appropriate and available level of care needed to support a member's path to recovery.

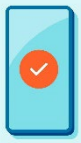
Mental Health
Optum applies Level of Care Utilization System for adults (LOCUS), Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII) as the clinical criteria for mental health disorder benefits.

They meet three main concepts that need to be considered and balance in effectively managing behavioral health services: (1) Use of wrap-around services; (2) tailored to specific age of the member; and (3) adopts a system of care approach.

Substance Use Disorders
Optum uses the American Society of Addiction Medicine (ASAM) as guidelines for substance abuse treatment and recovery.

A link to the Optum Clinical Criteria can be found on the Clinical Resources tab on the Optum TCo website or at providerexpress.com.

Best Practice Guidelines



Please contact Optum TCo at 1-800-640-5349 directly to discuss available mental health or substance use disorder benefits available to our members.

A link to the Best Practice Guidelines can be found at providerexpress.com. Select the Clinical Resources tab, and follow links for the Optum Clinical Criteria, then select applicable age group and condition. Additional important State guidelines can be found under the Provider tab on the OSUMH website at OSUMH (utah.gov).

Timely access to outpatient services

Definitions:
Emergent Care: Covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition.

Initial contact: An initial request to the Contractor for services by an Enrollee, the Enrollee's parent, legal guardian, or other representative, agency or Provider that is made during normal business hours and includes enrollees who are in the community, but not a hospital, at the time the contact is made. Initial Contacts may be made by telephone or in person. Contacts by an Enrollee, the Enrollee's parent, legal guardian, or other representative or agency to generally discuss mental health services or a need for a referral are not Initial Contacts. Initial Contacts are only those contacts that include discussion of an actual appointment for the first face-to-face service.

Urgent care: Covered Services provided to an Enrollee when the report of the Enrollee or the Enrollee's agent during the Initial Contact does not indicate dangerousness, but the Enrollee's functioning is seriously impaired, and symptoms are moderate to severe.

Non-urgent care: Covered Services provided to an Enrollee when, based on the report of the Enrollee or the Enrollee's agent during the Initial Contact, symptoms are determined to be generally less intrusive and less serious to those requiring Urgent Care.

Timely access to outpatient services
To ensure that all members have access to appropriate treatment as needed, we develop and maintain a network with adequate numbers and types of clinicians and require that the network adhere to specific access standards, which are outlined as follows.

In all cases, we expect that you will respond within 24 hours to a member request for routine outpatient care for MH/SUD services. The table below outlines Medicaid Timely Access Standards, within which you are expected to offer a face-to-face evaluation for members initiating services with you for the first time.

If you are unable to take a referral within these standards direct the member to call Optum TCo toll-free 1-800-640-5349 so that they can obtain a new referral. Members can also access a Provider Directory online at: tooele.optum.com. Optum TCo employs a variety of methods to monitor member access to care.

Timely Access Standards		
Level of Care	**Contact Method**	**Time Standard for Initial Contact**
Emergent	Phone	Clinical screening by telephone within 30 minutes and outpatient face-to-face appt. within 1 hour of phone screening
	Walk-in	Outpatient face-to-face service within 1 hour
Urgent		Face-to-face covered service within a maximum of 5 business days from initial contact
Non-urgent		Face-to-face covered service within 15 business days from the initial contact

Once a provider has completed an initial mental health evaluation, a member may be placed on a waiting list for non-urgent services, if the member agrees to this placement. A follow-up appointment **must** be scheduled within 20 business days from the date of the placement on the waiting list, regardless of the diagnosis or treatment.

Mental health and substance use disorder providers must submit timely access data in ProviderConnect NX™ when a member requests an initial service, and an appointment time is offered. This must be done regardless of if the member accepts the date and time initially offered, schedules an appointment, or attends the appointment. The data reported only relates to whether the initial appointment time offered meets timely access standards based on the identified level of acuity. Participating network providers must comply with Timely Access to Care requirements. If they fail to comply, a corrective action plan will be required.

In addition to submitting Timely Access data to Optum TCo, providers are required to have a standardized method for tracking timely access information for each member. During monitoring visits, providers must be able to demonstrate, for a given member, whether timely access was offered and met. The date and time of the initial contact must be documented. When the circumstances are deemed emergent, it is also necessary to document the time of the initial contact since timely access is measured by minutes. The time between the date of the initial contact and the date of the initial evaluation will be used to measure whether Timely Access was met.

Document the DATE & TIME of the initial contact.

Emergent circumstances are measured in MINUTES.

Many providers choose to document the initial contact:

- in the demographics section of the clinical record
- in the intake paperwork

- in the mental health assessment information
- in a log with the ability to produce the information for specific members when requested.

Providers may choose the standardized method for tracking timely access which works best for their practice.

Members discharging form acute inpatient care must me scheduled within **5 business days** from date of discharge.

In cases where a member is being discharged from acute inpatient care, urgent care appointment criteria is met, therefore a follow-up appointment must be scheduled within five business days from the discharge date. This is in alignment with Health Effectiveness Data and Information Set (HEDIS) standards requiring a follow-up after hospitalization appointment within five business days/seven calendar days. At times, it is clinically appropriate for the member to receive follow-up care sooner, especially in cases where medication changes have occurred and/or when an updated safety plan is needed. This appointment is expected to be included in the inpatient facility discharge plan.

The effort made by outpatient clinicians to meet the needs of members being discharged from a facility are greatly appreciated, including for those members who may not have been in treatment with you prior to their admission to inpatient services.

Levels of care requiring pre-authorization

Definitions:

Civil commitment: A legal process through which an individual with symptoms of severe mental illness is court-ordered to receive treatment that may occur in a hospital (inpatient) or in the community (outpatient). All citizens have civil liberties that need to be protected under both federal and state laws, so following “due process” is of paramount importance.

Treatment is not punishment. The state may need to deprive someone of their civil liberties because the individual poses a danger to self or others due to mental illness.

Community Mental Health Center (CMHC): An institution that provides mental health services required by §1916(c) (4) of the Public Health Service Act and is certified by the appropriate state authorities as meeting such requirements.

Involuntary hospitalization: A legal procedure used to compel an individual to receive inpatient treatment for a mental health disorder against his or her will. A Blue Sheet is initiated to hold them involuntarily for 24 hours for assessment and treatment. A White Sheet will hold them in the hospital for ongoing treatment and is the precursor to a civil commitment hearing.

Post-stabilization care services: Inpatient covered services related to an Emergency Medical Condition that is provided after a member is stabilized in order to maintain the stabilized condition or improve or resolve the member's condition.

Protective custody: The act of law enforcement officials placing a person in a government facility or foster home to protect them from a dangerous person or situation. Examples include: a child who has been neglected or battered or in danger from someone violent, domestic violence and acute intoxication.

Prior authorization and concurrent reviews

All levels of service require authorization.

- Providers and facilities are required to submit a service authorization for each member who is to receive treatment, care, or services. For lower levels of care, your agency will be issued a provider (agency) specific authorization number; for higher levels of care, you will call the Optum SLCo Clinical Team to request member-specific authorizations.
- Please call 1-800-640-5349 and follow the prompts to make an initial pre-authorization request for inpatient services. Authorizations requests are accepted 24 hours a day, 7 days a week. Concurrent reviews are conducted during business hours from 8:00 am to 5:00 pm MT only.
- Initial and concurrent authorization requests for higher levels of care for mental health (residential, day treatment and intensive outpatient) and substance use disorder (ASAM 3.5 - 2.1) treatment may be emailed securely to utclin@optum.com.
- Providers must initiate the concurrent review process two business days prior to the expiration of the previous authorization for these higher levels of care.
- If the provider tries to enter an authorization for a level of care that requires clinical review, the system will alert the provider that they must contact Optum TCo County. The provider will be notified when authorization has been approved.
- SUD HLOC: Initial authorization requests are submitted on the SUD UM Initial Authorization Spreadsheet. Concurrent requests are submitted on the SUD UM Submission form with an updated ASAM assessment. • For MH Residential: For adults only, Initial authorizations are submitted on the MH UM Initial Authorization Spreadsheet. Concurrent requests are submitted on the Optum TCo HLoC Request-LOCUS form. For Youth, initial requests are submitted on the Optum Medicaid HLOC referral for and concurrent submitted on the High Level of Care Concurrent Review form.
- Psychological/Neuropsychological testing require pre-authorization. Please submit the completed request form via secure email to utclin@optum.com. Please contact the Optum TCo Clinical Team at 1-800-640-5349 for further information.

Authorizations requests are accepted 24 hours a day, 7 days a week.

Call 1-800-640-5349 and follow prompts

Levels of care

Lower levels of care do not require a pre-authorization. Optum assigns agency specific, contracting provider service authorizations (blanket authorizations).

Higher levels of care require pre-authorization, which is obtained by calling the Optum TCo Clinical Team at 1-800-640-5349.

The following levels of care require prior authorization and continued stay reviews/authorizations regardless of funding streams:

Mental Health Treatment	
Level of care	**Review frequency**
Mental Health Inpatient Treatment	1-3 days (TBD)
Mental Health Residential Treatment	For youth: 60 days after initial authorization, then every 30 days after for ongoing authorization. For adults: 30 days after initial authorization, then every 60 days after for ongoing authorization.
Mental Health Partial Hospitalization/Day Treatment	60 days after initial authorization, then every 30 days after for ongoing authorization.
Mental Health Intensive Outpatient Treatment	Every 60 days

Substance Use Disorder Residential Treatment	
Level of Care	**Review Frequency**
ASAM 3.5 Partial Hospitalization/Day Treatment	30 days after initial authorization, then every 60 days after for ongoing authorization.
ASAM 3.1 Intensive Outpatient Treatment	Every 60 days
ASAM 2.5 Partial Hospitalization/Day Treatment	Every 60 days
ASAM 2.1 Intensive Outpatient Treatment	Every 60 days

Psychological and Neuropsychological testing	
Psychological and Neuropsychological Testing	Concurrent review only if additional codes or services

Psychological and Neuropsychological testing

If psychological and Neuropsychological testing is needed, a pre-authorization is required. However, there is no concurrent review for psychological and Neuropsychological testing. If additional testing is need after the approved pre-authorization, a new request needs to be made.

Concurrent utilization review

The provider of services agrees to comply with all the Optum Tooele County Utilization Review (UR) policies and procedures for both Mental Health and Substance Use Disorder services and will complete clinical and other documentation as required in the member record.

Business hours and after-hours admissions

Optum Tooele County is open from 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding holidays and is available at 1-800-640-5349. Initial inpatient authorization requests may be submitted by calling this number, 24 hours a day, 7 days a week. Concurrent reviews for continued inpatient authorization are conducted during business hours with an Optum TCo Clinical Care Advocate. All other authorization requests for higher levels of care may be submitted via secure email to utclin@optum.com. Requests to renew existing authorizations must be submitted two days in advance of expiration of the existing authorization.

Post-service reviews

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

Optum TCo requires **prior authorization** of behavioral health services and does not routinely conduct post-service reviews.

Exceptions may be made when there are extenuating circumstances such as when:

- A member is **unable** to provide insurance information in an emergency situation.
- The member's Optum TCo Medicaid eligibility is retrospectively activated after covered services have been delivered.
- The member is admitted under the wrong benefit.
- Medicaid is not the primary insurer and the member is admitted under Third Party Liability (TPL) and requires a secondary authorization.

In these situations, the provider must submit the request for post-service review to Optum as soon as they become aware of correct coverage, and no later than 365 days from the date of service.

Post-service authorization will ONLY be considered if at least one of the above circumstances exists.

Requests for post-service authorization of services are to be made in writing, and are to include the following:

- The dates of service, the name of the practitioner/facility, and/or treating physician/clinician (as applicable);
- Information about any extenuating circumstances that prevented obtaining authorization at the time of service;
- Contact information of the requestor (name, address, email address, telephone number);

- 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.

Once all information is received, Optum TCo makes a coverage determination and notifies the requesting facility/provider, and member in writing within 30 calendar days of receipt of the complete post-service review request. Optum Tooele County may extend this timeframe by 14 calendar days when needed.

Please send post-service review requests to:
Mail: Optum Tooele County Reviews
12921 S Vista Station Blvd, #200
Draper, UT 84020
Email: TooeleReviews@optum.com
Fax: 1-877-331-0272

IMPORTANT: Retrospective authorization requests and claims for dates of service ***after*** 6/30/23, need to be sent to Utah Medicaid Fee-for-Service. Optum only manages retrospective eligibility reviews, authorization, and payment for dates of service prior to 7/1/23.

Care coordination expectations

Optum TCo expects that network clinicians and facilities will consult and coordinate treatment with other behavioral health and/or medical care clinicians and facilities, treating members in a manner consistent with industry standards. Optum expects providers to obtain the member's consent to exchange appropriate treatment information with other treating professionals. Some members may decline the release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision.

The following are guidelines to meet these expectations:

- During the diagnostic assessment session, request the member's written consent to exchange information with all appropriate treating providers.
- Following the assessment, provide other treating professionals with the following information within two weeks:

    - Summary of the member's evaluation
    - Diagnosis
    - Treatment plan summary (including any medications prescribed)

- Primary clinician treating the member is expected to:
    - Update other behavioral health and medical care clinicians when the member's condition changes.
    - Update the other behavioral health and medical providers when changes are made to medications including starting a new medication, discontinuing a medication, or adjusting the dosages of medications.
    - Update other behavioral health and/or medical clinicians when serious medical conditions warrant closer coordination.
    - Apprise other providers of any sentinel event to include hospitalizations, emergencies, or incarceration.
    - Report transitions in levels of care.
    - At the completion of the treatment, a copy of the Discharge Summary document is to be sent to the other treating professionals.
    - Attempt to obtain all relevant clinical information that other behavioral health and/or medical care clinicians may have pertaining to the member's mental health or substance use conditions.
    - To ensure continuity of care, if a provider terminates their contract with Optum (either voluntarily or involuntarily), it is expected that the provider will communicate with any subsequent providers (with written member consent) to ensure the member's care is not disrupted.

Discharge planning

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. Members (and their families, when appropriate) are expected to be actively involved in this aspect of care. Optum TCo Care Advocates support providers in the discharge planning process. The Optum Care Coordination/Clinical team is available to assist with discharge planning as needed.

For inpatient and residential levels of care, prior to discharging a member, the referring provider shall coordinate post-discharge follow-up care with Optum TCo. The referring provider and Optum TCo shall assure that the member has a follow-up plan including a scheduled appointment with the appropriate receiving providers as deemed necessary.

In addition to the discharge planning process, a Discharge Summary document must be completed by the provider upon termination of treatment. This must be included in the member's clinical record.

Documentation: Records of persons served

In addition to the documentation requirements found in the Utah Medicaid Behavioral Health Services Provider Manual (utah-medicaid-official-publications), the member record must contain the following documentation, as applicable. This pertains to all Tooele County Medicaid members.

Treatment documentation:

- Services will be documented in the clinical record at the time of service, to include date, exact time of service, duration, type of service, and be signed by the rendering staff with verifiable signature and credentials.
- Evidence of supervision must be documented within the record, if therapeutic services are rendered by a clinician who is not independently licensed.
- Documentation will reflect that discharge planning is an ongoing process.
- Written documentation will be developed and maintained for each service or session for which billing is made and will be recorded and coded as outlined in the Utah Medicaid Behavioral Services Provider Manual.
- Services will be provided by a practitioner with the proper credentialing and/or training or is developing skills with appropriate supervision from a properly credentialed or trained practitioner.
- The note will be legible, signed, dated, and saved in the EHR.
- Per Utah Medicaid, documentation is to be completed at the time of service.

Progress notes:

Progress notes reflect clinically appropriate interventions and services, to include the member's response.

- Documentation will be specific to the member of record and will be related to areas addressed in the Treatment Plan.
- Notes will include changes in member behavior, strengths and limitations, attitude and beliefs, progress, or lack of progress and how the service provided related to the Treatment Plan.
- Notes will document who is in attendance during the session and group notes are to list the number of members and the name(s) of staff present for each group service in alignment with the client ratio outlined in the Utah Medicaid Behavioral Health ServicesProvider Manual.
- Associated encounter or progress notes are to include rationale for the treatment plan and medical necessity for continued services.
- Gaps in service such as sickness, vacation, incarceration, home visits, no shows and cancellations are expected to be documented in the EHR.
- Documentation of efforts to contact the member and reschedule timely is to be included.

Requirements for the individual member record

Intent: The member record serves as a clinical tool in the formulation of a comprehensive representation of the individual served. A complete and accurate record is necessary to ensure that clinical and legal standards are met. The services must be matched to the needs of the member. The services must be rendered in an organized, efficient and timely manner. There must be fiscal accountability and services must be appropriate. Access to relevant information regarding each person served is necessary.

Standards: The record is organized, complete, current, and legible and clearly documents all services provided to the member. Service activities rendered by the provider will be updated and filed at the time of service. All documents generated by the organization that require signatures will include the appropriate original or electronic signatures, to include the rendering provider's credentials. All billing information will be supported by information in the individual record. The member record will be reviewed as one measure of the quality of program services.

Individual member records are:

- ✔ organized
- ✔ complete
- ✔ current
- ✔ legible
- ✔ document all services provided to the member

The record will contain all demographic, treatment, billing, and outcome information. If there is information that cannot be included in the electronic record, a paper record will be maintained. The file must include correspondence related to the person served, authorizations for release of information, grievance procedures, TB test results (for residential treatment), documentation regarding medications, member, and staff signatures, where required, and any other information pertinent to the member. Valid ID, proof of Medicaid eligibility each month, fee agreements, and continuous review of member fees must be included in the file.

The individual record is maintained in a manner protective of confidentiality and compliant with 45 CFR/HIPAA (Health Insurance Portability and Accountability Act) Part 164 documentation/privacy standards, and other applicable federal privacy guidelines as may be applicable. For SUD members only, the individual record is to be maintained in a manner protective of confidentiality compliant with 42 CFR Part 2, and other applicable federal privacy guidelines as may be applicable.

Items to be included in the member record

Assessment

All members entering treatment will meet with a licensed mental health therapist (LMHT), defined as a therapist practicing within the scope of their licensure in accordance with Utah Code Ann. § 58-60-101 et seq. The member and LMHT shall meet individually and face-to-face to complete a comprehensive, individualized Psychiatric Diagnostic Examination (PDE) assessment to determine diagnosis and need for services. The diagnosis will be based upon the current Diagnostic Statistical Manual (DSM) of the American Psychiatric Association (APA) criteria. The

assessment will include adequate justification for the diagnosis and will clearly indicate the need for immediate treatment based on medical necessity.

Assessments are to be strength-based and member driven. Assessments are also considered ongoing with two overarching principles (please refer to the Preferred Practice Guidelines issued by OSUMH for further detail):

- The member remains at the center of all clinical efforts, whether they are Engagement, Assessment, Planning or Treatment. Relevance to the member and their needs are expected to guide each provider in deciding how to engage the member, what information to gather and document, what strategies to plan and how treatment is delivered. While accurate and complete documentation of services and the gathering of information for organizational purposes and other systemic demands are important, they remain secondary to the needs of the member.

- An important aspect of effective treatment is the ability for providers to engage members so that the member has hope for their recovery and desires to participate in treatment. One barrier to effective engagement is the belief that all elements of assessment and planning must be gathered at the very beginning of services. Therefore, Medicaid guidelines emphasize that assessment and planning are a process rather than an event and are expected to be balanced with the process of engagement. A more concerted focus on engagement will result in improvements in member retention and improved treatment outcomes. Member diagnosis will be reflected through assessment information and be updated as new information suggests.

With these principles in mind, the assessment shall meet the below guidelines, where appropriate.

- Working diagnoses may change and shall be continuously evaluated and updated consistent with new information.

- A diagnosis is made based upon the International Classification of Diseases 10 (ICD-10) and/or Diagnostic Statistical Manual of the American Psychiatric Association (DSM-5) criteria. There shall be adequate justification for the diagnosis and the assessment shall clearly indicate the need for services.
- Assessments shall consider how culture (values, traditions, family and religious practices, spiritual beliefs and beliefs about mental illness and addiction, etc.) impact recovery.
- Providers are expected to be aware that individual differences in culture can be misinterpreted as problems.
- Immediate safety needs of the member are assessed and addressed. This includes but is not limited to suicide risk assessment. Assessments should include the use of the Columbia Suicide Severity Rating Scale (C-SSRS) or other suicide risk assessment with subsequent, same day, safety planning as needed.
- Person Centered and strengths-based questions will lead both member and therapist in a solution-oriented direction. This establishes a bridge between assessment and development of a person-centered treatment/recovery plan.
- Assessments are expected to be provided in a manner which does not attribute blame.

- Family/caregivers are a primary source of information about the child/youth, although the child/youth must be present. The child/youth is expected to participate in all aspects of the assessment and subsequent treatment recovery planning and implementation.
- In addition to family/caregivers, other sources such as schoolteachers and physicians can provide essential/accurate information. Releases of Information are expected to be requested when other sources are identified, and efforts are expected to be made to contact these sources.
- Per OSUMH mandate the OQ® Measures Questionnaires must be offered to members five years and older upon admission and included in treatment planning. Members receiving inpatient services only or treatment for substance use disorders only are not subject to this requirement.
- The setting in which an evaluation takes place can be critical to the success of the interview. The setting is expected to accommodate the individual's cognitive, language and emotional status.
- With children and youth, evaluation may incorporate specific techniques that may include interactive play, projective approaches, direct discussion, structured observations or other means of seeking information.
- With all members, care should be taken to avoid questions that lead an individual to answer in a particular way.
- If the member has dependent children, an appropriate referral for evaluation or services for the youth shall be made when appropriate.
- Inquiring about substance use is an essential part of the initial assessment. Because substance abuse often coexists with other conditions, therapists shall continually assess for substance abuse and encourage appropriate treatment/recovery supports as needed. If there is evidence that the individual is dependent upon and/or under the influence of a chemical substance, an evaluation for the need for medical detoxification shall be made.
- All substance abuse assessments are to be completed using ASAM dimensions. All six dimensions must be reassessed as directed by the Utah OSUMH.

Children and youth assessments: Children and Youth Assessments will include information received from family or caregivers as well as results from standardized behavioral assessments for school aged children and youth whenever available. In addition to the relevant items listed above, the assessment shall also include, but is not limited to:

- Developmental milestones to include receptive and expressive language development
- Psychiatric and medical history, including vision and hearing problems
- School functioning and performance including any formal testing conducted by the school or other providers
- Emotional development and temperament
- Peer relations

- Family relationships, responsibilities, and perceptions of the child/youth and their difficulty and the subsequent impact on the family
- Cultural influences, religious beliefs, spiritual beliefs
- Unique family or environmental circumstances impacting the youth
- Parental/family medical and behavioral health history and impact on child/youth
- SED
- History of trauma, abuse and/or neglect

Additional areas to be considered as part of the assessment

- Reason for referral and present concerns: nature, duration, frequency, precipitants, circumstances, and consequences of the problem(s), mental status examination, including thought (content and process), perception, mood, level of suicidal risk, affect, memory, judgment, appearance, and orientation.
- Psychiatric and medical history of member and their family
- Strengths, interests, and hobbies
- Family or environmental circumstances
- Legal involvement and involvement with outside agencies (i.e., court, probation, etc.)

Treatment Plan

The provider of services agrees that at the time of admission, and prior to delivery of any services other than the assessment, a LMHT will establish a formal, individualized, person-centered Treatment Plan for every individual. The plan shall be consistent with standards for individual treatment/ recovery plans, congruent with the level of care, 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. Optum recommends treatment plans be strengths-based to highlight the member's improvement versus symptom reduction. The treatment plan will be written in the following format:

- **Problem statement**: The Problem Statement identifies the need or concern perceived by the member that led them to seek treatment services. The Problem Statement uses the member's words and is expected to be based on the barriers identified in the MH evaluation.
- **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 and are expected to be aspirations for the immediate future. 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 individual'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:

- **Methods**: Methods are the strategies, interventions, and tasks that the member, family, peers, community support and/or staff will provide in order 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 that the member was included in the planning process and that the plan addressed their individual needs. OSUMH also requires providers to apply information gleaned from the OQ®/Y-OQ® in treatment planning. 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 Plan Reviews

Treatment Plan Reviews shall be documented in the clinical record. The review will include the date and duration of service, an update of progress towards established treatment goals, the appropriateness of services being offered, explain the need for continued participation, ongoing discharge planning, and include the signature and credentials of the individual rendering service. For mental health treatment plan reviews, information from the OQ®/Y-OQ® Clinician Reports must be incorporated. Completion of goals and objectives achieved and those which are no longer relevant must be closed.

Treatment Plan Reviews will be conducted by a LMHT meeting in an individual, face-to- face interview with the member to review the Medical Necessity, appropriateness of treatment interventions, and measure progress on the treatment plan. Based on the needs of the member and with the member's participation, changes to the Goal, Objectives, and Methods will be made on the treatment plan in the EHR with an attached note justifying the changes. At a minimum, Continuing Stay/Treatment Plan Reviews will be conducted every six months for all members with who meet criteria for serious mental illness (SMI), and every three months for those who do not meet criteria, with completion during the calendar month in which it is due. Reviews will be conducted more frequently if the nature of needed services changes or if there is a change in the individual's condition or status.

For members receiving treatment for a substance use disorder. Continuing Stay/Treatment Plan Reviews will be conducted every two weeks for ASAM levels 3.5 and 3.3, at a minimum of every thirty days for ASAM levels 3.1 and 2.5, and every 60 days for ASAM levels 2.1 and 1.0.

Discharge Summary

At the time of discharge, a Discharge Summary document will be prepared in EHR that includes the member level of engagement to include examples, current diagnoses, the extent to which the treatment plan Goal, Objectives and Methods were achieved, services provided, reason for discharge or referral and recommendation for additional services. Referrals for and connections to needed supportive services must be made and noted. A LMHT will be involved in the discharge process

and is responsible for any clinical action. Prior to discharge the provider of services agrees to demonstrate outreach attempts when a member fails to attend prescribed services.

Concurrent Utilization Review

The provider of services agrees to comply with all the Optum Tooele County Utilization Review (UR) policies and procedures and will document participation as required in the member record.

Reporting requirement

The provider of services agrees to comply with all Mental Health Event Data Set (MHE) and all TEDS reporting requirements in SAMHIS. Evidence of TEDS and SAMHIS information are to be present in the member record.

Mental Health Event Records for members receiving MH services

Mental Health Event Records capture numerous unique data elements related to member care. 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 PCNX. All Mental Health services must have a Mental Health Event Recorded completed in PCNX upon admission and every 90 days thereafter. Further instructions can be found at tooele.optum.com/content/ops-tooele/tooele/en/provider-county-staff.html under Provider Training Documents.

Treatment Episode Data Set (TEDS) for members receiving treatment for SUD

TEDS data is collected on all members being treated for Substance Use Disorders through ProviderConnect NX™. All information must be completed monthly.

Privacy practices

All aspects of Optum TCo operations are compliant with required HIPAA privacy practices as well as other applicable Utah and federal laws pertaining to the privacy, confidentiality, release, and maintenance of member information, including information related to substance or alcohol abuse. Similarly, Optum TCo requires its providers to comply with all applicable Utah and federal regulations concerning privacy and the release of confidential member information. Providers are required to train all staff members on HIPAA privacy regulations and must maintain records dealing with HIPAA privacy issues for at least ten years.

HIPAA is a federal law enacted to ensure privacy and security of a member's Protected Health Information (PHI). PHI is defined as individually identifiable health information that is transmitted or maintained in any form or medium. A few examples of PHI include an individual's name, social security number or member identification number, address, and date of birth. We recommend you review both, 45 CFR and 42CFR Part 2 (Confidentiality of substance use disorder patient

records), to ensure your Release of Information (ROI) form and information sharing practices currently reflects all requirements related to behavioral health and the Medicaid members you serve. Additionally, you may consider consulting with legal counsel for questions related to your policies and procedures to protect member PHI.

HIPAA Privacy Rule: The use and disclosure of PHI

Optum TCo has established policies relating to requests for and disclosure of PHI in accordance with HIPAA and other applicable federal and state laws. These policies ensure that only the minimum amount of information necessary is disclosed to accomplish the purpose of the disclosure or request.

The HIPAA Privacy Rule requires providers to implement and enforce policies and procedures to comply with the rules. There are six main patient rights under HIPAA; as listed below:

- The right to receive a Notification of Privacy Practices (NPP);
  - The NPP is expected to be given to Medicaid members to sign when they first visit a new healthcare provider.
- The right to obtain a copy of their PHI;
  - Once a request is received by the provider in writing, a copy of the medical records must be produced within 30 days.
- The right to request correction to errors in their PHI;
  - Any request to change a health record must be submitted in writing.
- The right to ask and obtain from a provider, to whom PHI was disclosed;
  - If requested, a provider is required to give information about who has received an individual's health data over the past six years.
- The right to request restrictions on how their PHI is used or disclosed;
  - Individuals have the right to restrict sharing of their health data for certain purposes other than treatment, payment, or healthcare operations. Individuals may dictate to whom their health information can be shared, such as family members, friends, caregivers, legal representatives, or other entities.

- The right to file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR), if they believe their rights related to PHI have been violated, or if they feel that their patient rights under HIPAA have been denied.
  - If the OCR determines that HIPAA Rules have been violated, fines can be issued for noncompliance.

Providers may request records containing PHI for their members from other healthcare providers and facilities, as well as from Optum TCo, without the member's approval if the purpose of the request is for **treatment, payment, or healthcare operations (TPO)** so long as the information requested and provided is the minimum necessary for the purpose of the request.

"TPO" as defined by HIPAA include:

(1) Treatment – Coordination or management of health care and related services;
(2) Payment purposes – The activities of a health plan to obtain premiums or fulfill responsibility for coverage and provision of benefits under the health plan; and
(3) Health Care Operations – The activities of a health plan such as quality review, business management, customer service, and claims processing.

The Privacy Rule requires a covered entity, such as a provider, to treat a "personal representative" the same as the patient, with respect to uses and disclosures of PHI. A personal representative is a person legally authorized to make health care decisions on behalf of a member or to act for a deceased patient or the estate. Once the personal representative has been authenticated, a provider can treat the personal representative as you would the member. You may give the personal representative whatever information you could give to the patient.

Providers may obtain detailed information about the HIPAA Privacy Rule by referring to the Office of Civil Rights website at hhs.gov/hipaa/index.html.

Disclosures related to Substance or Alcohol Abuse

The **Federal Substance Abuse Regulations** apply to any information (whether in writing or not) which could either directly or indirectly identify a member who has an identified substance use disorder. Although HIPAA covers substance abuse information, the federal substance abuse regulations are even more restrictive than HIPAA, and they do not allow disclosure without the member's written consent except in very limited circumstances (i.e., the federal substance regulations do not contain a "treatment" exception as HIPAA does). The related regulation is 42 CFR Part 2.

HIPAA Security Rule

Like the HIPAA Privacy Rule, the HIPAA Security Rule requires covered entities such as Optum TCo and its providers to safeguard member Protected Health Information (PHI). This rule requires providers to:

- Ensure the confidentiality, integrity and security of all electronic PHI.
- Protect against any reasonably anticipated threats or hazards to the security and integrity of PHI.
- Protect against any reasonably anticipated uses or disclosures of PHI that are not permitted or required; and
- Provide training to all staff on the requirements of the Security Rule.

Some suggested precautions and tips to protect PHI

- Maintain the privacy of phone contacts.
- Keep confidential records secure.
- Dispose of all PHI in designated bins for shredding.
- Pick up any printed confidential information from printers or fax machines immediately even from secure areas.

- Record only necessary information in the patient's record.
- Do not discuss any patient information in the elevators or outside the building.
- De-identify PHI to the full extent possible when making an authorized disclosure.
- Encrypt laptops (and any portable devices) containing PHI.
- Verify the identity of any caller requesting PHI.
- If an employee leaves their workstation for any period of time, secure or log-off of the computer.
- If you are sending a document containing multiple member names, such as a Remittance Advice (RA), redact any names or PHI on members not the subject of the communication.

Faxes:

- Use a fax cover sheet with a privacy statement at the bottom.
- Double check the fax number before transmitting.
- Remove all faxes from the paper tray after faxing.
- Use a dedicated fax machine or fax line to send or receive PHI.

Email:

- Secure emails containing PHI.
- Do not use "Reply All".
- Ensure email is secure if communicating with members or other health care professionals.
- Do not use member PHI in the heading line of an email.

Guidelines for storing member records

Below are additional guidelines for completing and maintaining treatment records for members:

- Practice sites must have an organized system of filing information in treatment records.
- Treatment records must be stored in a secure area, and the practice site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable laws and regulations. All paper records must be maintained in a locked room or case.
- The practice site must have a process in place to ensure that records are available to qualified professionals if the treating clinician is absent.
- Treatment records are required to be maintained for ten years from the date of service, or in accordance with state or federal laws or regulations, whichever is longer. Termination of the Participation Agreement has no bearing on this requirement.
- Financial records concerning covered services rendered are required to be maintained from the date of service for ten years, or the period required by applicable state or federal law, whichever is longer. Termination of the Participation Agreement has no bearing on this requirement.
- All financial and program records pertaining to services for minors (members under the age of 18) shall be retained for 10 years or until the child reaches the age of twenty-two (22), which ever period is longer.

Communication with Primary Care Physicians and other health care professionals

Definitions:

Accountable care organization (ACO): A health plan that utilizes a network of providers to improve savings and manage care. In Utah, ACOs manage the medical portion of a member's Medicaid benefits.

Primary Care Physician (PCP): Primary care providers who are trained in the full spectrum of personal health and wellness. PCPs coordinate care with specialists when needed and direct patients to the right place for additional care.

Coordination of care

To coordinate and manage care between behavioral health and medical professionals, Optum TCo expects that you will seek to obtain the member's consent to exchange appropriate treatment information with medical care professionals (e.g., primary physicians, medical specialists) and/or other behavioral health clinicians (e.g., psychiatrists, therapists).

Coordination and communication are expected to take place at:
The time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate.

Coordination of services improves the quality of care to members in several ways:

- It confirms for a primary physician that their patient followed through on a behavioral health referral.
- It minimizes potential adverse medication interactions for members who are being treated with psychotropic and non-psychotropic medication.
- It allows for better management of treatment and follow-up for members with coexisting behavioral and medical disorders.
- It can reduce the risk of relapse with members in some populations, as with substance use disorders.
- It allows behavioral health and medical providers to create a comprehensive care plan.
- It promotes a safe and effective transition from one level of care to another.

The following guidelines are intended to facilitate effective communication among all treatment professionals involved in a member's care:

- During the diagnostic assessment session, request the member's written consent to exchange information with all appropriate treatment professionals who are providing treatment.
- After the initial assessment, provide other treating professionals with the following information within two weeks:
  - Summary of member's evaluation

Request the member's written consent to exchange information.

    - Diagnosis
    - Treatment plan summary (including medications prescribed)
    - Primary clinician treating the member
- Update other behavioral health and/or medical clinicians when there is a change in the member's condition or medication(s).
- Update other health care professionals when serious medical conditions warrant closer coordination.
- Apprise primary care physicians of any sentinel event to include hospitalizations, emergencies, or incarceration.
- Report transitions in levels of care.
- At the completion of treatment, send a copy of the discharge summary to the other treating professionals.
- Attempt to obtain all relevant clinical information that other treating professionals may have pertaining to the member's mental health or substance use conditions.

If a member refuses consent, review the potential risks and benefits of this decision and note in the clinical record.

Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum TCo, as well as accrediting organizations, expects you to make a “good faith” effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the member.

In cases where a member does not have a PCP, please link the member to their designated ACO who manages their medical benefit. The ACOs can identify PCPs for the member. Take Care Utah is also available to assist members with insurance questions and to identify a PCP. They may be reached at 1-801-433-2299.

Quality assessment and performance improvement (QAPI)

Reporting a sentinel event

Definitions:

- **Adverse reaction to treatment:** Serious adverse reaction to treatment requiring an urgent or emergency intervention.
- **Attempted suicide:** A deliberate, self-injurious behavior that has the potential to cause serious harm or death to the person but does not result in death. Suicide "gestures" (such as cutting, ingestion of small amounts of medication, etc.) should not be included in this category.
- **Damage to property:** Damage to property including that which occurs secondary to the setting of a fire, due to intentional actions of a member while in a behavioral health treatment setting.
- **Elopement:** The unauthorized leave or absence of member without permission, including not returning from pass, for longer than 24 hours past the designated return time.
- **Emergency medical condition:** A medical condition manifesting itself by acute symptoms of

sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in

1. placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

- **Environmental hazard:** Unsafe conditions which create an immediate threat to life or safety, including, but not limited, to fire or contagious diseases requiring quarantine.
- **Financial exploitation:** The act or process, performed intentionally, knowingly, or recklessly, of using a member's property for another person's profit, advantage, or benefit without legal entitlement to do so.
- **Homicide:** The act of terminating another person's life.
- **Self-injurious behaviors:** Self-inflicted harm requiring an urgent or emergency intervention. Examples include cutting, burning (or "branding" with hot objects), picking at skin or re-opening wounds, hair-pulling (trichotillomania), hitting (with hammer or other object), bone-breaking and head-banging.
- **Sexual behaviors:** Sexual contact of any type with other members, staff or third party whether consensual or not, while in a treatment program (i.e., sexual abuse, sexual assault, rape, attempted rape, touching, or indecent exposure).
- **Suicide:** The deliberate act of causing one's own death.
- **Violent/assaultive behavior (Non-lethal):** In a behavioral health setting with physical harm to self or others. Examples include physical assault with weapon, physical assault with no weapon, fight and attempted homicide.

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.

For the purpose of this manual, facility-based treatment is defined as inpatient, residential, day treatment, intensive outpatient, Assertive Community Treatment, supportive living and ASAM 3.5 to 2.1 levels of care.

Potential sentinel events are defined as any of the following events:

- A completed suicide engaged by a member who, at the time of his/her death, was engaged in behavioral health (BH) treatment at any level of care or was engaged in treatment within the previous 60 calendar days.
- A serious suicide attempt by a member, requiring an overnight admission to a hospital medical unit, that occurred *while* the member was receiving facility-based treatment (i.e., behavioral

health inpatient, residential, partial hospital, intensive outpatient) OR within 30 days of discharge from BH facility-based treatment.

- An unexpected death of a member that occurred while the member was receiving facility-based treatment.
- A report of a serious physical assault **by** a member, requiring medical intervention at a medical facility/medical unit/ER, that occurred while the member was receiving BH facility-based treatment.
- A report of a sexual assault **of** a member that occurred on facility premises while the member was receiving BH facility-based treatment.
- A report of a serious physical assault **by** a member, requiring medical intervention at a medical facility/medical unit/ER, that occurred while the member was receiving BH facility-based treatment.
- A report of a sexual assault **by** a member that occurred while the member was receiving BH facility-based treatment.
- A homicide that is attributed to a member who, at the time of the homicide, was engaged in BH treatment at any level of care or was engaged in BH treatment within the previous 60 calendar days.
- A report of an abduction of a member that occurred on facility premises while the member was receiving BH facility-based treatment.
- An instance of care (at any level) ordered or provided to a member by someone impersonating a physician, nurse or other health care professional.

Procedure:

- Upon discovery of an incident which meets one of the definitions listed above, an assigned representative from the agency/provider is required to contact the Optum TCo Quality Team at 1-800-640-5349 as soon as reasonably possible. The phone call is then followed up with completion of the Sentinel Event Report form within 24-hours of phone contact. The form is faxed to 1-866-588-9583 or emailed to slcoquality@optum.com.
- At times, information necessary to understand the circumstances of the sentinel event may not be available within the first 24 hours. In such cases, the behavioral mental health care provider is to fax the additional information to Optum TCo within five (5) business days.

Call upon discovery

Send form within 24 hours of phone contact

- Optum TCo may request additional clinical records of the member identified in the Sentinel Event Report.
- The Report will be reviewed internally, and a decision will be made regarding the next level of analysis. If it is determined that a quality-of-care issue may have contributed to the event, the case is designated for review by United Behavioral Health Sentinel Event Committee (UBH SEC).
- The UBH SEC will make referrals for follow-up actions if deemed necessary. Actions may include written feedback related to observations, a recommendation for a site audit and/or

record review, a corrective action plan, provider or agency unavailable status and other steps to ensure member safety.

- In all sentinel events involving any facility-based care, Optum works collaboratively with the facility to improve member safety.

QAPI Plan

The QAPI Plan is a central tenet in the way we evaluate treatment and outcomes. We are continually monitoring multiple areas of our performance, our impact on stakeholders, and constantly looking for ways to improve. Providers are required to review the Optum QAPI plan annually, which is posted on our website, and to participate in quality initiatives to measure access, quality, and value.

Audits

As per contract language, all providers will be expected to participate in audits. There are a variety of entities that conduct audits throughout the year and may or may not include Office of Substance Use and Mental Health, Optum, UDOH Medicaid and Office of Inspector General. These audits may include a site visit, treatment records review and/or claims validation. The number and types of audits a provider experiences in a given year varies greatly and cannot be predicted in advance. Therefore, it is highly encouraged that all providers continually be audit ready. This means having all documentation, policies and procedures, as well as required postings up to date. If you have any questions about audit readiness, please contact the Optum TCo QAPI Team at 1-800-640-5349.

Member appeals and complaints/grievances

Definitions

Adverse Benefit Determination (ABD):

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service.
2. The failure to reach a decision on a Service Authorization Request within the required
3. timeframes.
4. The reduction, suspension, or termination of a previously authorized service.
5. The denial, in whole or in part, of payment for a service, but not if the denial, in whole or in part, of a payment for a service is solely because the Claim does not meet the definition of a Clean Claim.
6. The failure to provide services in a timely manner, as defined as failure to meet performance standards for appointment waiting times specified by the State.

7. The failure of Optum and/or the COUNTY to act within the time frames established for resolution and notification of Grievances and Appeals.
8. For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right to obtain services outside the network; or
9. The denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

Appeal: A request made by a member, their authorized representative, or a provider for Optum TCo to review an Adverse Benefit Determination (ABD).

Authorized representative: An individual appointed by a member or other party, or authorized under state or other applicable law, to act on behalf of a member or other party involved in an appeal or complaint/grievance.

Grievance/complaint: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or an employee, failure to respect the Enrollee's rights regardless of whether remedial action is requested.

Grievance system: The processes Optum implements to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the process to collect and track information about them.

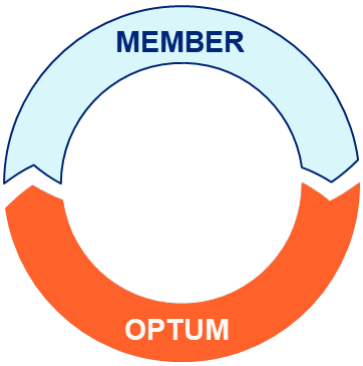
Medically necessary: Defined by Utah Administrative Code R414-1-2 as: (a) it is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap; and (b) there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

Notice of Adverse Benefit Determination (NABD): Written notification to a member and provider of an Adverse Benefit Determination.

Notice of appeal resolution: Written notification to a member and a provider when applicable of Optum TCo's resolution of an appeal.

Member appeals

The Optum TCo has developed its Appeals processes to comply with all relevant requirements for the Tooele County programs and to ensure satisfaction, safety, and respect for member rights including access to appropriate care. In addition, these processes ensure the collection of data, and subsequent action, when any of those goals are not met.



Optum TCo oversees the Member Appeal process and provides information regarding the basis for their appeal decisions. The appeal

processes are conducted in a manner that does not give deference to the prior Adverse Benefit Determination.

Optum TCo does not take punitive action against a member or a provider who requests an appeal or a fair hearing.

Member appeals process

An appeal is a request for review by the Optum TCo of an Adverse Benefit Determination. An appeal may be made by a member, a member's authorized representative, or a provider.

Requesting a member appeal

Appeals must be requested within 60 calendar days from the date of the initial Notice of Adverse Benefit Determination. The member's copy of the Notice of Adverse Benefit Determination will include an appeal form and an explanation of the appeals process. An explanation of the appeals process is also included on the Optum Remittance Advice.

An appeal may be submitted to Optum TCo either orally or in writing. Optum TCo will assist members or providers as needed to file appeals. The Optum TCo will acknowledge receipt of the appeal either orally or in writing and explain the process that will be followed to resolve the appeal.

Only members may file for continuation of services during an appeal.

If the Adverse Benefit Determination being appealed is to terminate, suspend or reduce a *previously authorized* course of treatment, ***and*** the covered services were ordered by an authorized Provider ***and*** the period covered by the original authorization has not expired, ***and*** the member wants benefits to continue during the appeal, then the request for continuation of benefits must be filed on or before the later of the following:

- Within ten (10) days of the Notice of Adverse Benefit Determination; or
- The intended effective date of the proposed Adverse Benefit Determination.

Appeal timeframes for resolution

There are two categories of appeals. Timeframes for resolving each type are outlined below.

Expedited appeal: Optum TCo will resolve an expedited appeal and provide notice to the affected parties no later than three (3) working days or 72 hours after Optum receives the expedited appeal request.

Non-expedited appeal: Optum TCo will resolve a non-expedited appeal and provide notice to the affected parties no later than thirty (30) calendar days from the day Optum receives the appeal.

Optum TCo may extend the time frame for making a decision on any appeal by up to fourteen (14) additional calendar days if the member or provider requests an extension or there is a need for

additional information and the extension is in the member's interest. Optum TCo will notify the affected parties in writing of any extension initiated by them.

If Optum TCo does not resolve an appeal within the required time frame, this constitutes an Adverse Benefit Determination. Optum TCo will give the member a Notice of Adverse Benefit Determination letter at the time Optum TCo determines the required time frame was not met. The member and/or provider do not need to go through Optum TCo appeal process again; instead, they may now request a State Fair Hearing.

Optum TCo will provide the member, member's representative, or provider a reasonable opportunity to present evidence related to the appeal.

An expedited appeal may not be requested for a service that has already been rendered. If the member or member's provider requests expedited handling of an appeal and Optum TCo denies the request, Optum TCo will:

- Transfer the appeal to the non-expedited or standard time frame of no longer than 30 calendar days from the day Optum TCo receives the appeal, with a possible 14-calendar day extension for resolving the appeal and providing Notice of Appeal Resolution to the affected parties;
- Make reasonable effort to give the affected parties prompt oral notice of the denial; and
- Mail written notice within two (2) calendar days explaining the denial, specifying the standard time frame that will be followed, and informing the affected parties that the member may file a grievance regarding this denial of expedited resolution of the appeal.

State Fair Hearings

You have the right to request a fair hearing with the Utah Department of Health and Human Services regarding an Adverse Benefit Determination made by Optum TCo. A fair hearing maybe pursued by the member, an authorized representative, or a provider.

Affected Parties are notified of their rights and timelines related to a fair hearing by Optum TCo in accordance with requirements. A fair hearing may be requested when the Member Appeal process has been exhausted and the decision was not wholly in favor of the member or provider, or when the Optum TCo was unable to make a decision on the appeal within the required time frame.

A fair hearing must be requested within one hundred twenty (120) calendar days from the date of the Optum TCo Notice of Appeal Resolution.

In the event that the member wants to continue benefits pending the outcome of a fair hearing, when a *previously authorized* course of treatment has been terminated, suspended or reduced, ***and*** the services were ordered by an authorized provider, ***and*** the original period covered by the

original authorization has not expired, the request for continuation of benefits must be filed on or before the later of the following:

- Within ten (10) calendar days after Optum TCo mails the Notice of Appeal Resolution; or
- The intended effective date of the proposed Adverse Benefit Determination.

Only members may file for continuation of services during a state fair hearing.

The Utah Department of Health and Human Services will reach its decision within ninety (90) calendar days from the date the member/provider filed the appeal with Optum TCo, not including the days the member/provider takes to file the request for fair hearing. In the case of a fair hearing request that meets criteria for the expedited appeal process but was not resolved within the Optum TCo expedited appeals time frame or was not resolved wholly in favor of the member/provider, the Utah Department of Health and Human Services will reach its decision within three (3) business days from the date it receives from Optum TCo all needed information, including information from the member's medical record.

The Utah Department of Health and Human Services will notify the affected parties in writing of the fair hearing decision and any appeal rights as provided by State and Federal laws and rules. Optum TCo will assist members/providers with required forms as needed to file the request for a fair hearing.

Complaints/grievances

Any member or authorized representative acting on behalf of the member can file a complaint. A representative, including a provider acting as a representative of the member, must receive written permission from the member to act as representative. Complaints are typically reported directly to Optum TCo but may also be filed with the Utah Department of Health and Human Services, the Utah Medical Assistance Program. Optum TCo verbally acknowledges receipt of an oral complaint at the time the complaint is received and by letter when the complaint is received in writing.

Optum TCo will process each complaint and provide notice to the complainant within 90 calendar days from the day Optum TCo receives the complaint. Optum TCo may extend the time frame for deciding on a complaint by up to 14 additional calendar days if the member requests an extension or there is a need for additional information and the extension is in the member's interest. Optum TCo will notify the complainant in writing of any extension initiated by Optum TCo.

Optum TCo will notify the affected parties of the disposition of the complaint either orally or in writing.

For complaints that include a potential Quality of Care issue, the review may be referred to a peer protected committee such that final outcomes cannot be shared with the grievant. In this case, Optum TCo will advise the person filing the complaint that the matter is being investigated and

addressed but will not be able to report ultimate outcome of that review. In these situations, the Complaint/Grievance Acknowledgment letter also serves as the resolution notification.

Contact information

Appeals may be filed by:

Phone:	1-800-640-5349
Fax:	1-877-331-0272
Email:	TooeleReviews@optum.com
Mail:	Optum TCo – Compliance Manager 12921 South Vista Station Boulevard #200 Draper, Utah 84020

Complaints/Grievances may be filed by:

Phone:	1-800-640-5349
Fax:	1-877-331-0272
Email:	TooeleReviews@optum.com
Mail:	Optum TCo – Compliance Manager 12921 South Vista Station Boulevard #200 Draper, Utah 84020

Notice of Adverse Benefit Determination (NABD):

Optum TCo requires all providers follow the rules of notifying a member when an Adverse Benefit Determination has occurred.

In regard to Providers, **Adverse Benefit Determination** means any of the following:

- The reduction, suspension, or termination of a previously authorized service;
- The failure to provide services in a timely manner, as defined as failure to meet performance standards for provision of first face-to-face services when due to a provider's limitations and the member is dissatisfied with this situation.

A Notice of Adverse Benefit Determination is the written notification sent to a member by the provider when the provider terminates, suspends, or reduces previously authorized Covered Services, and the member informs the provider that they disagree with the change, and the provider affirms the decision; or the provider fails to offer services in a timely manner as defined by Timely Access standards and the member is dissatisfied with this.

Timelines

The provider will notify the member and mail a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires and within the following time frames:
If the ABD is due to the reduction, suspension, or termination of a previously authorized service, the provider will send the NABD:

- At least 10 days before the date the ABD will become effective; or

- 5 days before the date the ABD will become effective IF the provider has facts indicating that the ABD should be taken because of probable fraud by the member, and the facts have been verified (if possible, through secondary sources).

If the ABD is due to the provider's inability to offer an appointment within the performance standard, the provider will send the NABD:
- At the time it is determined that the provider cannot meet the performance standard.

Requirements for the Provider NABD
The Provider NABD:
- Will be in writing;
- Will meet language and format requirements to ensure ease of understanding;
- Will state that oral interpretation is available and how to access oral interpretation services;
- Will state the Determination the Provider intends to make;
- Will state the reason for Determination;
- Will state the date the Determination will become effective;
- Will include the right to file an Appeal with the Optum;
- Will include the procedures for filing an Appeal

Attachments to the NABD
The following documents must be sent with the NABD letter:
- Appeal Request Form
- Instructions for Filing an Appeal

All provider NABD letter templates and forms are located on our website at tooele.optum.com.com

Please also send an electronic version of the NABD to Optum TCo at the following email address: slcoreviews@optum.com.

If you have any questions about this procedure, please contact Optum TCo at 1-800-640-5349 and ask for the Compliance Manager.

Claims processing and payment

You are responsible to determine the eligibility of a qualified beneficiary at the time service is rendered. Eligibility is not a guarantee of payment but is a key component of initiating services and payment processing. An authorization number is required on all claims. For lower levels of care, your agency will be issued a provider (agency) specific authorization number; for higher levels of care, you will go through Optum's clinical team to obtain member-specific authorizations.

Payment is based on contracted rates for eligible services for which prior authorization has been obtained.

Coordination of Benefits (COB)

Some Members are eligible for coverage of allowable expenses under one or more additional health benefit plans. In these circumstances, payment for allowable expenses shall be coordinated with other plan(s). It is your responsibility to inquire and collect information concerning all applicable health plans available to a member and communicate such information to Optum TCo.

If Optum TCo is a secondary plan, you will be paid up to the Optum TCo contracted rate. You **may not** bill members for the difference between your billed usual and customary charge and the amount paid by the primary plan(s) and Optum TCo.

When Optum TCo is the secondary payor, claims must include all pertinent information from the primary insurance explanation of benefits (EOB) and be submitted within one (1) year from the date of service. For a claim to be paid, you must still ensure an authorization exists within the Optum TCo system when Optum is secondary.

Third Party Liability

Because Optum Medicaid is the payor of last resort, providers are required to bill the primary insurance carrier first for any member who has coverage on the date of service. Optum may then be billed as secondary for any remaining unpaid balance within 365 days from date of service. The source of truth for Optum in determining other coverage is the State of Utah's Medicaid eligibility file. Members should be encouraged to keep their primary insurance information up to date with Utah Medicaid.

Members should keep their primary insurance information up to date with Utah Medicaid

If a member has Medicare and Medicaid Coverage, please utilize the following guidelines:

- If the agency is <u>not</u> paneled with Medicare, Optum will be billed as primary insurance carrier.
- If the agency is paneled with Medicare and the service provided is a CPT code, the agency shall bill Medicare/Medicaid Crossover Over Office. Both the Medicare and Medicaid portion (if any) will be adjudicated by the Crossover office. Optum does not expect to receive these claims, and if received, Optum will deny.
- If the agency is paneled with Medicare and the service being provided is a HCPC, the agency will bill Optum Medicaid as primary.

Crime Reparations Funds

Per Utah Administrative Code 270-1-12, when considering out-of-pocket expenses for individuals who qualify Crime Victims Reparation Funds and who are eligible for Medicaid, Optum Medicaid are expected to be billed prior to the Crimes Reparations fund.

Co-pays

As of 1/1/2018, inpatient facilities experienced a $75 reduction in the total cost of the inpatient stay. Utah Medicaid allows inpatient providers to pursue a $75 co-payment from the member. This co-pay is at the discretion of each facility.

Billing "No shows"

The Utah Medicaid Behavioral Health Services Provider Manual outlines permissible billing of broken appointments.

A broken appointment is not a service covered by Medicaid. Since the charge is not covered, any provider may bill a Medicaid patient when all of the below conditions are met:

- The provider has an established policy for acceptable cancellations. For example, the patient may cancel 24 hours before the appointment.
- The patient has signed a statement agreeing to pay for broken appointments.
- The provider charges all patients in the practice for broken appointments. The charge cannot be billed only to Medicaid patients.

Claim submissions

Use of claim creation and submission through ProviderConnect NX™ or an EDI clearinghouse is required for primary claims for providers in the Optum TCo network. All claims, including paper claims, must include the NPI. For additional information please see pg. 3.

All claims, regardless of format and submission method, must be submitted within 90 days of date of service. This does NOT apply to Post-Service Reviews or situations where Medicaid is the secondary payor. All other situations will be reviewed on a case-by-case basis.

In cases of Retrospective Medicaid Eligibility, all outpatient level of care claims must be submitted within 90 days of the member receiving Retro Medicaid Eligibility. For levels of care requiring review by the Optum TCo Clinical Team, refer to the section of this manual entitled *Post-Service Reviews*. For all retrospective eligibility granted after 6/30/23, claims are expected to be submitted to Utah Medicaid Fee for Service. (see pg. 16 for additional information).

ProviderConnect NX™: Optum TCo encourages you to submit claims using PCNX™ to ensure all required claim elements are entered until/unless you have initiated services via EDI. This system checks for validity of data prior to submission, reducing errors. More information about PCNX™ is available by contacting saltlakecounty.networkbox@optum.com.

EDI/Electronic Claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format.

Any provider requesting EDI claim submission shall complete EDI onboarding, including successful testing and approval from Optum Tooele County. We will ensure the Optum information system is properly configured for EDI claims processing and will assist in answering questions, such as data interchange between a Provider and a Payor, and Utah Health Information Network (UHIN). Please contact Optum Tooele County for approved clearinghouse vendors.

Prior to sending any EDI claims, please contact Network Services at
saltlakecounty.networkbox@optum.com
or call us at 1-800-640-5349

Paper Claims: Professional claims may be submitted using the CMS-1500 (or successor forms) until 10/1/2024; Facility claims may be filed using the UB-04 (or successor forms) for secondary claims only for Optum SLCo network providers (unless special arrangements are made with Network Services) until 1/1/2025. In order for claims to be processed, all required fields must be completed and accurate. Paper claims should be submitted to:

Optum Tooele County Claims
P.O. Box 30761
Salt Lake City, UT 84130-0761
Or
Fax: 1-248-733-6373

Payment

Claim adjudication processing is completed twice per month and providers will receive payment via EFT transaction and/or check.

Claims/customer service

Optum Claims Representatives are available to assist with claims processing questions. To contact a Claims representative, call toll-free 1-800-640-5349 and follow the prompts to reach Claims/Customer Service.

Provider responsibilities and standards

Professional responsibility

In accordance with the Participation Agreement, you are required to provide services in a manner that is consistent with professional and legal standards applicable at the time of service regardless of a member's benefit plan or terms of coverage. Providers are expected to post and/or make available Member Rights information, located at the end of this manual and on the Optum TCo website.

If you object to providing a service on moral or religious grounds, you must furnish information about the services not covered to the following entities: (1) Optum TCo upon contracting or when adopting the policy during the term of the contract; (2) members before and during enrollment; (3) members within 90 days after adopting the policy with respect to any service.

The Americans with Disabilities Act

Providers are expected to comply with protections and accommodations as covered by the Americans with Disabilities Act. This includes, but is not limited to, protections against discrimination that limit or prevent access to services based on the presence of the disability and modifications to facilities or equipment that accommodate individuals to gain access to services offered for which they are eligible.

Cultural responsiveness

Definitions:

Indian: an individual, as defined by 25 U.S.C. §1603(13), 1603(28), or 1679(a) or who has been determined eligible, as an Indian, under 42 CFR §136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian Health Care Providers.

Indian Health Care Provider (IHCP): a health care program, operated by Indian Health Services (HIS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 USC §1603).

Cultural Responsiveness

Optum TCo members represent a richly diverse population, and we are committed to supporting ongoing curiosity and attentiveness to the unique experiences of all our members. Culture not only refers to race and/or ethnicity, but also to unique characteristics of a community's population related to factors such as geography, age, gender, language, local history, and economics. Taking into consideration specific cultural characteristics is important to improving the effectiveness and quality of services and for achieving positive outcomes.

Optum TCo offers annual training and resources to providers to guide culturally responsive practices. Please contact the Network Services Team if you have had training in this area and are interested in having this highlighted in your provider profile.

Nicotine Cessation Initiative

The Utah Department of Health and Human Services and the Utah Office of Substance Use and Mental Health partners with local community health departments, public substance abuse and mental health authorities, and providers through the Nicotine Cessation Initiative. The goal is to promote health and wellness in people with mental illness and/or substance use disorder. With support, education, and treatment, people can and will recover from symptoms of mental illness and addictions, including nicotine dependency.

Currently, all publicly funded SUD and MH programs must be nicotine free and adhere to the following rules:

- No one will be denied treatment because of their nicotine use.
- Assessment, education, treatment planning and Nicotine Replacement Therapy (NRT) will be provided to all members as appropriate.

The Utah Office of Substance Use and Mental Health requires providers to screen all members for nicotine use. When clinically appropriate, members are to be diagnosed with a corresponding DSM-5 disorder and cessation services are to be offered. Optum TCo requires all network providers to have policies in place to address this initiative. Upon admission to the network, your agency's policies must be submitted to Network Services. For resources go to: waytoquit.org/healthcare-providers/behavioral-health/

Provider relationship with member

Optum TCo recognizes that the therapeutic alliance is central to the member's recovery. Nothing in this manual is intended to interfere with your relationship with members as patients.

Optum TCo believes that through the efforts of our network, members will have the best opportunity to achieve a level of functioning that promotes recovery and resiliency and improves quality of life. One important component of this goal is collaboration between Optum TCo and you, the provider. We encourage you to direct questions and concerns to an Optum TCo Network Service representative. **Providers should never involve members in any dispute between the Provider and Optum TCo.**

Written notification of status changes for clinicians and facilities

You are required to notify Network Services in writing within 10 calendar days of any changes to:

- The status of the practice, including changes in practice location, ownership, billing address, or telephone or fax number;
- The status of professional licensure and/or certification such as revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, or any other adverse action;
- The status of professional liability insurance;
- Potential legal standing (any malpractice action or notice of licensing board complaint filing);
- The Tax Identification Number (TIN) used for claims filing;
- The programs you offer (services you provide must continue to meet our credentialing criteria);
- The exclusion status found in List of Excluded Individuals Entities (LEIE) and System for Award Management (SAM). Providers may update the attestation using the DHHS prohibited affiliation attestation form for this submission. (Instructions can be found at Program Integrity Exclusion Search)

Notify Network Services in writing within 10 calendar days of these changes.

Providers are expected to have written policies and procedures for conducting delegated searches, including any known aliases, for maintaining documentation searches were conducted and for reporting any exclusion findings to Optum.

Searches are expected to be conducted for all individuals that you employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with. If during these searches a match is identified and confirmed, you must notify Optum, in writing, within 30 calendar days and a new attestation must be completed.

Many of these notifications can be handled by updating your clinician profile on Provider Express (providerexpress.com) or by sending an email to: saltlakecounty.networkbox@optum.com.

Failure to report changes in a timely manner may result in claims payment delays and/or adversely affect network participation.

Continuation of services after termination

Network clinicians who voluntarily withdraw from the network are required to notify Network Services in writing, 90 calendar days prior to the date of withdrawal. With the exception of terminations due to quality-related issues, fraud or change in license status, clinicians are obligated to continue to provide treatment for all members under their care for a period of 90 calendar days after the effective date of the contract termination or until one of the following conditions is met (whichever is shortest):

- The member is transitioned to another Optum TCo clinician;
- The current episode of care has been completed; or
- The member's Optum TCo benefit is no longer active.

Please note Utah laws will be followed when they provide for a longer post-termination timeframe.

To ensure continuity of care, Optum TCo will notify members affected by the termination of a clinician at least 30 calendar days prior to the effective date of the termination whenever feasible. Members may be directed to the Optum Tooele County Clinical Team for assistance in selecting a new clinician by calling 1-800-640-5349.

Network facilities that voluntarily withdraw from the network are required to notify Network Services in writing, 120 calendar days prior to the date of withdrawal unless otherwise stated in your Participation Agreement or required by state law. Optum can continue to issue authorization for treatment during the termination period at the contracted rate, as provided by your Participation Agreement.

To ensure there is no disruption in a member's care, Optum TCo has established a 120 calendar-day transition period for

Voluntary withdrawal from the network requires prior written notice:
Network clinicians – 90 days
Network facilities – 120 days

Members will be notified at least 30 days prior when feasible.

voluntary terminations. In the event there is imminent risk to a member requiring immediate transfer to another facility, Optum TCo and the facility will coordinate to ensure a safe and effective transition of care.

In some cases, you and Optum TCo may determine it is in the best interest of a member to extend care beyond these timeframes. Optum TCo will arrange to continue authorization for such care at the contracted rate. Clinicians and facilities may continue to collect all applicable Medicaid co-payments. The facility continues under contract at the existing rates through the completion of the episode of care at any level of care provided by the facility. Members may not be balance billed during this period, or any other time, for services.

Pending or potential litigation

Network providers and subcontractors are required to notify Optum of any pending or potential litigation or administrative action against the individual, facility, or entity within seven (7) calendar days of receiving notice or becoming aware of the threatened litigation.

Program Integrity (Fraud, Waste, and Abuse)

This section outlines key elements of Program Integrity, Fraud, and Waste and Abuse (FWA) regulations and is provided as a resource for Providers in Tooele County.

Definitions

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 Medicaid Member practices that result in unnecessary cost to the Medicaid program.

Fraud: 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 63A-13-102, Fraud means intentional or knowing:
(1) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, a claim, reimbursement, or services; or
(2) a violation of a provision of Utah Code Sections 26B-3-1102 through 26B-3-1106.

Waste: Overutilization of resources or inappropriate payment.

Whistleblowers: Employees who come forward and disclose illegal activity (wrongdoing) in the workplace. See Utah Code Section 67-21-3, Utah Protection of Public Employees Act. Under the

Federal False Claim Act, employees who know that fraud against the government is taking place in their workplace can file suit called a Qui Tam lawsuit to stop the fraud.

Federal False Claims Laws

Federal Civil False Claims Act; 31 U.S.C. §§ 3729 - 3733
Congress enacted the federal civil False Claims Act in 1982. The act is designed to enhance the government's ability to identify and recover losses due to fraud.

Provisions

The federal civil False Claims Act makes it a crime for any person or organization to knowingly make a false record or file a false claim with the government for payment. "Knowingly" means that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard for whether the information is true or false. Based on this guidance, specific intent to defraud is not required for there to be a violation of the law.

The False Claims Act is enforced by the filing and prosecution of a civil complaint. Under the act, civil actions must be brought within six years after a violation or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than ten years after the date on which the violation was committed.

Penalties

A person or entity found to have violated the civil False Claims Act is subject to a civil money penalty. The False Claims Act sets penalties at $5,000 to $10,000 per violation. However, subsequent federal law periodically adjusts the amounts for inflation.

Qui Tam and Whistleblower protection provisions

The False Claims Act authorizes the U.S. Attorney General to bring legal actions alleging violations of the statute. The statute also allows private citizens to file a lawsuit in the name of the United States for false or fraudulent claims submitted by individuals or companies that do business with, or are reimbursed by, the United States. Commonly known as a ***qui tam*** action, a lawsuit brought under the act by a private citizen begins with the filing of a civil complaint in federal court.

As an incentive to bring these cases, the law provides that whistleblowers who file a **qui tam** action may receive a percentage of the money recouped as a reward. This reward may be reduced, however, if for example the court finds the whistleblower planned and initiated the violation. The act also provides that "whistleblowers" who prosecute clearly frivolous **qui tam** claims can be held liable to a defendant for its attorneys' fees and costs.

Whistleblowers are given certain protections under the act from retaliation for bringing an action under the law, such as being discharged, demoted, or harassed.

The Federal Program Fraud Civil Remedies Act; 31 U.S.C. §§ 3801 - 3812

The Program Fraud Civil Remedies Act ("PFCRA") creates administrative remedies against persons who make, or cause to be made, false claims or statements to certain federal agencies (including the U.S. Department of Health and Human Services). This act was created as a way to address lower dollar frauds and generally applies to claims of $150,000 or less.

The Program Fraud Civil Remedies Act imposes civil money penalties on any person who makes, presents, or submits, or causes to be made, presented, or submitted, a claim that the person knows or has reason to know is false, fictitious, or fraudulent. If found liable, the person is subject to civil money penalties of up to $5,000 per false claim or statement and up to twice the amount claimed in lieu of damages.

Reported violations are investigated by the Office of the Inspector General within the U.S. Department of Health and Human Services. The U.S. Attorney General must approve any enforcement actions.

Federal Sarbanes-Oxley Act of 2002

The federal Sarbanes-Oxley Act of 2002 focuses on corporate accountability. The law contains important whistleblower protections.

Section 806 of the law creates whistleblower protection for stock company employees who provide information to investigators or file complaints or other notices with their superiors, corporate executives, or government entities.

Section 1107 of the law makes it a crime for anyone to retaliate, including interfering with employment or livelihood, against someone for "providing to a law enforcement officer any truthful information relating to the commission or possible commission of any federal offense." This protection applies to employees of nonprofit corporations as well as stock companies.

Agencies contracted with Optum TCo and receive annual payments of at least $5,000,000.00 are responsible for development of a separate False Claims Act Policy and must distribute the information to all employees. All agencies receiving annual payments less than $5,000,000.00 may disseminate the information below or develop their own False Claims Act Policy for distribution to employees. See Optum TCo website (tooele.optum.com) to access the False Claims Act Provisions document under the Provider Tab.

False Claims Act provisions

All individuals involved in providing mental health care to Medicaid Members on behalf of Optum Tooele County (TCo), heretofore known as Staff, shall not knowingly present, or cause to be presented, a false or fraudulent claim, for payment or approval, to any federal, state or local

government agency, or to any managed care organization or other entity that acts as a government subcontractor for administering healthcare benefits.

Staff shall not knowingly:

- falsify, conceal or cover up a material fact;
- make any false, fictitious, or fraudulent statement or representation material to an obligation to pay or transmit money or property; or
- make or use any materials known to contain false, fictitious or fraudulent information in order to get a false or fraudulent claim paid or approved by any federal, state or local government agency, or any managed care organization or other entity that acts as a government subcontractor for administering healthcare benefits;
- conceal or improperly avoid or decrease an obligation to pay or transmit money or property to the federal, state or local government agency, or to any managed care organization or other entity that acts as a government subcontractor for administering healthcare benefits.

All Staff shall make reasonable inquiries into and investigate any suspected overpayments made by the federal government, a federal agency, or any managed care organization or other entity that acts as a federal government subcontractor for administering healthcare benefits. The investigation shall be conducted with deliberate speed.

If an overpayment is suspected, any Staff is expected to immediately report the suspected overpayment to Optum TCo.

If an overpayment to a provider is confirmed, the provider must reimburse Optum TCo within 30 days of notification.

The following activities are examples of activities that may be considered violations of the federal False Claims Act or similar state or local laws:

- “Double billing” – billing a payor multiple times for a single item or one- time service;
- Falsely certifying that a contract meets established requirements or guidelines;
- Conspiring with others to get a false claim paid;
- Claims resulting from an anti-kickback violation (See the Anti-Kickback Policy in Related Policies below);
- Knowingly keeping and not reporting funds improperly paid under Medicaid, Medicare, TRICARE, other state-based health care programs or other government health program – otherwise known as a reverse false claim;
- Knowingly submitting claims for services ordered or provided by an excluded provider;
- Submitting reports or claims to government agencies that are known to be false, erroneous or that are submitted with reckless disregard for the accuracy of the information;
- Knowingly charging for services not rendered or charging for more complex and costly procedures than those actually provided (“up- coding”);
- Billing for brand-named drugs when generic drugs are actually provided;
- Submitting false or forged enrollment applications for a government funded program; or

- Submitting claims for services that were actually rendered but which were not medically necessary.

Your actions could violate the federal False Claims Act or similar state laws even if you do not intend to do so.

Staff shall not knowingly conceal or fail to disclose knowledge of an event affecting a right to any benefit or payment.

All Staff shall report any suspected violations of the federal False Claims Act, applicable state false claims act(s), any similar state or local laws or agency policy. Reports of potential improper activities shall be made to Optum TCo directly or the Utah Department of the OIG.

Staff failure to comply with this Policy could lead to disciplinary action, up to and including termination of participation within the Provider Network.

Staff may not retaliate against employees, agents, or contractors, who, in good faith, investigate, file or participate in a whistleblower action. Optum TCo requires that all providers, and their employees, who participate in administration of Medicaid behavioral health services comply with this provision and all federal and state laws or agency policy that prohibit the submission of false or fraudulent claims in connection with federal healthcare programs. Optum TCo also requires that its subcontractors (provider facilities) distribute this information to their employees to educate them on the federal and state statutes.

All staff shall receive the information set forth in this document.

Suspected FWA – Next steps

If you suspect any FWA, you must make four contacts.

Contact:

- Optum TCo Compliance Manager at 1-800-640-5349 or email 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 Division of Medicaid and Health Financing Karen Ford at kford@utah.gov
- Utah Program Integrity at 1-855-403-7283 or online at oig.utah.gov/report-fraud/

When reporting the information, please include the following:

- Name and identification number of the suspected individual
- Type of Provider or Staff position, if applicable
- Nature of complaint and

- Approximate dollars involved, if applicable.

Network development and maintenance

Optum TCo is responsible for arranging for the provision of a comprehensive spectrum of behavioral health services to support recovery and resiliency. To fulfill this responsibility, we administer a provider and facility network consisting of certified or licensed qualified professionals from the disciplines of psychiatry, psychology, psychiatric nursing, clinical social work, licensed counseling, and chemical dependency, case management and peer support. As providers, you represent an array of clinical and cultural specialties. The network includes a variety of facility-based behavioral health programs that offer all levels of services which allows us to meet the clinical, cultural and geographic needs of members and families.

Rendering providers

Individuals who provide the specific services to the member are considered a rendering provider.

All individuals offering services in an agency must apply for and receive the following:

- National Provider Identifier (see pg. 3 in this manual for application process)
- Utah State Medicaid ID (see pg. 51 in this manual for web address)

It is mandatory all Providers who prescribe medication be enrolled with the Department of Health and Human Services (DHHS) for pharmacy claims to be paid.

Provider credentialing

Optum TCo credentials providers (individual practitioners) who are licensed to practice independently according to rigorous criteria that reflect professional and community standards as well as applicable laws and regulations. These criteria include (but are not limited to) satisfaction of the following standards:

- Independent licensure or certification in your state(s) of practice
- License is in good standing and free from restriction and without probationary status
- Board Certification or Board Eligibility for psychiatrists
- Current certification through the Federal Drug Enforcement Agency (DEA) for prescribing providers
- Professional Liability Coverage: a minimum of $1 million occurrence/$1 million aggregate for master's-level and doctoral-level providers and a minimum of $1 million/$3 million for physicians (exceptions to insurance amounts may be made as required by applicable state law)
- Utah State Medicaid ID acquired through the following link: medicaid.utah.gov/become-medicaid-provider.

You will be asked to sign a release of information granting Optum TCo and its agents access to information pertaining to your professional standing. This is required for primary verification and/or review of records from any professional society, hospital, insurance company, present or past

employer, or other entity, institution, or organization that does or may have information pertaining to your professional standing. This is necessary to complete the credentialing process. Failure to provide such release will prevent credentialing to be completed and will adversely affect your ability to participate in the network.

Provider re-credentialing

In accordance with our commitment to the highest quality of clinical treatment, we re- credential providers every 36 months unless state law or client policies requires a different re-credentialing cycle. During re-credentialing, you will be required to provide your current copy of:

- Professional licensure and/or certification
- Federal Drug Enforcement Agency (DEA) certificate (if applicable)
- Professional and general liability insurance

In addition, you may be asked to:

- Attest to your areas of clinical specialty and appropriate training supporting the identified specialties.
- Sign a release of information granting access to information pertaining to your professional standing.

This is required for primary verification and/or review of records from any professional society, hospital, insurance company, present or past employer, or other entity, institution, or organization that does or may have information pertaining to your professional standing. Failure to provide such release will prevent re-credentialing from being completed and will adversely affects your ability to participate in the network.

You are required to provide a copy of all professional documents whenever they renew or change.

Facility credentialing and re-credentialing

Optum TCo follows the guidelines of National Committee for Quality Assurance (NCQA) for credentialing and re-credentialing standards which are applicable to all network providers unless otherwise required by law. As part of the credentialing and re-credentialing process, facilities are required to submit documentation supporting their professional and community standing and defining their program offerings. This documentation includes (but is not limited to):

- Current copies of all licenses required by your state for the services you offer
- Current copies of accreditation certificate and/or letter from accrediting body
- General and professional liability insurance certificates
- W-9 forms
- Signed malpractice claims statement/history
- Staff roster, including attending physicians
- Daily program schedules
- Program description
- Facility Billing Information Form

In the event that your facility is not accredited by an agency recognized by Optum TCo or does not hold State Department of Health and Human Services certification, an on-site audit will be required prior to credentialing and again prior to re-credentialing.

Credentialing and re-credentialing rights and responsibilities

As an applicant to the Optum TCo network, or as a network provider or facility in the process of credentialing or re-credentialing, you are entitled to:

- Be informed of your rights.
- Be informed of your credentialing or re-credentialing status upon request.
- Review information submitted to support your credentialing or re-credentialing application. This does not apply to personal or professional references, internal Optum TCo documents, or other information that is peer-review protected or restricted by law.
- Make corrections to erroneous information identified by Optum TCo in review of your credentialing or re-credentialing application. In addition to the above rights, you have the following responsibilities:
    - Submit any corrections to your credentialing or re-credentialing application in writing within 10 business days of your notification by Optum TCo.
    - Provide updated demographic information within 10 calendar days of the occurrence of any changes.

Provider information and training

Our curriculum for new providers includes a full orientation to the values, administrative processes, and clinical priorities of Optum TCo.

As part of the ongoing process to make certain that providers are familiar with all operational processes, Optum TCo will host ongoing free trainings. Trainings will be delivered at varying time of day and in multiple locations throughout the year. Free continuing education units (CEUs) are most often available for trainings with a clinical focus.

Providers are strongly encouraged to attend all training events, and in some cases, attendance is mandatory. Providers will receive an email notice regarding any upcoming training along with a registration link. Please provide Optum TCo Network Services with a list of who in your organization needs/would like to receive email updates by sending their information to saltlakecounty.networkbox@optum.com.

Categories of training and/or resources offered include, but are not limited to the following: Recovery and Resiliency Training (some examples listed here);

- Strengths-based Assessment
- Effective Use of Peer Support for providers and supervisors of peer support
- Developing Comprehensive Care Plans (including WRAP® Plans)
- Certified Peer Support Specialist State of Utah Sanctioned Trainings
- Refresher trainings for CPSS

- CPSS ethics and professionalism
- Suicide Prevention, Awareness and Response
    - Question Persuade Refer Suicide Gatekeeper Training (QPR)
    - Mental Health First Aid (MHFA)

Administrative Training and Technical Support (some examples listed here);

- Network Orientation
- Annual Claims Adjudication Calendars
- Companion Guides (837P Professional & 837I Institutional) – Optum specific
- ProviderConnect NX™ Users Guide and Recorded Trainings
- Sentinel Event Reporting Requirements
- Service Registration, Eligibility Verification, Referrals, etc.
- Care Coordination Process and Administration
- Complaints/Grievance process
- Appeals/State Fair Hearing process
- HIPAA and Privacy Requirements
- Adverse Benefit Determinations

Clinical Education and Training (some examples listed here);

- Discharge Planning
- Suicide Prevention & Intervention
- Trauma Informed Person-Centered Care
- Culturally Responsive Practice
- Treatment Planning
- The Golden Thread
- Substance Use Disorders for the Mental Health Therapist

Manual updates and governing

Manual updates

This manual is updated periodically as procedures are modified and enhanced. The current version of the Manual is always available on our website tooele.optum.com or you may request a paper copy by contacting Network Services.

Governing law and contract

This Manual and the Utah Medicaid Program Regulatory Requirements Appendix shall be governed by, and construed in accordance with, applicable federal, state, and local laws. To the extent that the provisions of this Provider Manual differ from the terms and conditions outlined in your Agreement, the subject matter shall first be read together to the extent possible; otherwise, and to the extent permitted by, in accordance with, and subject to applicable law, statutes or regulations, the Agreement shall govern.

Appendix A

Member rights posters are available on the following pages.

Medicaid Member Rights

You have the right to:

- Get mental health care regardless of your race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability.
- Get information on the Prepaid Mental Health Plan that is easily understood.
- Be treated with respect and dignity.
- Have your privacy protected.
- Get information on all treatment choices in a way that is clear and you can understand.
- Receive information on the Prepaid Mental Health Plan in a language and format that is easily understood.
- Take part in treatment decisions about your mental health care, including the right to refuse treatment.
- Be free from restraint or seclusion if it is used these ways:
  - To coerce (force) or discipline;
  - As a reaction (to retaliate) or for convenience;
  - As specified in Federal regulations on the use of restraint and seclusion.
- Get a copy of your mental health record. You may also ask that it be amended or corrected.
- Get mental health or substance abuse covered services in the amount you need and when you need them.
- Be free to use your rights at any time and not be treated badly by the County, by Optum, or by your Provider if you do. If you have been treated unfairly or discriminated against for any reason, please call any of the numbers listed below:
  - Optum Compliance Manager: 1-800-640-5349
  - Medicaid's Constituent Services: 1-877-291-5583
  - The Federal Office for Civil Rights: 1-800-368-1019, ocrmail@hhs.gov (email), www.hhs.gov/ocr (web site), or 1- 800-537-7697 (TDD)

Optum

Derechos de Los Miembros de Medicaid

Tienes derecho a:

- Obtener atención de salud mental independientemente de su raza, color, nacionalidad, discapacidad (mental o física), sexo, religión o edad.
- Obtener información sobre el Plan de Salud Mental Prepago que se entienda fácilmente.
- Ser tratado con respeto y dignidad.
- Tener su privacidad protegida.
- Obtener información sobre todas las opciones de tratamiento de una manera clara y que pueda comprender.
- Recibir información sobre el Plan de Salud Mental Prepago en un idioma y formato que se entiendan fácilmente.
- Participar en las decisiones de tratamiento sobre su atención de salud mental, incluido el derecho a rechazar el tratamiento.
- Estar libre de restricciones o reclusión si se usa de estas formas:
  - Coaccionar (forzar) o disciplinar;
  - Como reacción (para vengarse) o por conveniencia;
  - Como se especifica en las regulaciones federales sobre el uso de restricción y reclusión.
- Obtener una copia de su registro de salud mental. También puede solicitar que se modifique o corrija.
- Obtener servicios cubiertos de salud mental o abuso de sustancias en la cantidad que necesite y cuando los necesite.
- Ser libre de usar sus derechos en cualquier momento y no sea tratado mal por el Condado, por Optum o por su Proveedor si lo hace. Si ha sido tratado injustamente o discriminado por cualquier motivo, llame a cualquiera de los números que se indican a continuación:
  - Gerente de Cumplimiento de Optum: 1-800-640-5349
  - Servicios Constituyentes de Medicaid: 1-877-291-5583
  - La Oficina Federal de Derechos Civiles: 1-800-368-1019 ocrmail@hhs.gov (correo electrónico), www.hhs.gov/ocr (sitio web), o 1-800-537-7697 (TDD)

Optum