



Provider Handbook

Salt Lake County

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## Important Notice

Optum SLCounty (SLCo), a service mark of Optum, provides this Provider Handbook as a more focused resource and contract extension for clinicians and facilities in Utah. Optum SLCo works closely with Salt Lake County Division of Behavioral Health (SLCo DBHS) to respond to the call for resiliency and recovery for individuals with coverage under the Salt Lake County Benefit Plans. The State Division of Medicaid and Health Financing also sets forth important requirements in the Utah Medicaid Provider Handbook. The Optum SLCo Handbook supplements but does not replace either the primary Optum Network Manual which is available on [www.providerexpress.com](http://www.providerexpress.com) or the State requirements for providers available on <https://medicaid.utah.gov/>. Some sections of the primary Optum Network Manual are repeated for convenience and topics or requirements that are specific to Optum SLCo are detailed here as well.

Optum SLCo expects all treatment provided to Optum SLCo Members be outcome-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. Optum SLCo 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.

## Introduction

**Welcome to Optum SLCo!** We are a mission-driven organization, committed to promoting recovery and resiliency and to strengthening community mental health and substance abuse systems. We recognize the critical role you play supporting consumers and families in Utah, and we look forward to working with you.

As we work together, you will become familiar with our committed public sector team comprised of leaders tested in complex state and local systems, including Arizona, Colorado, Texas, Nevada, Tennessee, California, Washington, Minnesota, Wisconsin, Idaho, and Utah. You will also find the resources of our parent company, UnitedHealth Group, brought to bear in service of recovery and resiliency for Utahns.

We strongly encourage network participants to become familiar with all aspects of the Optum Network Manual, which guides our overall contract with you and this Optum SLCo Handbook Addendum. Because we value your time, we have incorporated a Resource Guide in this handbook so you can see key contacts as well as web-based resources at a glance.

Optum SLCo 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.

Tracy Luoma  
Executive Director  
Optum SLCo

## Recovery and Resiliency

## **Background and Introduction**

*“Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”* SAMSHA, December 22, 2011

Recovery is achieved through the 10 fundamental principles established in a consensus statement by more than 110 expert panelists representing mental health consumers, families, providers, advocates, researchers, managed care organizations, state and local public officials, and others (SAMHSA, 2004). The core components of recovery include approaches that support: (1) self-direction, (2) individualized and person-centered interventions, (3) empowerment, (4) a holistic perspective, (5) nonlinear methodologies, (6) a strength-based point of view, (7) peer support, (8) respect, (9) responsibility, and (10) hope.

While recovery involves the empowerment of those who live with mental and substance use conditions to become all-the-way well, the responsibility to promote this lies throughout the continuum of health care and community based services. This is achieved by fostering the resources that are respectful, responsive to individual needs and preferences, and promote recovery. This includes the provision of available tools and services to help individuals and their families make informed decisions about their care and to support them in their recovery. A consumer-centered recovery approach includes the responsibility to build programs, find solutions, and expand services for those with mental and substance use conditions. Helping individuals to achieve recovery must be the goal of all health care services.

A cornerstone of consumer-centered recovery is the central role of consumers and peer support services throughout all systems of care and health promotion. The lived experience of consumers with mental health and substance use conditions are a valuable resource in the empowerment and support of recovery.

Optum SLCo has embraced a commitment to consumer-centered and recovery-oriented programs. This approach requires innovation in all levels of health care and management and must include partnerships with consumers, provider systems, and others that support this goal. This is an ongoing commitment and is constantly evolving as we strive to build resources for those living with a mental health or substance use disorder and to partner with those who provide services to them. This summary of recent initiatives is intended as a report on progress towards the goals of promoting recovery-focused systems of care. It can serve as a model for consumer-run organizations, managed care systems, and clinical service providers to illustrate how recovery systems can be designed, built, and incorporated into routine practice.

## **The Role of Peer Support in Health Care and Recovery**

The role and effectiveness of peer support services has been well demonstrated in both chronic disease management for medical conditions and in recovery for those with mental and substance use conditions. For chronic disease management, the Diabetes Self Management Program (DSMP) (Lorig, et al., 2009) has been found effective for improving patients' health activation, hypoglycemia, physician communications and interactions, improved diet and lifestyle, and reducing symptoms of depression. Other examples abound throughout health care, and for patients being treated for cancer,

peer supports have been found to help address isolation, consolidation of information, and the enablement of empowerment (Power, Hegarty, 2010).

In behavioral health care, Peer Support Specialists have an active role in the recovery process. The range of services they provide includes independent peer support, case management, peer wellness coaching, education and advocacy, and as active participants on treatment teams in a full range of clinical settings (Salzer, et al., 2010). In provider settings Peer Support Specialists are able to promote recovery; enhance hope and social networking through role modeling and activation; and supplement existing treatment with education, empowerment, and aid in system navigation (Chinman, et al., 2006). Peer support also fosters whole health coordination, linking both physical and mental health.

The Health and Recovery Program (HARP), an adaptation of the Diabetes Self Management Program (DSMP), has shown peer support as an effective tool for helping mental health consumers to become improved managers of their chronic illnesses (Druss, et al., 2010). Outcomes from HARP have demonstrated improvements in physical health related quality of life, physical activity, and medication adherence.

Consumer-run organizations that provide Peer Support Services have been successful at promoting community integration, improving daily living activities, and lowering symptom distress (Yanos, et al., 2001). When consumer-run Peer Support Services are paired with traditional community mental health center care, the combined services promote better recovery outcomes (Segal, 2010). The evidence indicates consumers who provide Peer Support Service can be a valuable resource in promoting and enhancing recovery.

### **Adopting a Consumer-Centered Recovery Approach**

Throughout the spectrum of behavioral health care services and community-based resources, there is variable commitment to the goal of recovery for those who live with mental and substance use conditions. Despite the existence of an evidence base for peer support in medical and behavioral health promotion, not all systems of care have embraced these principles. Optum SLCo has made a fundamental commitment to its responsibility to foster and provide consumer-centered recovery resources.

This commitment is achieved through an ecosystems approach to support recovery initiatives and resources at the individual, community, provider systems, and whole health integration levels. Optum SLCo's programs promote peer services and recovery-oriented systems of care. To achieve this, Optum SLCo recognizes the importance and necessity for partnerships and collaborations that support these goals. Some examples, presented here, showcase projects and programs that demonstrate this commitment.

Optum SLCo is indebted to our partners and collaborators in this journey and encourages the adoption of the goal of consumer empowerment and consumer-centered recovery for all areas of mental health and substance abuse care.

### **Partnering with Individuals and Families to Empower Recovery**

The experience of consumers and families has been described as the "True North" that should guide all health care (Berwick, 2002). All care should be responsive and respectful to the needs of consumers and their families (IOM, 2001). This approach

must be adopted throughout all health care operations. The development of consumer-centered educational resources helps to promote personal empowerment and supports recovery. Information and education are vital components for consumers to become active participants in the development of recovery goals and plans.

Optum SLCo is committed to both developing and providing these tools for consumers. Electronic, print, and other mediums are effective resources for consumer-centered materials and tools, and must be broadly available. More information about Recovery and Resiliency is posted to the Optum SLCo Website: [www.optumhealthslco.com](http://www.optumhealthslco.com). This site has been created to use consumer based research findings to articulate the consumer voice. Materials are written by consumers, professionals, and others to describe and disseminate the principles of consumer-centered recovery. In addition, a series of recovery-based videos are being developed by consumers to help their peers answer common questions about diagnosis, treatment and recovery, and to provide hope and inspiration.

## Optum SLCo Resources

**Website:** [www.optumhealthslco.com](http://www.optumhealthslco.com)

Our website is a shared resource for providers and practitioners, consumers and families, and other community stakeholders. Providers and practitioners will find both general resource information such as training opportunities and Level of Care Guidelines, as well as a host of features designed to streamline your administration, including secure transactions online.

The Optum SLCo provider portal offers online clinical and administrative content to providers and practitioners. This service is offered at no cost. Online clinical and administrative content is available to all visitors to the provider portal on Provider Express.

In addition to the secure transactions available through ProviderConnect™ (see details below, in Online Services), you will find key forms, reference guides, training opportunities, and important updates. Contact information for Optum SLCo staff is also available on the site.

## Network Services Contact Information

The Optum SLCo Network Services Team is locally available and ready to assist you with general information and contractual questions. Our toll-free number includes prompts to direct you to the Network Services Team. You may also go online and click the “Contact Us” tab at the top of our website.

Optum SLCo  
Salt Lake County Network Services  
2525 Lake Park Blvd  
West Valley, UT 84120

**Phone:** 1 (877) 370-8953

**Fax Number:** 1 (855) 466-3117

**E-mail:** [saltlakecounty.networkbox@optum.com](mailto:saltlakecounty.networkbox@optum.com)

The Network Services team can answer questions and assist with such activities as:

- Joining the network
- Network status updates
- Making changes to your practice or program information, including but not limited to:
  - Demographic changes (address or phone number)
  - Changes or additions to facility program offerings
  - Updates or changes to Tax ID or EIN
- ProviderConnect-related questions

### **Working Together: Training Opportunities**

As part of the ongoing process to make certain that Optum SLCo providers are familiar with the Optum SLCo operational processes, Optum SLCo will host ongoing free training forums. Providers are strongly encouraged to attend each training offered, and in some cases are required to attend. Providers will receive an email notice regarding any upcoming training along with a registration link. Please provide Optum SLCo Network a list of who in your organization needs/would like to receive email updates by sending their information to [saltlakecounty.networkbox@optum.com](mailto:saltlakecounty.networkbox@optum.com).

### **Claims/Customer Service**

Optum Claims Representatives are available to assist with claims processing questions. To contact a Claims representative, call toll-free 1 (877) 370-8953 and follow the prompts to reach Claims/Customer.

## **ONLINE SERVICES**

### **Provider Connect**

ProviderConnect is your primary tool for managing secure transactions including: benefit and eligibility inquiries, authorization requests, Mental Health Event Records entry, and electronic claim submissions. Upon completion of all credentialing, Optum SLCo will issue a user ID and password to enable access to the secure transactions conducted on ProviderConnect.

ProviderConnect may be accessed using Internet Explorer web browser. No software installation is required at the Provider's facilities. This is achieved through the use of web services that transmit consumer treatment and billing data through a web browser safely and securely. This is accessible through a link at [www.optumhealthslco.com](http://www.optumhealthslco.com).

### **Benefits of ProviderConnect**

- Access consumer demographic, treatment and service authorizations records
- Submit bills / claims
- Minimize paper-based communication, eliminating redundant data
- Reduce errors at time of entry through edit checks that ensure data validity
- Complete HIPAA compliant transactions are HIPAA compliant
- Generate reports based on authorizations, requests and claim transactions

Refer to the training materials on [www.optumhealthslco.com](http://www.optumhealthslco.com) for more information regarding use of this system. Clinical and administrative content information includes:

- News and updates
- Training modules on a variety of administrative and technical topics
- Level of Care Guidelines
- Optum SLCo service contact information
- Required Forms

Through ProviderConnect, secure online transactions for the clinical network include:

- Service registration – Enables required notification to Optum SLCo that a consumer is being treated and it simplifies the collection of state required data
- Online claim submission – Supports the direct submission of your professional claims electronically using the ProviderConnect provider portal
- Claim status inquiry – Provides access to the processing status of submitted claims
- Electronic Payments (EPS) – Provides access to claim payment details processed via electronic funds transfer.
- Explanation of Benefits (EOB) may be obtained upon completion of registration through ProviderExpress at [www.providerexpress.com](http://www.providerexpress.com), another secure online portal. If access to ProviderExpress is not available to you or your organization, please notify Optum at [saltlakecounty.networkbox@optum.com](mailto:saltlakecounty.networkbox@optum.com) to obtain copies of your EOBs via secure email delivery.

### **Obtaining a ProviderConnect User ID**

To obtain a user ID and password for ProviderConnect or for technical support, please email Network Services at [saltlakecounty.networkbox@optum.com](mailto:saltlakecounty.networkbox@optum.com) or call toll-free 1-877-370-8953. You must have this user ID and password before you can access any secure transaction feature in ProviderConnect. Your user ID and password are sent by secure e-mail or secure fax when Optum SLCo has a secure e-mail or fax on file, otherwise it is sent through the U.S. Postal Service. If you are newly contracted with the Optum SLCo Network, you must first attend a New Provider Training as part of your contractual obligations Before obtaining access to Provider Connect.

### **Electronic Claims**

Electronic claim submission is easy and efficient. We invite you to use our online secure transaction (ProviderConnect) or you can submit claims electronically through UHIN, an Electronic Data Interchange (EDI) clearinghouse, using payer ID HT006885-001. *Prior to sending any EDI claims*, please contact Network Services at [saltlakecounty.networkbox@optum.com](mailto:saltlakecounty.networkbox@optum.com) or call us at 1-877-370-8953 if you have any questions about how UHIN is used and/or to ensure we have your provider information properly setup for this type of claims processing.

### **Eligibility Inquiry**

You are responsible to determine the eligibility of a qualified beneficiary prior to services being rendered. You are also responsible to verify Medicaid eligibility on a monthly basis, 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 801-538-6155 to determine the status of a consumer covered by Medicaid. In order to use the Medicaid Eligibility Lookup Tool, you will need to register online at <https://medicaid.utah.gov/eligibility>.

If you are not able to access the Utah Medicaid Eligibility phone line or Lookup Tool, you may also call Optum SLCo at 1-877-370-8953.

## Glossary

**Abuse:** (1) Any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault consistent with NMSA 1978, §30-47-1; or (2) provider practices that are inconsistent with sound fiscal, business, medical or service related 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.

**Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

**Adverse reaction to treatment:** Serious adverse reaction to treatment requiring an urgent or emergency intervention.

**Appeal:** A request from a member or provider (acting on behalf of a member with member's authorization or on provider's own behalf) for review by Optum SLCo of an action/adverse benefit determination.

**ASAM:** American Society of Addiction Medicine

**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.

**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.

**Damage to property:** Damage to property including that which occurs secondary to the setting of a fire, due to intentional actions of a consumer while in a behavioral health treatment setting.

**Detentions for Criminal Activity:** An individual detained in an adult or adolescent institution, county jail, or detention center as punishment for a crime or pending formal sentencing or for a violation of their probation or parole.

**Elopement:** The unauthorized leave or absence of consumer without permission, including not returning from pass, for longer than 24 hours past the designated return time.

**Environmental Hazard:** Unsafe conditions which create an immediate threat to life or safety, including, but not limited, to fire or contagious diseases requiring quarantine.

**Expedited Appeal:** A federally mandated provision for an expedited resolution within three working days of a requested appeal by Optum SLCo

**Federally Qualified Health Centers (FQHC):** A federally qualified health center is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-a-Likes. A FQHC Look-A-Like is an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.

**Financial Exploitation:** The act or process, performed intentionally, knowingly, or recklessly, of using a consumer's property for another person's profit, advantage or benefit without legal entitlement to do so.

**Fraud:** Intentional deception or misrepresentation by a person or an entity with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law, consistent with NMAC 8.305.13.10.

**Grievance:** An oral or written statement by a member, provider or other party, expressing dissatisfaction with any aspect of Optum SLCo or its operations that is not an Optum SLCo "action"/adverse benefit determination.

**Homicide:** The act of terminating another person's life.

**Indian Health Services (IHS):** A hospital/clinic established and operated by the Federal Indian Health Service.

**Injuries/Emergency Services:** unanticipated admission to a hospital or other psychiatric facility; or the unanticipated provision or emergency services that result in medical care for this individual which would not be routinely provided by a primary care provider. Such services include, but are not limited to the following: treatment for broken bones, lacerations requiring sutures, poisoning or contacting poison control for treatment, burns requiring specialized medical treatment, or other conditions requiring emergency medical services (EMS), specialized treatment at an urgent care facility or an emergency room. Injuries/Emergency Services excludes adverse reaction to treatment and medication errors.

**Involuntary Hospitalization:** A legal procedure used to compel an individual to receive inpatient treatment for a mental health disorder against his or her will.

**Medication or Treatment Errors:** Medication under or overdose or medication errors requiring treatment.

**Notice of Action:** Written notification to a member and written or verbal notification to a provider when applicable, of an Action that will be taken by Optum SLCo.

**optumhealthslco.com:** Optum SLCo Web portal for providers and for members. Includes general information, manuals, forms and newsletters are available to any portal visitor. In addition, a variety of secure, self-service transactions including service registration are available to network providers.

**PAD:** Psychiatric advance directive

**Post-stabilization Care Services:** Inpatient Covered Services related to an Emergency Medical Condition that are 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 in order to protect him/her from a dangerous person or situation. Examples include: a child who has been neglected or battered or in danger from someone violent, domestic violence, acute intoxication, and psychiatric beds unavailable.

**Rendering Provider:** The individual who provides care to the member.

**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, head-banging, or multiple piercing and multiple tattooing.

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

**Sexual Behaviors:** Sexual contact of any type with other consumers, 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.

**Treatment, Payment, or Health Care Operations:** As defined by HIPAA: (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.

**Tribal 638 Facility (638):** A hospital/clinic is operated by a Native American/Indian tribe and funded by Title I or Title III of the Indian Self-Determination and Education

Assistance Act (P.L. 93-638. (see 25 CFR 900).

**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.

**Waste:** The allocation or expenditure of resources significantly in excess of need for the principal purpose of personal or commercial gain.

## PROVIDER ROLES AND RESPONSIBILITIES

Optum SLCo believes that through the efforts of our clinical network, consumers 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 SLCo and you. We encourage you to direct questions and concerns to your Optum SLCo Network Service representative. **Providers should not involve consumers in any dispute between the Provider and Optum SLCo.**

### 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 or 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)

Many of these notifications can be handled by updating your ProviderExpress account at [www.providerexpress.com](http://www.providerexpress.com) or by sending an email to: [saltlakecounty.networkbox@optum.com](mailto:saltlakecounty.networkbox@optum.com). Failure to report changes in a timely manner may result in claims payment delays and/or adversely affect network participation.

### Action and Notice of Action (NOA):

Optum SLCo requires all providers follow the rules of notifying a consumer when an Action has occurred.

**Action:** Any of the following:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial in whole or in part, of payment for a 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.

A Notice of Action is the written notification sent to a consumer when any of the above situations occur. Additionally, when a *Notice of Action* is sent to a consumer, an *Appeal Request Form* must also accompany the NOA.

If you have a situation that would require an NOA, it must be sent to the consumer within 14 calendar days of the determination. In addition, an electronic version of the NOA must be sent to Optum at the following email address: [slcoreviews@optum.com](mailto:slcoreviews@optum.com). If you have any questions about this procedure, please contact Optum at 1-877-370-8953 and ask for the Quality Specialist. Templates for the *NOA* and the *Appeal Request Form* can be found at [www.optumhealthslco.com](http://www.optumhealthslco.com) under the **Provider Tab**.

### **Provider Relationship with Consumer**

Nothing in this manual is intended to interfere with your relationship with consumers as patients.

### **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 consumer's benefit plan or terms of coverage. Providers should post and/or make available Consumer Rights information.

[https://www.optumhealthslco.com/content/dam/ops-optslcty/slc/docs/Client%20Forms%20&%20Posters/Client%20Rights\\_FINAL\\_20161208.pdf](https://www.optumhealthslco.com/content/dam/ops-optslcty/slc/docs/Client%20Forms%20&%20Posters/Client%20Rights_FINAL_20161208.pdf)

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 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.

### **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. Consumers (and their families, when appropriate) should be actively involved in this aspect of care.

### **National Provider Identification**

The purpose of a National Provider Identifier (NPI) is to improve the efficiency and effectiveness of the electronic transmission of health information. The implementation of this provision in 2007 is in compliance with HIPAA. Optum SLCo requires the billing clinician to include the NPI number and taxonomy code on all claims.

All rendering providers participating in the Optum SLCo network are required to comply with CMS (Center for Medicare and Medicaid Services) rules regarding the use of NPI (National Provider Identifier) on the submission of claims.

**What is an NPI?** The NPI is a unique identification number for covered health care providers used in the administrative and financial transactions adopted under HIPAA.

The NPI is a 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. For a full overview on the use of NPI, please visit the NPI section of the CMS web site at <http://www.cms.hhs.gov/NationalProvIdentStand/>

**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 payer 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.**

### **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.

### **Interpreter Services**

Optum SLCo 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.

All other interpretive services will be arranged by providers on an individualized basis and at no cost to the client. Family members should not be called upon to act as an interpreter for a client. Arrangements can be made through local interpretive services organizations. To pay for the service, all providers will make financial arrangements with the interpretive services agency. All providers may then bill Optum SLCo for the use of these services via CPT code T1013.

### **Service Registration and Utilization Management**

Optum SLCo expects providers and facilities to submit a Service Registration for each consumer who is to receive treatment, care, or services. Through ProviderConnect, Service Registrations are to be completed by providers and facilities for all provided outpatient services. Higher levels of care require pre-authorization which is obtained by calling the Optum SLCo Clinical Team at 877-370-8543.

Service Registration via ProviderConnect asks concise questions for service and funding relevant questions which will:

- Reduce the administrative burden on the provider to determine funding source(s) for the consumer as the service registration process on the provider portal will link the consumer with the most appropriate funding source
- Enhance awareness of available funding and service utilization to remove barriers to participation, increase provider confidence, and minimize under spending due to uncertainty
- Provide detailed summaries and accurate reporting

Service Registrations can be submitted 24 hours/day. Some service registrations will require review by the Optum SLCo Clinical Team and authorizations based on those reviews (e.g., inpatient level of care). The provider portal will alert the provider that he/she must call Optum SLCo.

## Timely Access to Outpatient Services

To ensure that all consumers 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 consumer request for routine outpatient care for MH/SA services. The table below outlines Medicaid Timely Access Standards, within which you are expected to offer an appointment.

Appointment Access Standards	
Routine Appointment (Non-urgent)	Within 14 business days of the request for services, unless the consumer requests a later time
Urgent Care Appointment	Within 5 business days
Emergent	Within 30 minutes by phone, 1 hour face-to face

In cases where a consumer is being discharged from acute inpatient care, Optum SLCo expects a follow-up outpatient appointment to occur within seven days from the discharge date. This is in alignment with Health Effectiveness Data and Information Set (HEDIS) standards. This appointment should be included in the inpatient facility discharge plan. The effort made by clinicians to meet the needs of consumers being discharged from a facility are greatly appreciated, including for those consumers who may not have been in treatment with you prior to their admission to inpatient services.

If you are unable to take a referral, direct the consumer to call Optum SLCo toll-free 1-877-370-8953 so that he or she can obtain a new referral. Consumers can also access a Provider Directory online at [www.optumhealthslco.com](http://www.optumhealthslco.com). Optum SLCo employs a variety of methods to monitor consumer access to care.

Once a provider has completed an initial mental health evaluation, a consumer may be placed on a waiting list for non-urgent services if the consumer 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.

Participating network providers must comply with Timely Access to Care requirements. If providers fail to comply, a corrective action will be implemented.

### **Cultural Responsiveness**

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 SLCo consumers represent a richly diverse population and we are committed to supporting ongoing curiosity and attentiveness to the unique experiences of all our consumers.

### **Provider Information and Training**

Our curriculum for new providers includes a full orientation to the values, administrative processes, and clinical priorities of Optum SLCo. Every network provider is to receive introductory training. Your Welcome kit includes information about accessing the online provider manual, content specific manuals, and training resources on the provider portal. New Providers are required to attend a New Provider Training, prior to seeing an Optum SLCo consumer. Additional trainings are provided in a range of media/settings including but not limited to print, online, telephonic/web-enabled, and in-person formats. Our Network Services staff will deliver training at varying times of day and in multiple locations.

### **Categories of training offered include, but are not limited to:**

Recovery and Resiliency Training (some examples listed here):

- Strengths Based Assessment
- Effective Use of Peer Support
- Developing Comprehensive Care Plans (including WRAP<sup>®</sup> Plans)
- Clinical Implications of Supported Employment
- Post Traumatic Stress Disorders
- Suicide Prevention, Awareness and Response

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

- Network Orientation
- Claims and Billing
- Critical Incident Reporting Requirements
- Service Registration, Eligibility Verification, Referrals and more
- Care Coordination Process and Administration
- Complaints, Disputes, Appeals and Grievance processes
- HIPAA and Privacy Requirements

Clinical Education and Training (some examples listed here):

- Optum SLCo Level of Care Guidelines
- Substance Abuse Level of Care Guidelines ( The ASAM Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition)
- Integration of Physical and Behavioral Health

Culturally Adapted Evidence-Based Practices  
Promising and Emerging Practices  
Prevention and Early Intervention

Our Provider Relations and Training staff, with assistance of consumer, family, and provider peer trainers, will deliver trainings year-round.

### Privacy Practices

All aspects of Optum SLCo 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 consumer information, including information related to substance or alcohol abuse. Optum SLCo requires all its providers similarly to comply with all applicable Utah and federal regulations concerning privacy and the release of confidential consumer information.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law enacted to ensure privacy and security of a consumer'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 consumer identification number, address, and date of birth.

### HIPAA Privacy Rule: The Use and Disclosure of PHI

Optum SLCo 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. These policies and procedures must incorporate the following consumer rights:

- The right to receive a notification of privacy practices;
- The right to authorize how their protected health information (PHI) is used;
- The right to see and obtain a copy of their PHI;
- The right to request to change incorrect or incomplete information in their PHI;
- The right to ask and obtain from a provider when and to whom PHI was disclosed;
- The right to request restrictions on how their PHI is used or disclosed;
- The right to have only the minimum amount of information needed released; and
- The right to file a complaint with the federal Department of Human Services, if they believe their rights related to PHI has been violated.

Providers are required to train all of their staff members on HIPAA privacy regulations and must maintain records dealing with HIPAA privacy issues for at least six years. All Optum SLCo employees are required to receive initial and annual refresher training on HIPAA privacy regulations.

Providers may request records containing PHI for their consumers from other healthcare providers and facilities, as well as from Optum SLCo, without the consumer'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.

“Treatment, Payment, or Health Care Operations” 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 consumer 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 consumer. (You can 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 [www.hhs.gov/ocr/privacy/index.html](http://www.hhs.gov/ocr/privacy/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 patient as an alcohol or substance abuser. 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).

### **HIPAA Security Rule**

Like the HIPAA Privacy Rule, the HIPAA Security Rule requires covered entities such as Optum SLCo and its providers to protect consumer 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 consumer names, such as a Remittance Advise, black out any names or PHI on consumers 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

#### **E-mail:**

- Secure emails containing PHI
- Ensure email is secure if communicating with consumers or other health care professionals
- Do not use consumer PHI in the heading line of an e-mail

#### **Guidelines for Storing Consumer Records**

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

- 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
- 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 seven 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 10 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

#### **Communication with Primary Physicians and Other Health Care Professionals**

To coordinate and manage care between behavioral health and medical professionals, Optum SLCo expects that you will seek to obtain the consumer'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 should 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 consumers in several ways:

- It confirms for a primary physician that his or her patient followed through on a behavioral health referral

- It minimizes potential adverse medication interactions for consumers who are prescribed psychotropic medication
- It allows for better management of treatment and follow-up for consumers with coexisting behavioral and medical disorders
- It can reduce the risk of relapse with consumers in some populations, as with substance use disorders

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

- During the diagnostic assessment session, request the consumer's written consent to exchange information with all appropriate treatment professionals
- After the initial assessment, provide other treating professionals with the following information within 7 days:
  - Summary of consumer's evaluation
  - Diagnosis
  - Treatment plan summary (including any medications prescribed)
  - Primary clinician treating the consumer
- Update other behavioral health and/or medical clinicians when there is a change in the consumer's condition or medication(s)
- Update other health care professionals when serious medical conditions warrant closer coordination
- Inform primary care and, when applicable, specialist physicians regarding laboratory and radiology results
- 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 patient's mental health or substance use problems

Some consumers 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 SLCo, 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 consumer.

## **Client Rights and Responsibilities**

You will find a copy of the Optum SLCo Client Rights and Responsibilities at the end of this manual and at <http://www.optumhealthslco.com>. You may request a paper copy by contacting asking your provider or downloading it from the website. These rights and responsibilities are in keeping with industry standards. All consumers benefit from reviewing these standards in the treatment setting. Optum SLCo requires that you display the Client Rights and Responsibilities in your waiting room and complete the Member Acknowledgment Form which documents that these standards have been communicated to Optum SLCo consumers.

### **Client Rights:**

- A client has the right to receive information on the Prepaid Mental Health Plan in the member's primary language, in alternative formats and in an easily understood language and format.
- A client has the right to be treated with respect and with due consideration for his/her dignity and privacy.
- A client has the right to use his/her rights at any time and not be treated badly.
- A client has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- A client has the right to participate in treatment decisions regarding his/her mental health care, including the right to refuse treatment.
- A client has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- When allowed by federal law, a client has the right to request and receive a copy of his/her medical records, and to request that they be amended or corrected.
- A client has the right to be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care.

### **Client Responsibilities:**

- Keep scheduled appointments.
- Cancel appointments 24 hours in advance.
- Be on time for your appointments.
- Participate with your therapist in your treatment plan and care.
- Call Medicaid at 1-801-538-6155 about changes to your address, phone number or insurance.
- Tell medical staff about all medications you are taking, including medical and mental health prescriptions, over-the-counter medications, herbs, and others.
- Complete any surveys that Optum SLCo providers give you, including client satisfaction surveys and treatment progress surveys.
- Respect the property, comfort and confidentiality of clients and providers.
- Notify your treatment provider when you want to stop getting service

### **Sentinel Event**

You find a detailed copy of the Sentinel Event Procedure at [www.optumhealthslco.com](http://www.optumhealthslco.com) under the Provider Section. Below is the definition of a Sentinel Event along with the expectation for reporting these events to Optum SLCo.

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 policy, potential sentinel events are defined as any of the following events:

- A completed suicide by a member who was engaged in treatment at any level of care at the time of the death, or 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 (i.e., inpatient, residential, partial hospital, intensive outpatient) treatment, OR within 30 days of discharge from facility based treatment;
- An unexpected death of a member that occurred while the member was receiving facility based treatment;
- A serious injury requiring an overnight admission to a hospital medical unit of a member that occurred on facility premises while the member was receiving facility based treatment;
- A report of a serious physical assault requiring medical intervention **of** a member occurring on facility premises while in facility based treatment;
- A report of a sexual assault **of** a member occurring on facility premises while in facility based treatment;
- A report of a serious physical assault requiring medical intervention **by** a member that occurs while the member was receiving facility based treatment;
- A report of sexual assault **by** a member that occurs while the member was receiving facility based treatment;
- A homicide that is attributed to a member who was engaged in treatment at any level of care at the time of the homicide, or within the previous 60 calendar days;
- A report of an abduction of a member occurring on facility premises while in facility based treatment; or
- An instance of care (at any level) ordered or provided for 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 SLCo Clinical Quality Manager at 801-982-3064 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.**
- 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 mental health care provider is to fax the additional information to Optum SLCo within five (5) business days.
- Optum SLCo may request additional clinical records of the member identified in the Sentinel Event Report.
- The Report will be reviewed internally and a decision 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 provide a summary of their review and Optum SLCo will inform the provider of the outcome of the review. Optum SLCo may take actions if it finds that there are concerns about quality of care. Actions may include written feedback related to observations, a recommendation for a site audit and/or record review, or a referral to Optum Network Services for further investigation.

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

### **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, passed into law in 2006 and updated in 2008, gives all individuals 18 years of age or older the right to have a psychiatric advance directive and 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, if they are unable to do so because of illness or incapacitation. A PAD also lets a consumer assign an "agent" to make decision for the consumer if the consumer 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 consumer. Both the consumer 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 consumer.

The law includes a standard PAD form which a consumer may use. This form is available at:

<http://www.nrc-pad.org/images/stories/PDFs/utahpadform.pdf>

Optum SLCo peer specialists are available to assist consumers in completing and understanding psychiatric advance directives.

### **Optum SLCo Provider Responsibilities Related to Psychiatric Advance Directives**

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

1. Provide adult consumers with written information on advance directive policies. This information shall include a description of applicable state law and regulation, consumer's rights under state law and regulation, Optum SLCo's policies respecting the implementation of the right to have an advance directive, and 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.
2. Honor advance directives within its Utilization Management protocols.
3. Educate its staff regarding advance directives and comply with the SE's policies and procedures and applicable state and federal law and regulations.
4. Ensure that consumers are offered the opportunity to prepare an advance request and that, upon request, are provided assistance in the process.
5. Not discriminate against a consumer in the provision of care or in any other manner discriminating against a consumer based on whether the consumer has executed a psychiatric advance directive.

### **Provider Responsibilities related to Psychiatric Advance Directives**

Optum SLCo providers are required to:

1. Provide written information to adult consumers concerning their right to formulate advance directives; this information shall include the provider's policies and procedures for advance directives as well as a clear statement of limitation if the provider cannot implement an advanced directive as a matter of conscience;
2. Document in the consumer's medical record whether or not the consumer has executed an advance directive;
3. Not discriminate against a consumer in the provision of care or in any other manner discriminating against a consumer based on whether the consumer has executed an advance directive;
4. Comply with federal and state law and regulations;
5. Educate staff and the community on issues concerning advance directives; and
6. Inform consumers that complaints concerning noncompliance with the advance directive requirements may be filed with the State Survey and Certification Agency, currently the Department of Health.

### **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.

### **On-Call and After-Hours Coverage**

You must provide or arrange for the provision of assistance to consumers in emergency situations 24 hours a day, seven days a week. You should inform consumers 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 should provide instructions to the consumers regarding what to do in an emergency situation. When you are not available, coverage for emergencies should be arranged with another participating clinician. Because certification of benefits may be required, Optum SLCo must be contacted.

### **Continuation of Services after Termination**

**Network clinicians** who voluntarily withdraw from the network are required to notify Provider Relations 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 Consumers under their care for a period of 90 calendar days after the effective date of the contract termination until one of the following conditions is met (whichever is shortest):

- The consumer is transitioned to another Optum SLCo clinician
- The current episode of care has been completed
- The consumer's benefit limit has been reached
- The consumer's Optum SLCo benefit is no longer active

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

To ensure continuity of care, Optum SLCo will notify consumers affected by the termination of a clinician at least 30 calendar days prior to the effective date of the termination whenever feasible. UBH will assist these consumers in selecting a new clinician.

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

To ensure there is no disruption in a consumer's care, Optum SLCo has established a 120 calendar-day transition period for voluntary terminations. In the event there is imminent risk to a consumer requiring immediate transfer to another facility, Optum SLCo and the facility will coordinate to ensure a safe and effective transition of care.

In some cases, you and the Care Coordinator may determine it is in the best interest of a consumer to extend care beyond these timeframes. Optum SLCo will arrange to continue certification for such care at the contracted rate. Clinicians and facilities may continue to collect all applicable co-payments and deductible amounts. 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. Consumers may not be balance billed during this period for these services.

## Recovery Plus

In 2010, the Utah Department of Health and the Utah Division of Substance Abuse & Mental Health partnered with local community health departments, public substance abuse and mental health authorities, and providers to develop the Recovery Plus Initiative.

Recovery Plus is an initiative to promote health and wellness in people with mental illness and/or substance abuse. With support, education, and treatment, people can and will recover from symptoms of mental illness and addictions, including tobacco dependency.

As of 2013, all publicly funded SUD and MH programs must be tobacco free. Recovery Plus Cardinal Rules:

1. No one will be denied treatment because of their tobacco use.
2. Assessment, education, treatment planning and NRT will be provided to all clients as appropriate.

Optum SLCo 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 more information on this important initiative see the State Directives and <http://recoveryplus.utah.gov>.

## NETWORK DEVELOPMENT AND MAINTENANCE

Optum SLCo is responsible for arranging for the provision of a comprehensive spectrum of behavioral health services to support recovery and resiliency. In order to fulfill this responsibility, we administer a provider and facility network consisting of licensed qualified professionals from the disciplines of psychiatry, psychology, psychiatric nursing, clinical social work, licensed counseling, and chemical dependency. 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 consumers and families.

The Credentialing Plan addresses the requirements for participation and the events justifying disciplinary action, including termination of participation in the network. You may also request that a paper copy be mailed to you by contacting your Regional Provider Relations Representative.

Key credentialing and re-credentialing information is highlighted below.

### Provider Credentialing

Optum SLCo 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:  
<https://medicaid.utah.gov/become-medicaid-provider>.

You will be asked to sign a release of information granting Optum SLCo 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 require 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 affect 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 SLCo follows the guidelines of National Committee for Quality Assurance (NCQA) for credentialing and recredentialing 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 SLCo or hold State Department of Health certification, an on-site audit will be required prior to credentialing and again prior to re-credentialing (see "On-site Audits" in the Quality Improvement chapter of this manual for more information).

## Credentialing and Re-credentialing Rights and Responsibilities

As an applicant to the Optum SLCo 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 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 SLCo documents, or other information that is peer-review protected or restricted by law
- Make corrections to erroneous information identified by Optum SLCo in review of credentialing or re-credentialing application In addition to the above rights, you have the following responsibilities:
- To submit any corrections to your credentialing or re-credentialing application in writing within 10 business days of your notification by Optum SLCo
- To provide updated demographic information within 10 calendar days of the occurrence of any changes

## All Rendering Providers

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

- National Provider Identifier (see pg 14 in this manual for application process)
- Utah State Medicaid ID (see pg 29 in this manual for application process)

## Supervisory Protocol

If you are employed with an agency and you are not independently licensed, you are required to receive supervision through an Optum process known as Supervisory Protocol. In most instances, your agency will take care of the details for you but if you have any questions, please feel free to contact Optum SLCo Network Services (see page 7) via email at [saltlakecounty.networkbox@optum.com](mailto:saltlakecounty.networkbox@optum.com) or toll-free 1-877-370-8953, follow the prompts to reach the appropriate department. You may also go online and click the “Contact Us” tab at the top of our website.

If you are a leader in an agency that does not yet have supervisory protocol and you are interested, you may contact Network Services as described above.

## SERVICE REGISTRATION

### Introduction

It is essential to proper coordination and continuity of care, including effective management of available benefits, that stakeholders in the behavioral health system are able to effectively organize and share information about the application of benefits to available treatment services. Optum SLCo has implemented a HIPAA-compliant Service Registration process that supports providers in coordinated treatment planning across funding streams. Service Registration enables required notification to Optum SLCo that a consumer is being treated and it simplifies the collection of state required data.

### Getting Started

Consumers may be registered by providers in one of three ways:

#### 1. Web-based authorizations through ProviderConnect for general outpatient

**services** (higher levels of care require provider to call Optum SLCo Clinical Services for registration and Clinical Pre-Authorization):

- Available weekdays during normal business hours, after hours, and weekends (24 hours by 7 days availability with the exception of scheduled maintenance).
- User ID and password are required (to request a user ID and password call toll-free 1-877-370-8953 and follow the prompts to Network Services).
- The user ID and password are used for all secure transactions, including Service Registration
- Log on to secure transaction features at [www.optumhealthslco.com](http://www.optumhealthslco.com)
- Follow ProviderConnect Step-by-Step guide for applicable authorizations. (Network Services is available to provide provider specific training for ProviderConnect.)

**2. Telephone registration for higher levels of care during business hours:**

- Available Monday through Friday, 8 a.m. - 5 p.m. Mountain Time.
- Call 1-877-370-8953 to initiate the Service Registration and/or Pre-Authorization.
- This method is a real-time resource that includes the built-in guiding system to ensure that the registration information is complete.

**3. After hours: call the UNI crisis line at: 801-587-3000.**

**Important Timeframes and Information**

Consumers initiating care for the first time must be registered by the treating provider within 30 calendar days of the initial face-to-face session. All applicable service requests must come through this process.

A Service Registration is required when a consumer presents to you to initiate treatment.

The Service Registration that you enter should contain all services that you provide for that member. Multiple services by the same treating provider can exist in one Service Registration.

Each provider will enter their own Service Registration for a given member. So if the member is seeing two or more providers concurrently or consecutively, they will have a Service Registration in place from each treatment source.

If you are requesting a service that requires a prior authorization, you must complete the Service Registration prior to submitting your request for authorization. Authorization must be obtained prior to delivery of that service.

Optum SLCo will work with providers on an individual basis to obtain any missing or additional information needed to successfully complete this conversion.

**Exclusions from Service Registration**

Programs or services that submit billing by invoice are excluded from Service Registration. Contact your assigned Contract Specialist for information about billing for invoice-based services.

### More Information

See the Service Registration training and information posted online or contact Optum SLCo Network Services. Refer to the Resource Guide located in this manual for contact information.

## Treatment Planning and Care Management

### Benefit Plans

There are five (5) Benefit Plans for Salt Lake County:

- Mental Health Traditional
- Mental Health Non-Traditional (Medicaid adult clients age 19 and over who are eligible for TANF)
- Mental Health Foster Care (IP ONLY) (Subsidized adoption Members who are exempted from the PMHP for outpatient Covered Services remain enrolled for inpatient Covered Services)
- Substance Abuse Traditional
- Substance Abuse Non-Traditional (Medicaid adults who are also eligible for the Non-Traditional MH plan)

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

### Eligibility

You are responsible to determine the eligibility of a qualified beneficiary prior to services being rendered. You are also responsible to verify Medicaid eligibility on a monthly basis, maintain evidence of this verification, and be prepared to provide this documentation if requested.

If you are a Utah State Medicaid Provider, you can use the online Medicaid Eligibility Lookup Tool or contact Utah Medicaid by phone at 801-538-6155 to determine the status of a consumer covered by Medicaid. You will need to register online at <https://medicaid.utah.gov/eligibility>.

Additionally, you may send an email request for Eligibility with only the consumer's Medicaid ID number to [saltlakecounty.networkbox.@optum.com](mailto:saltlakecounty.networkbox.@optum.com) or call Optum SLCo at 1-877-370- 8953.

### What is Non-Traditional Medicaid?

The Non-Traditional Medicaid Plan is a reduced benefit plan provided to Medicaid-eligible adults ages 19 through 64 who:

- 1) Are not blind, disabled or pregnant;
- 2) Are in a medically needy aid category and are not blind, disabled, or pregnant; or
- 3) Are in a Transitional Medicaid aid category-Rate Code C and some Rate Code J.

Effective November 1, 2017, service day limits to Non-Traditional Medicaid for Mental Health benefits are being eliminated. As with Traditional Medicaid, services are now

determined by medical necessity. For SUD services, Medicaid covers all SUD services as determined by ASAM criteria including case management services. It is important to note Non-Traditional Medicaid members remain ineligible for 1915(b)(3) services (Personal Services, Psycho-educational Services, Respite, and Supportive Housing).

### Prior Authorization and Concurrent Reviews

All levels of service require authorization.

- In most instances, outpatient authorization must be requested by the Provider through ProviderConnect.
- For higher levels of care, telephonic or email prior authorizations are required.
  - During business hours, please call 1-877-370-8953
  - After hours: The Optum SLCo number provides prompts for after-hours review of inpatient prior authorization requests. Other higher levels of care authorizations must be completed during business hours with an Optum SLCo Care Advocate.

Concurrent review is required for higher levels of care and will be conducted telephonically or by secure email approval with Optum SLCo Clinical staff.

### Ongoing Process for Prior Authorization and Concurrent Reviews

- All services that require pre-authorization will require concurrent review for continuation of care.
- Providers must initiate the concurrent review process two business days prior to the expiration of the previous authorization for inpatient, residential, day treatment, or IOP levels of care.
- Requests for pre-authorizations should be made by calling 1-877-370-8953.

### Levels of Care Requiring Pre-Authorization

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

<b>Level of Care:</b>	<b>Review:</b>
• Mental Health Inpatient Treatment	1-3 Days
• Mental Health Residential Treatment	Every 30 days
• Mental Health Partial Hospitalization/Day Treatment	Every 30 days
• Mental Health Intensive Outpatient Treatment	Every 60 days
• Substance Use Disorder Residential Treatment	
◦ ASAM 3.5	Every 15 days
◦ ASAM 3.3	Every 15 days
◦ ASAM 3.1	Every 30 days
• ASAM 2.5 Partial Hospitalization/Day Treatment	Every 30 days
• ASAM 2.1 Intensive Outpatient Treatment	Every 60 days
• Transportation	Varies
• Psychological Testing	Required for requested units beyond initial authorization

## Level of Care Guidelines

**Mental Health:** Optum SLCo has created Level of Care Guidelines which provide objective and evidence-based support for care advocacy decisions regarding the level of care.

The Level of Care Guidelines 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.

**Substance Use Disorders:** Optum uses the ASAM assessment dimensions (American Society of Addiction Medicine) as guidelines for substance abuse treatment and recovery. These guidelines are used concurrently with the Level of Care guidelines as referenced above.

### Level of Care Guidelines can be found at:

A link to the Level of Care Guidelines can be found at [www.providerexpress.com](http://www.providerexpress.com). Select the applicable level of care for more details.

**Please contact Optum SLCo at 1-877-370-8953 directly to discuss what services are available through the Utah Medicaid mental health or substance use disorder benefit.**

### Best Practice Guidelines can be found at:

A link to the Best Practice Guidelines can be found at [www.providerexpress.com](http://www.providerexpress.com) select the Clinical Resources tab, and follow links for Level of Care Guidelines, and select applicable age group and condition.

Additional important State guidelines can be found on the Utah Division of Substance Abuse and Mental Health website at: [www.dsamh.utah.gov](http://www.dsamh.utah.gov)

## Documentation: Records of Person's Served

**In addition to the documentation requirements found in the Utah Medicaid Provider Manual for Mental Health Centers, the client record must contain the following documentation, as applicable. This pertains to all Salt Lake County Medicaid Consumers.**

Requirements for the individual client record (the term CONTRACTOR refers to the Provider):

**Intent:** The client 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, that services are matched to the needs of the client and take place in an organized, efficient and timely manner, that there is fiscal accountability and that all appropriate individuals have access to relevant information regarding each person served.

Standards: The record is organized, complete, current, legible and clearly documents all services provided to the client. Service activities provided by the CONTRACTOR 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. All billing information will be supported by information in the individual record. The client record will be reviewed as one measure of the quality of program services.

The CONTRACTOR will obligate by contract all substance abuse contractors to utilize the electronic health record (EHR) chosen by COUNTY which currently is the Utah Web Based Infrastructure for Treatment Services (UWITS) as the primary record for all County (including Medicaid) clients. The CONTRACTOR is responsible for keeping their data comprehensive and updated. Those using an alternative certified system must have a COUNTY approved interface to the UWITS system in order to satisfy all the State TEDS and other State and COUNTY data requirements. Costs of producing and testing an interface to the UWITS system will be the responsibility of the CONTRACTOR.

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, authorization for release of information, grievance procedures, TB test results (for residential treatment), documentation regarding medications, client and staff signatures, where required, and any other information pertinent to the client. Additionally, for non-Medicaid clients proof of residency, valid ID, Medicaid eligibility, fee agreements, continuous review of client 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.

The client record will include:

Assessment: All clients 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 client 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 of the American Psychiatric Association (DSM) 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 client driven. Assessments are also considered ongoing with two overarching principles (please refer to the Preferred Practice Guidelines issues by the Division of Substance Abuse and Mental Health for further detail):

1. The client remains at the center of all clinical efforts, whether they are Engagement, Assessment, Planning or Treatment. Relevance to the client and their needs should guide each provider in deciding how to engage the client, 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 client.
2. An important aspect of effective treatment is the ability for providers to engage clients so that the client 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, these guidelines emphasize that assessment and planning are a process rather than an event, and should be balanced with the process of engagement. A more concerted focus on engagement will result in improvements in client retention and improved treatment outcomes.

With these principles in mind, the assessment shall consist of the following guidelines, where appropriate:

1. Working diagnoses may change and shall be continuously evaluated and updated consistent with new information.
2. Immediate safety needs of the client are addressed.
3. 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 V) criteria. There shall be adequate justification for the diagnosis and the assessment shall clearly indicate the need for services.
4. Assessments shall consider how culture (values, traditions, family and religious practices, spiritual beliefs and beliefs about mental illness and addiction, etc.) impact recovery.
5. Providers should be aware that individual differences in culture can be misinterpreted as problems.
6. Person Centered and strengths-based questions will lead both client and therapist in a solution-oriented direction. This establishes a bridge between assessment and development of a person centered treatment/recovery plan.
7. Assessments should be provided in a manner which does not attribute blame.
8. Family/care givers are a primary source of information about the child/youth and should participate in all aspects of the assessment and subsequent treatment recovery planning and implementation.
9. In addition to family/care givers, other sources such as school teachers and physicians can provide essential/accurate information. Releases of Information should be requested when other sources are identified and efforts should be made to contact these sources.

10. The Documentation Update Training 2014, listed on the Optum SLCo Website contains a list of possible areas to be considered as part of an ongoing assessment. The list is not exhaustive and does not constitute a required set of assessment items. Clinicians should keep in mind the principle of relevance (that relevant information should be gathered).
11. The setting in which and evaluation takes place can be critical to the success of the interview. For children and youth the setting should accommodate the child's cognitive, language and emotional status.
12. 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.
13. With children and youth care should be taken to avoid questions that lead a child to answer in a particular way.
14. If the client has dependent children, appropriate referral for evaluation or services shall be made.
15. Inquiring about substance abuse 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.

Clients receiving Substance Use Disorder treatment require ongoing assessment with The ASAM Criteria, Third Edition. . Client Diagnosis will be reflected through assessment information and be updated as new information suggests.

1. In addition to the above requirements for adults, 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. The assessment shall also include, but is not limited to:
  - a. Developmental milestones to include receptive and expressive language development
  - b. Psychiatric and medical history, including vision and hearing problems
  - c. School functioning and performance including any formal testing conducted by the school
  - d. Emotional development and temperament
  - e. Peer relations
  - f. Family relationships, responsibilities, and perceptions of the child/youth and his/her difficulty and the subsequent impact on the family
  - g. Cultural influences, religious beliefs, spiritual beliefs
  - h. Unusual family or environmental circumstances
  - i. Parental/family medical and behavioral health history and impact on child/youth
  - j. Serious Emotional Disorders (SED)

Treatment Plan: The CONTRACTOR agrees that at the time of admission a LMHT will establish a formal, individualized, person-centered Treatment Plan for every client. The plan shall: be consistent with standards for individual treatment/recovery plans,

incorporate the goals of the client and include the involvement of family and natural supports, respect the wishes and needs of the client within funding limitations, and follow clinical best practice standards. The treatment plan will be written in the following format:

- a. Goal. The Goal is a statement that summarizes the individual's or family's desires for change and resolution to a problem or need, captured in their own words. Goals are identified throughout the assessment. They are not necessarily measurable, but are reasonably attainable or recognized within an episode of continuing care.
- b. Objectives. Objectives will be established that address the client'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.
- c. Methods. Methods are the strategies, interventions and tasks that the client, family, peers, community support and/or staff will provide in order to reach the goal and objectives. Methods will be short-term, behaviorally measurable and use action verbs and identifiable outcomes such as what, who, when, where and why.

It must be evident that the client was included in the planning process that the plan addressed the client's individual needs, and that information from the PDIE, and any other pertinent documentation was considered in the planning process. A LMHT will be responsible for any clinical action, and will sign off the treatment plan in the EHR. A copy of the treatment plan will be made available to the client.

Treatment Documentation: Services will be documented in the EHR at the time of service, will include date, exact time of service, duration, type of service, identify the rendering staff with verifiable signature, credentials and evidence of supervision, if necessary. 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 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 signed off and saved in the EHR.

Documentation will be specific to the client of record and will be related to areas addressed in the Treatment Plan. Notes will include changes in client behavior, attitude and beliefs, progress or lack of progress and how the service provided related to the Treatment Plan. Gaps in service such as sickness, vacation, incarceration, home visits, no shows and cancellations should be documented in the EHR as a "Miscellaneous Note."

Treatment Plan Reviews: Treatment Plan Reviews shall be documented in the EHR. 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, include the signature and credentials of the individual rendering service, and incorporate OQ/YOQ data to support the current treatment plan or any changes made to the plan.

Treatment Plan Reviews will be conducted by a LMHT meeting in an individual, face-to-face interview with the client to review the Medical Necessity, appropriateness of treatment interventions, and measure progress on the treatment plan. Based on the needs of the client, 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 severe and persistent mental illness (SPMI) clients, and every three months for non-SPMI clients, 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 client's condition or status. For Substance Abuse populations, 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 summary will be prepared in EHR that includes the current diagnosis, 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. An LMHT will be involved in the discharge process and is responsible for any clinical action.

The CONTRACTOR agrees that clients will be discharged and the case closed in EHR no later than 90 days after the last contact for non-SPMI clients and 180 days for all SPMI clients from date of last contact. However, if a non-SPMI client receives only medication management services, the client will be discharged and the case closed no later than 180 days from date of last contact. Prior to discharge the CONTRACTOR agrees to demonstrate outreach attempts when a client fails to attend prescribed services. Substance Abuse Treatment providers are required to discharge a consumer no later than 30 days after the last contact with the case closed in UWITS no later than 60 days after the last contact with the consumer.

Concurrent Utilization Review: The CONTRACTOR agrees to comply with all the COUNTY Utilization Review (UR) policies and procedures and will document that participation as required in the client record (See Section B, Fiscal and Reporting Requirements, B 4 A).

Reporting Requirement: The CONTRACTOR agrees to comply with all Mental Health Event Data Set (MHE) reporting requirements in SAMHIS.

Further CONTRACTOR agrees to track outcomes systems data utilizing the OQ/YOQ and maintain a record of client OQ/YOQ scores within the EHR. OQ/YOQ will be given to clients at intake, every thirty days or every visit (whichever is less frequent), and at discharge. The instrument is to be completed by the client or by the parent/guardian for clients under the age of 12.

### **Mental Health Event Records (For consumers receiving MH services)**

Mental Health Event Records capture numerous unique data elements related to consumer 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 ProviderConnect. All Mental Health services must have a Mental Health Event Recorded completed in

ProviderConnect upon admission and every 90 days thereafter.

### **Treatment Episode Data Set (TEDS)**

TEDS data is collected on all consumers being treated for Substance Use Disorders through the UWITS system. All information must be completed monthly.

### **Quality Assessment & Performance Improvement (QAPI)**

The Quality Assessment & Performance Improvement (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.

### **Outcomes Questionnaire (OQ) and Youth Outcomes Questionnaire (YOQ)**

Mental health providers must complete the Outcomes Questionnaire and Youth Outcomes Questionnaire in compliance with state requirements: at onset of services, every 30 days thereafter, and at discharge.

The Utah Division of Substance Abuse and Mental Health (DSAMH) requires all providers serving Medicaid Members to utilize the OQ/YOQ outcome measures, as outlined in the Division Directives:

[http://dsamh.utah.gov/pdf/contracts\\_and\\_monitoring/Divison%20Directives\\_FY2015%20Final.pdf](http://dsamh.utah.gov/pdf/contracts_and_monitoring/Divison%20Directives_FY2015%20Final.pdf). These measures are required for all adults (OQ), and children age 6-17 (YOQ) who are in outpatient care.

Optum SLCo will send a Logon and Password to you upon completing New Provider Training. If you have questions please contact our QAPI Team at 877-370-8953.

### **Member Acknowledgment Form**

Consumers will initially receive the Member Handbook from the State of Utah. Providers should also offer new clients a Member Handbook as they seek services. Providers should have Members sign the Member Acknowledgement Form, which is posted to [www.optumhealthslco.com](http://www.optumhealthslco.com), indicating that the provider has offered them a Handbook and answered any questions they may have. This form should be maintained in the consumer's medical record. Each time a member seeks services at a new facility, a Member Handbook must be offered. In addition, even if a copy of the Handbook is declined, the Providers must discuss with the Member the following areas: Grievances, Client Rights, Transportation, Emergency Services and Choice of Therapist.

### **Business Hours and After Hours Admissions**

Optum SLCo Salt Lake County is open from 8 a.m. to 5 p.m. Monday through Friday excluding holidays and is available at 1 (877) 370- 8953. This number provides prompts for after-hours review of inpatient authorization requests. All other higher levels of care authorizations must be conducted during business hours with Optum SLCo Clinical Care Advocate.

## Claims Processing and Payment

You are responsible to determine the eligibility of a qualified beneficiary at the time service is rendered. You will also need to go through ProviderConnect to obtain authorization for all Medicaid benefits. 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.
- For facilities, when the contracted rates include Provider fees, the facility is responsible for payment of all rendering provider and for notifying the physicians that payment will be made by the facility and not by Optum SLCo.

### 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 SLCo.

If Optum SLCo is a secondary plan, you will be paid up to the Optum 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 SLCo.

### Co-Pays

Effective 01/01/2018, inpatient facilities will experience a \$75 reduction in the total cost of the inpatient stay. Inpatient facilities may then pursue a \$75 co-payment from the member. Billing the \$75 co-pay is at the discretion of the facilities.

### Claim Submissions

Use of electronic filing through ProviderConnect or an EDI clearinghouse is strongly recommended. All claims, including paper claims, must include the National Provider Identifier (NPI). **All claims, regardless of format and submission, must be submitted within 90 days of date of service. This does NOT apply to Retro Reviews or situations where Medicaid is the secondary payer. All other situations will be reviewed on a case by case basis.**

In cases of Retro Medicaid Eligibility, claims must be submitted within 90 days of the consumer receiving Retro Medicaid Eligibility. When Optum SLCo is the secondary payer, claims must be submitted on paper with a primary insurance EOB attached within one (1) year from the date of service.

**ProviderConnect:** Optum SLCo encourages you to submit claims using ProviderConnect to ensure all required claim elements are entered. This system checks for validity of data prior to submission, reducing errors. More information about ProviderConnect is available in the Resource section of this Handbook and also online at [www.optumhealthslco.com](http://www.optumhealthslco.com).

**EDI/Electronic Claims:** Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format, for example, data interchange between a Provider and a Payor. Please check with Optum

SLCo on the clearinghouse vendors approved by Optum SLCo to submit claims through this route. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. For Optum SLCo claims use Payor ID # HT006885-001. *Prior to sending any EDI claims*, or If you have any questions about how UHIN is used, please contact Network Services at [saltlakecounty.networkbox@optum.com](mailto:saltlakecounty.networkbox@optum.com) or call us at 1-877-370-8953 to ensure we have your provider information properly setup for this type of claims processing.

**Paper Claims:** Professional claims may be submitted using the CMS-1500 (or successor forms) and Facility claims may be filed using the UB-04 (or successor forms). In order for claims to be processed all required fields must be completed and accurate. Paper claims should be submitted to:

Optum SLCo Salt Lake County  
Claims Department  
P.O. Box 30761  
Salt Lake City, UT 84130-0761

Or Fax: 248-733-6373

### **Billing “No Shows”**

#### **The Utah Medicaid Provider Manual**

**(<http://health.utah.gov/medicaid/pdfs/SECTION1.pdf>) 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 **three conditions are met:**

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

### **Payment**

Provider payments are made every two weeks will not include a Provider Remittance Advice (PRA). Instead, you will access the PRA directly from your ProviderExpress located at [providerexpress.com](http://providerexpress.com).

### **Customer Service Claims Help**

To contact Claims Customer Service, call 1(877) 370-8953 and follow the prompts to access support..

### **Program Integrity (Fraud, Waste, and Abuse)**

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

### **Definitions**

**Abuse:** Provider practices that are inconsistent with sound fiscal, business, or medical

practices resulting in unnecessary Medicaid costs. Reimbursement for services that are not medically necessary, fail to meet professionally recognized standards of care, or any practice that results in increased costs to Medicaid are also considered abuse. Criminal intent need not be alleged or proved to establish abuse. See 42 C.F.R. § 455.2.

**Anti-Kickback Statute:** The Anti-Kickback Law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under Federal health care programs. The Anti-Kickback law is intended to ensure that referrals for healthcare services are based on medical need and not based on financial or other types of incentives to individuals or groups.

**Deficit Reduction Act of 2005 (DRA):** The Deficit Reduction Act of 2005 contains many provisions reforming Medicare and Medicaid which are aimed at reducing Medicaid fraud. Under Section 6032 of the DRA, every entity that receives at least five million dollars in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any contractor or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a contracted provider with Optum SLCo, you and your staff are subject to these provisions.

**Medicaid Fraud:** Knowingly, recklessly, or intentionally presenting false information to the Medicaid agency with the intent to receive some unauthorized Medicaid benefit for any person or entity. See Utah Code Ann. §§ 26-20-1, et seq.; Utah Administrative Rules, R414-22; and 42 C.F.R. § 455.2. Medicaid fraud violations may also be brought under more general state and federal theft and fraud statutes.

**Utah State False Claim Act: Utah Code, Title 26, Chapter 20, False Claims Act:** The law is designed as a mechanism to combat fraud and abuse in government health care programs. The law allows civil actions to recover damages and penalties when healthcare providers submit false claims. These laws often also permit qui tam suits, which are lawsuits brought by individuals, typically employees or former employees, of healthcare providers that submit false claims.

**Waste:** Generally means over-use of services, or other practices that result in unnecessary costs. In most cases, waste is not considered caused by reckless actions but rather the misuse of resources

**Whistleblowers:** Employees who come forward and disclose illegal activity (wrongdoing) in the workplace. [Utah Code, Title 67, Chapter 21](#), 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**

### **1. 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.

## **A. Prohibitions**

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.

## **B. Penalties**

A person or entity found to have violated the civil False Claims Act is subject to a civil money penalty of not less than \$5,500 and not more than \$11,000, plus three times the amount of damages the federal government sustained.

## **C. 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.

## **2. 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.

### 3. 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 that 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 SLCo website ([www.optumhealthslco@optum.com](mailto:www.optumhealthslco@optum.com)) to access the False Claims Act Provisions document under the Provider Tab.**

### False Claims Act Provisions:

1. All individuals involved in providing mental health care to Medicaid Members on behalf of Optum Salt Lake County (SLCo), 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.
2. All Staff shall not knowingly:
  - a. falsify, conceal or cover up a material fact;
  - b. make any false, fictitious or fraudulent statement or representation material to an obligation to pay or transmit money or property; or
  - c. 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.
3. All Staff shall not knowingly 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.
4. 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.
  - 4.1 If an overpayment is suspected, any Staff should immediately report the

suspected overpayment to Optum SLCo.

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

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

- a. "Double billing" – billing a payor multiple times for a single item or one-time service;
- b. Falsely certifying that a contract meets established requirements or guidelines;
- c. Conspiring with others to get a false claim paid;
- d. Claims resulting from an anti-kickback violation (See the Anti-Kickback Policy in Related Policies below);
- e. 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;
- f. Knowingly submitting claims for services ordered or provided by an excluded provider;
- g. 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;
- h. Knowingly charging for services not rendered or charging for more complex and costly procedures than those actually provided ("upcoding");
- i. Billing for brand-named drugs when generic drugs are actually provided;
- j. Submitting false or forged enrollment applications for a government funded program; or
- k. 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.

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

6.1 Staff should 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 can be made to Optum SLCo directly, the Salt Lake County Division of Behavioral Health Services, or the Utah Department of the OIG.

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

8. Staff may not retaliate against Employees, agents or contractors, who, in good faith, investigate, file, or participate in a whistleblower action.

9. Optum SLCo requires that all providers, and their Employees, who participate in administration of Medicaid mental 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 SLCo also requires that its subcontractors distribute this information to their Employees to educate them on the federal and state statutes.

10. All Staff shall receive the information set forth in this document.

### **WHAT DO I DO IF I SUSPECT FWA?**

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

#### **Contact:**

- Optum SLCo at 1.877.370.8953, ask for the Compliance Manager or email, [connie.mendez@optum.com](mailto:connie.mendez@optum.com) Your call may be anonymous and even if you give your name, your information will be kept confidential.
- Salt Lake County Behavioral Health Services-Brian Currie, LCSW at [BCurrie@slco.org](mailto:BCurrie@slco.org)
- Bureau of Managed Health Care in the Division of Medicaid and Health Financing-Karen Ford at [kford@utah.gov](mailto:kford@utah.gov)
- Utah Program Integrity at 1.855.403.7283 or by going to: <http://www.oig.utah.gov/reportfraud.html>

**When reporting the information, please include the following:**

- Name and identification number of the suspected individual;
- Source of complaint (if anonymous, indicate as such);
- Type of Provider or staff position, if applicable
- Nature of complaint; and
- Approximate dollars involved, if applicable

## **Consumer Appeals and Grievances**

### **Definitions**

**Action:** Any of the following:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial in whole or in part, of payment for a 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 Optum SLCo's limitations and the member is dissatisfied with this. It is the provider's responsibility to send out an NOA if the provider fails to provide the service in a timely manner. or
- The failure of Optum SLCo to act within the time frames established for resolution and notification of appeals and grievances.

**Appeal:** a request for review by the County of an action/adverse benefit determination made by Optum SLCo.

**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 grievance.

**Grievance:** An expression of dissatisfaction about any matter other than an action/adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of providers, staff, etc., failure to respect the Member's rights, denial of a request for expedited resolution of an appeal, or extension of time frame for making standard authorization decisions.

**Grievance System:** An overall system that includes a grievance process, appeal process, and access to the State's fair hearing system.

**Medically Necessary:** Any mental health service that is necessary to diagnose, correct or ameliorate a mental illness or condition, or prevent deterioration of that mental illness or condition or development of additional health problems and there is no other equally effective course of treatment available or suitable that is more conservative or substantially less costly.

**Notice of Action:** Written notification to a member and provider, of an action/adverse benefit determination that will be taken by Optum SLCo.

**Notice of Appeal Resolution:** Written notification to a member and a provider when applicable of the County's resolution of an appeal.

## Consumer Appeals

Optum SLCo has developed its Appeals and Grievances processes to comply with all relevant requirements for the Salt Lake County programs and to ensure satisfaction, safety, and respect for consumer 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.

The Salt Lake County Division of Behavioral Health Services (SLCo BHS) oversees the Consumer Appeal process and provides information regarding the bases for their appeal decisions. The appeal processes are conducted in a manner that does not give deference to the prior action. Optum SLCo supports the SLCo BHS in its resolution of the appeal, including any and all aspects of clinical care involved. Optum SLCo does not take punitive action against a consumer or a Provider who requests an appeal or a fair hearing.

### Consumer Appeals Process

An appeal is a request for review by the County of an action taken by Optum SLCo. An appeal may be made by a consumer, a consumer's authorized representative, or a provider. Providers acting on behalf of a consumer must include a copy of the written consumer consent, when requesting the appeal. Review of an action or authorization of requested services may include the type or level of service, the reduction, suspension, or termination of a previously authorized service, the denial, in whole or in part, of payment for a service, or the failure to provide services or a determinations in a timely manner constitutes and action.

## Requesting a Consumer Appeal

Appeals must be requested within 60 calendar days from the date of Optum's initial Notice of Action letter. The consumer's copy of the Notice of Action will include an appeal form and an explanation of the appeal process.

An appeal may be submitted to SLCo BHS either orally or in writing. An oral appeal must be followed by a written confirmation of the appeal, within 5 business days of the oral appeal unless an expedited resolution to the appeal is requested. An oral request for an expedited resolution does not require a follow-up written request. Optum SLCo or the SLCo BHS will assist consumers or providers as needed to file the written appeal. The SLCo BHS will acknowledge receipt of the appeal either orally or in writing and explain the process that will be followed to resolve the appeal.

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

- Within ten (10) days of the Notice of Action; or
- The intended effective date of the proposed action.

## Appeal Timeframes for County Resolution

There are two categories of appeals, below outlines timeframes for resolving each type.

**Non-Expedited:** The SLCo BHS will resolve a non-expedited appeal, and provide notice to the affected parties no later than thirty (30) calendar days from the day the SLCo BHS receives the appeal.

**Expedited:** The SLCo BHS will resolve an expedited appeal and provide notice to the affected parties no later than three 72 hours after the SLCo BHS receives the expedited appeal request.

The SLCo BHS may extend the time frame for making a decision on an 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. SLCo BHS will notify the affected parties in writing of any extension initiated by them.

If the SLCo BHS does not resolve an appeal within the required time frame, this constitutes an action. The SLCo BHS will give the consumer a Notice of Action letter at the time the SLCo BHS determines the required time frame was not be met. The SLCo BHS will provide Optum SLCo with a copy of the Notice of Action. The consumer and/or provider does not need to go through the SLCo BHS appeal process again; instead they may now request a State Fair Hearing.

Optum SLCo supports the SLCo BHS in its resolution of the appeal including providing any documents to be considered during the appeals process, subject to HIPAA and Utah confidentiality requirements. The SLCo BHS will provide the consumer, consumer'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 consumer or consumer's provider requests expedited handling of the appeal and the SLCo BHS denies the request, the SLCo BHS will:

- Transfer the appeal to the non-expedited or standard time frame of no longer than 30 calendar days from the day the SLCo BHS 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.

### Consumer Fair Hearings

Only Medicaid recipients have the right to request a fair hearing with the Utah Department of Health regarding an action taken by Optum SLCo. A fair hearing may be pursued by the consumer, an authorized representative, or a provider acting on behalf of the consumer.

Affected Parties are notified of their rights and timelines related to a fair hearing by the SLCo BHS in accordance with requirements. A fair hearing may be requested when the Consumer Appeal process has been exhausted and the decision was not wholly in favor of the consumer or provider, or when the Salt Lake County Division of Behavioral Services 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 SLCo BHS' Notice of Appeal Resolution. In the event that the consumer wants to continue benefits pending the outcome of a fair hearing, when a *previously authorized* course of treatment has been terminated, suspended or reduced, the services were ordered by an authorized provider, and the original period covered by the original authorization has not expired, the request for a fair hearing and continuation of benefits must be submitted within ten (10) calendar days after the SLCo BHS mails the Notice of Appeal Resolution.

The Utah Department of Health will reach its decision within ninety (90) calendar days from the date the consumer/provider filed the appeal with the SLCo BHS, not including the days the consumer/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 SLCo BHS expedited appeals time frame or was not resolved wholly in favor of the consumer/provider, the Utah Department of Health will reach its decision within three (3) business days from the date it receives from Optum SLCo and the SLCo BHS all needed information, including information from the member's medical record.

The Utah Department of Health 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 SLCo or the SLCo BHS will assist consumers/providers with required forms as needed to file the request for a fair hearing.

## GRIEVANCES

A grievance is any expression of dissatisfaction with Optum SLCo or its Providers or with the care or services provided by Optum SLCo or its Providers. Grievances do not apply to actions/adverse benefit determinations which are subject to the appeals process such as a utilization management or payment decision. Appeals are handled through the SLCo BHS appeals process.

Any consumer or authorized representative acting on behalf of the consumer can file a grievance. A representative, including a Provider acting as a representative of the consumer, must receive written permission from the consumer to act as representative. Grievances are typically reported directly to Optum SLCo but may also be filed with the Utah Department of Health, the Utah Medical Assistance Program or the SLCo BHS. In this event, the SLCo BHS will apprise the grievant how to file with Optum SLCo or, if preferred will notify Optum SLCo and the grievance which will be considered an oral grievance. Optum SLCo verbally acknowledges receipt of an oral grievance at the time the grievance is received and by letter when the grievance is received in writing.

Optum SLCo will process each grievance and provide notice to the complainant within 45 calendar days from the day Optum SLCo receives the grievance. Optum SLCo may extend the time frame for making a decision on a grievance 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 SLCo will notify the complainant in writing of any extension initiated by Optum SLCo.

Optum SLCo will notify the affected parties of the disposition of the grievance either orally or in writing.

In the event that the grievance is first filed with the Utah Department of Health, the Utah Medical Assistance Program or the SLCo BHS, Optum SLCo will also notify the SLCo BHS of the disposition orally or in writing.

For Grievances 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 consumer. In this case, Optum SLCo will advise the person filing the grievance that the matter is being investigated and addressed, but will not be able to report ultimate outcome of that review.

### Contact Information

#### Appeals can be filed by:

**Phone:** 385-468-4707 **Fax:** 385-468-4740

**Mail:** Salt Lake County Division of Behavioral Health Services

**Attn:** Mental Health Quality Assurance Manager

P.O. Box 144575

2100 South State Street Suite S2300

Salt Lake City, UT 84114-4575

**TTY:** Dial 711 (Relay Utah), provide the operator with the County number you are calling

## Grievances can be filed by:

**Phone:** 1-877-370-8953 **Fax:** 1-855-718-6743

**Mail:** Optum SLCo

**Attn:** Grievance Coordinator

2525 Lake Park Blvd

West Valley City, UT 84120

**TTY:** Dial 711 (Relay Utah), provide the operator with the number you are calling

## Provider Disputes and Retro Reviews

### Provider Disputes

A **Practitioner/Facility Dispute** is defined as a timely request by a practitioner or facility, or appropriate representative, *acting on their own behalf* and NOT on behalf of a consumer, for a review of a non-coverage determination.

You have a right to request a dispute review of any decision not to provide you payment for a service (in whole or in part).

Practitioners and facilities acting on their own behalf are defined as those who dispute a non-coverage determination when the service has already been provided to the consumer and there is NO consumer financial liability.

A practitioner/facility dispute request must include a *clearly expressed* desire for reconsideration of a non-coverage determination, with an indication as to why the non-coverage determination is believed to have been issued incorrectly, and that Optum SLCo is able to investigate.

Practitioner/facility dispute requests must be filed within 180 days from the date of Optum's initial non-coverage determination Notice.

Practitioner/facility dispute requests must be submitted in writing.

Practitioner/facility dispute requests must contain the minimum necessary information to process the request.

Optum does not consider correspondence to be a practitioner/facility dispute request until the minimum necessary information related to the request is received from the practitioner, facility or appropriate representative.

Minimum necessary information includes:

- i. Each applicable date of service;
- ii. Consumer identifying information;
- iii. Practitioner/facility identifying information;
- iv. The dollar amount in dispute, if applicable;
- v. The practitioner's or facility's explanation of the nature of the dispute; and
- vi. Supporting documentation, if applicable.

Provider Dispute requests must also include the contact information of the requestor (name, address, email address, telephone number).

In the event that Optum does not receive the minimum necessary information to process the correspondence received from the practitioner or facility, a written notice is sent to the practitioner or facility within 30 calendar days of receipt that contains the following information:

- i. A description of the information needed; and
- ii. A statement that failure to provide the requested information within 45 calendar days of receipt will result in Optum making a coverage determination with the documentation/information that we already have.

### Contact Information

Provider Disputes should be submitted to:

Optum SLCo Reviews Department / 2SE-07-132  
2525 Lake Park Blvd  
West Valley City, UT 84120

Or via Fax to: 855-718-6743

Or via email to: [slcoreviews@optum.com](mailto:slcoreviews@optum.com)

**What happens next?** If you request a dispute review, a review will be conducted by someone who was not involved in making the initial non-coverage determination/denial, and who is not a subordinate to the person who made the initial non-coverage determination/denial.

Optum SLCo makes the practitioner/facility dispute determination and notifies the practitioner or facility in writing within 30 calendar days of receipt of the complete dispute review request.

### Arbitration

Practitioners and facilities may seek arbitration to address disputes not resolved after completion of the formal practitioner/facility dispute process, as described in the practitioner's or facility's contract with Optum SLCo and/or applicable state law.

### Retrospective Reviews

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

Optum SLCo **requires prior authorization** of behavioral health services and does not routinely conduct retrospective reviews. Exceptions may be made when there are extenuating circumstances such as when:

- A member was **unable** to provide insurance information in an emergency situation.
- The member's Medicaid eligibility is retrospectively activated after covered services have been delivered.

- In cases where Optum is the secondary payor to another insurance plan.

**Retrospective authorization will ONLY be considered if at least one of the above circumstances exists.**

Requests for retrospective 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 attending physician (if applicable)
- Information about any extenuating circumstances that may have 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 age and gender and any relevant bio-psychosocial history and current family involvement;
- The history of treatment;
- The treatment plan

**What happens next?** Optum SLCo makes a coverage determination and notifies the practitioner/facility, attending physician (when applicable), and member in writing within 30 calendar days of receipt of the complete retro review request.

## **Handbook Updates and Governing Law**

### **Manual and Handbook Updates**

This handbook is updated periodically as procedures are modified and enhanced. You will be notified a minimum of 30 calendar days prior to any material change to the manual or handbook unless otherwise required by regulatory or accreditation bodies. The current version of the handbook is always available at [www.optumhealthslco.com](http://www.optumhealthslco.com) or you may request a paper copy by contacting your Network Services representative.

### **Governing Law and Contract**

This handbook 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 Handbook differs 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.