



Optum Provider Network Training

May 21, 23 2013



DOCUMENTATION



Optum Provider Manual

www.optumhealthslco.com

Utah Medicaid Provider Manual

<http://health.utah.gov/medicaid/index.html>

ASSESSMENT-Reminders

- Assessments are to be:
 - strength-based and client driven
 - updated at least annually and include a summary of prior year Outcome Questionnaire/Youth Outcome Questionnaire (OQ/YOQ) scores and clinical analysis.
 - establish Medical Necessity

TREATMENT PLAN-Reminders

- All clients must have a treatment plan!
- Treatment Plans are to be:
 - Individualized and strength based focused
 - must incorporate the following: diagnosis, individual goals, OQ Measures and medical necessity.
 - ****NEW:** An individual identified.....is responsible to conduct reassessments/treatment plan reviews with the client as clinically indicated to ensure the client's treatment plan is current and accurately reflects the client's rehabilitative goals and needed mental health services. ***Utah Medicaid Provider Manual- Rehabilitative Mental Health and Substance Use Disorder Services (pg. 10)***

PROGRESS NOTES-Reminders

- Progress Notes are evidence of a Provider's services to or on behalf of a client and relate to the client's progress in treatment.
 - Progress Notes must clearly relate to the treatment plan objectives and goals of the client as established in the Treatment Plan.
 - Include the duration of a service
 - Justify the length of service through the content of the note

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PROGRESS NOTE-Cont'd

- Each Progress Notes must “stand on its own” regarding Medical Necessity; identifying a clear link to the Plan helps meet this requirement. This can be accomplished with an opening statement.

-For example: Met with Connie for an Individual session. The goal/objective focus of today’s session included _____

-Another example: The purpose of today’s Session was to review Connie’s progress on her objective of documenting her triggers prior to self-harming.



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RECENT PROGRESS NOTE ISSUES

- The progress note indicates a service was provided while the client was in a setting (i.e. inpatient or jail) where s/he was ineligible for outpatient services due to a lock out period.
- A service provided that is not a part of the identified service
- The progress note contains personal opinions
- Focus of the note is almost exclusively on the client's responses rather than the Interventions provided.



Traditional v Non-Traditional Medicaid



What is Non-Traditional Medicaid?

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

Mental Health benefits for this plan include

**30 service days of inpatient per calendar year and
30 service days of outpatient per calendar year**

As a Provider, you are responsible to work closely with your client, inquiring if the client has or is currently receiving services from other providers within the current calendar year and to track the number of service days left available. If you are providing services to a client who has Non-Traditional Medicaid, please contact Optum to confirm the number of service days already used within the calendar year. If an enrollee has not exhausted the available inpatient days, these service days may be converted to outpatient service days if clinically appropriate.

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Program Integrity

The Big 3-False Claims Act, FWA, Prohibited Affiliations



The False Claims Act ("FCA") provides, in pertinent part, that:

- (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

What is Fraud, Waste and Abuse (FWA)?

Fraud

Intentional misrepresentation to gain a benefit

Waste

Any unnecessary consumption of health care resources

Abuse

Unsound business practice that results in undue remuneration

- Federal Health Care Fraud and Abuse Control Program (HCFAC) won judgments or negotiated settlements of nearly \$4.1 billion.
- 743 defendants convicted for healthcare fraud-related crimes
- Federal prosecutors had 1,873 health care fraud criminal investigations pending, involving 3,118 potential defendants, and filed criminal charges in 489 case involving 1,430 defendants.
- Since, 1997, HCFAC has recovered \$20.7 billion dollars.

Source: HCFAC Annual Report for FY2011 (Feb 2012)

Prohibited Affiliations

- **§ 438.610 Prohibited affiliations with individuals debarred by Federal agencies.**
- (a) *General requirement.* An MCO, PCCM, PIHP, or PAHP may not knowingly have a relationship of the type described in paragraph (b) of this section with the following:
 - (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
 - (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

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Program Integrity

False Claims Act

- If part of an agency, develop policies that include detailed information about the False Claims Act. If not part of an agency, it is still your obligation to develop a written rule about the Act and how it may impact you.
- Include Whistleblower Protections

Fraud, Waste, and Abuse

- Be familiar with documentation requirement and appropriate billing practices
- Provide ongoing trainings and education regarding all aspects of FWA
- If suspect FWA practices, please report it. Optum, Salt Lake County

Prohibited Affiliations

- Monthly, complete searches on two web-sites, System for Award Management (SAM) and List of Excluded Individuals/Entities (LEIE) Search includes all employees who “touch” or have an impact on Medicaid..
- If a name comes up, review the name at the next level which requires using the individual’s SSN.
- After completed searches, send an Attestation to Optum Compliance Manager reviewing the results of the searches.

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COMPLIANCE PROGRAM

- Under Health Reform Law:
 - As a condition of enrollment in Medicare, Medicaid, and CHIP, providers must establish a compliance program.
 - Core components of compliance program to be established by the Secretary of HHS in consultation with the OIG.
 - Will be specific to particular industry or category of supplier or provider.
 - Effective after HHS issues regulations.

90 day timely filing

- All “clean” claims must be submitted within 90 days from date of service.
- Claims that do not fall into the above category will also be reviewed: i.e. retro eligibility, TPL, actively working denials with our IT or claims team, special circumstances recognized prior to billing.
- Additionally, we will also review claims submitted more than 90 days late if two components are present:
 - Claims are submitted on a HCFA 1500
 - A letter accompanies the claims indicating the reason for the late submission.
 - The claims will then be reviewed and you will be informed if payment will occur or the reason for the denial.



Thank You.

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