



## OPTUM Salt Lake County

Quality Assurance & Performance Improvement Bulletin

November 2018

Dear Providers,

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

-The Optum Salt Lake County QAPI Team

---

### **Administrative Updates**

#### **Timely Access Documentation**

In addition to submitting Timely Access data to Optum SLCo on a monthly basis, providers are required to have a standardized method for tracking timely access information for each client. During monitoring visits, providers must be able to demonstrate, for a given client, whether timely access was offered and met. The date of the initial contact must be documented. When the circumstances are deemed emergent, it is also necessary to document the time of the initial contact, since timely access is measured by minutes. The time between the date of the initial contact and the date of the initial assessment will be used to measure whether Timely Access was met. Therefore, many providers choose to document the initial contact in the clinical record in a demographics section or on the intake paperwork. Others choose to add it to the actual mental health assessment information. Other providers maintain a log of initial contacts and are able to produce the information for specific members when requested. Providers may choose the standardized method for tracking timely access which works best for their practice.

#### **Fee agreement Language and Non-Covered Services**

Per Utah Medicaid regulations and your contract with Optum Salt Lake County, consumers may not be billed or balance billed for Medicaid covered services. Effective immediately, signed fee agreements between a provider and members eligible for Salt Lake County Medicaid must include the following statement:

***Optum Salt Lake County Medicaid members do not have to pay for covered services received when they have Medicaid.***

In addition, a provider may bill members for a non-covered service when all of the following are met:

1. The provider has a policy for billing all patients for services not covered by a third party, not just Medicaid members;
2. The provider has informed the member of this policy;
3. The provider has advised the member they will be responsible for payment, before delivering the service;
4. The provider has a written agreement with the member with the expectation for payment which includes the details of the service and the cost to the member.

## **Member Handbook and Member Acknowledgement Form**

Consumers will initially receive the Member Handbook from the State of Utah when they become eligible for Optum Salt Lake County Medicaid. In addition, providers are required to offer new clients a Member Handbook as they seek services. As part of this process, providers are encouraged to have the client sign the Member Acknowledgement Form, indicating the provider has offered the Handbook and answered any questions. This form is available at [www.optumhealthslco.com](http://www.optumhealthslco.com) and should be saved in the client's medical record once completed.

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

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

## **Client Rights Poster**

The Client Rights poster has had a minor update (English and Spanish). Please access the newly updated versions at: <https://www.optumhealthslco.com/content/ops-optslcty/salt-lake-county/en/provider-county-staff.html>. Please print the latest version(s) and replace those currently posted in your lobby/office.

## **Eligibility Lookup Options**

Consumer eligibility must be verified and recorded on a monthly basis. Providers should have a standardized method for tracking eligibility that can be demonstrated during monitoring visits. There are two ways to check eligibility for Optum Medicaid consumers.

### Monthly Authorization Report

By the 5<sup>th</sup> of each month, Optum SLCo sends an Authorization Report to each contracted provider, which includes all authorizations extended into that month. If an authorization was not extended, the reason is indicated. It is then the responsibility of the provider to follow-up with the member to discuss their eligibility and on-going treatment. Optum SLCo is authorized to reimburse providers only when services are rendered when a consumer is eligible for Optum Salt Lake County Medicaid.

### Eligibility Lookup Tool

Access to the Eligibility Lookup Tool can be found at: <https://medicaid.utah.gov/eligibility>

This link takes you to a page that explains how to access the Medicaid Eligibility Lookup Tool. You must have a Utah-ID account to gain access. If you are certified with Medicaid, you should have a Utah-ID (or instructions for accessing it). If you do not have a Utah-ID, or if you are not sure, please contact the Utah Department of Health Medicaid Information Line at 801-538-6155 (select option 3, then option 4).

To access the tool, click on the link near the bottom of the page titled Eligibility Lookup Tool. After this, you will be prompted to enter your Utah-ID. Once you have successfully logged in, you will be directed to the tool (see below). There are instructions at the top of that page, which explain the information required to access eligibility status.

## Eligibility Lookup Tool

Provider ID *	<input type="text"/>	(NPI/Atypical Provider ID)
Unique Identifiers		Demographics
Member ID	<input type="text"/>	First Name <input type="text"/>
SSN	<input type="text"/>	Last Name <input type="text"/>
Date of Service *	<input type="text"/>	Date of Birth <input type="text"/> (mm/dd/yyyy)
Eligibility inquiries are limited to 36 months from the current date.		
If you need additional assistance, please contact Customer Service at 1 (800) 662-9651 OR (801) 538-6155.		<input type="button" value="Submit"/> <input type="button" value="Clear"/>

Tip: If you are treating a member who loses Optum Salt Lake County Medicaid eligibility, you may support the individual in contacting their worker through the Division of Workforce Services. You may also contact Take Care Utah with the Utah Health Policy Project and request help from an “assistor” who can access the consumer’s Medicaid record and research the case. They may also be able to help with the steps necessary to reinstate the member’s eligibility, if possible.

Take Care Utah: 801-433-2299

### Eligibility for 1915 (b)(3) Services

Consumers must meet specific criteria to be eligible for these services, and providers must document the criteria in the clinical record to justify the service.

1915(b)(3) services include:

- Personal Services (H0046)
- Psychoeducational Services (H2027)
- Respite Services (S5150)
- Supportive Living (H2016)

Per the Utah Medicaid Handbook, the criteria for these services are listed below.

1. Only PMHP enrollees with Traditional Medicaid are eligible for these services. They are not a benefit for enrollees age 19 or older with Non-Traditional Medicaid.
2. Consumers who receive the PMHP for inpatient psychiatric care only, are excluded (i.e. foster care/K code Medicaid, children with the adoption subsidy.)
3. Consumers must be receiving mental health services. They are excluded if receiving treatment for substance use disorders only.
4. The consumer must meet SPMI/SMI or SED criteria at the time the services are rendered.
5. The services must be medically necessary and documented as such in the clinical record.
6. The services must be prescribed through the treatment plan.

*Special Note: If you have been seeing a consumer with a different payment source, who later becomes eligible for Optum Salt Lake County Medicaid, you must cover all the administrative components as you would with a new consumer.*

### Updates to July Training Materials

Please see the attached training materials with updates for the C-SSRS and safety planning, as well as suggestions for using the database searches for LEIE/SAM exclusions.

## Clinical Updates

### **Treatment Plan Reviews**

Per the Optum SLCo Provider Handbook, treatment plan reviews are to be conducted by a licensed mental health therapist (LMHT) in an individual, face-to-face interview with the client to review medical necessity, appropriateness of treatment interventions, and progress on the treatment plan. Reviews must be documented in the clinical record, to include the signature, date and credentials of the individual rendering the service.

Rather than conducting treatment plan reviews in specified time intervals, plans should be updated whenever the consumer has achieved a goal or objective, or when there is a change in priorities. At a minimum, treatment plan reviews must be conducted for clients receiving mental health services every three months for non-SPMI clients with completion during the calendar month in which it is due, and every six months for all clients with severe and persistent mental illness (SPMI). For those receiving substance use specific treatment, continuing stay/treatment plan reviews are required on the following schedule, based on ASAM level of care.

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

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

### **Consumer Outreach Documentation**

Gaps in service of any duration, such as sickness, vacation, incarceration, no shows and cancellations should be documented in the clinical record. In an electronic health record, this is often entered as a "Miscellaneous Note" or included in a contact notes section of the record.

When a consumer fails to attend prescribed services, providers are required to make multiple outreach attempts and document these efforts in the clinical record before proceeding with discharge.

### **Discharge Documentation**

At the time of discharge, a summary must be entered into the clinical record that includes the current diagnosis, the extent to which the treatment goals were achieved, a summary of services provided the reason for discharge or referral, and additional resources and/or recommendations for additional services. Discharges must be completed based on the following criteria:

SPMI/SMI/SED Criteria Met	Duration From Last Service
No	90 days
No and receives medication management only	180 days
Yes	180 days

Providers who offer substance specific treatment are required to discharge a consumer, no later than 30 days after the last face-to-face contact with the consumer. The case must be closed in UWITS, no later than 60 days after the last face-to-face contact.

The Mental Health Event Record should be updated at discharge for all consumers who receive mental health services. In addition, a final OQ/Y-OQ® is required to be administered at discharge.