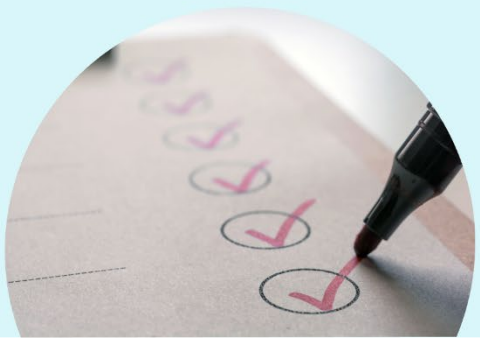

QAPI Bulletin

November 2024

Please review the following information which includes updates based on the most recent Salt Lake County audit results.

An attestation you have read and agree to implement these changes is required. After reading, please email your attestation to slcoquality@optum.com.

Please note:

- The Utah Medicaid Rehabilitative Mental Health and Substance Use Disorder Services manual has been renamed to the Behavioral Health Services manual. Provider are encouraged to review the Behavioral Health Services provider manual available at the Medicaid website.
- The Division of Integrated Healthcare issues a bimonthly Medicaid Information Bulletin important information for Medicaid providers. If you are not already subscribed, please consider doing so. Medicaid Information Bulletin

Timely access

Timely access information should be recorded in Provider Connect NX™ (PCNX™). In addition, providers are required to have a standardized method for tracking timely access AND they must document the following in members' clinical records:

- The date of initial contact.
- The level of urgency (emergent in-person or emergent by phone, urgent, non-urgent).
- The date/time of first appointment offered.
- Whether or not the member accepted that first appointment offered and if not, why.
- Whether or not the first appointment offered met the timely access standard and if not, why.

This information is expected to be documented any time a new member requests services AND any time a member requests a service after they have previously been discharged from care (i.e. a new episode of care).

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

Monthly eligibility checks submissions

Providers are responsible to determine the eligibility of a qualified beneficiary prior to services being rendered for all levels of care or specialty services. 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 Optum SLCo members. In the case of higher levels of care, when prior authorization has been obtained.

Providers are also responsible to verify Medicaid eligibility monthly and maintain evidence of this verification when members receive on-going treatment. This evidence should include a screenshot of the verified eligibility from the Medicaid Eligibility Lookup Tool for each member. Please have this information accessible and be prepared to provide this documentation when requested.

Providers who are unable to provide evidence of monthly eligibility checks will be asked to submit a corrective action plan to explain how they will implement this process into their practice.

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

Fee agreement language to be updated

Per the Utah Medicaid regulations and your contract with Optum, members may not be billed, or balance billed for Medicaid Covered Services. Signed fee agreements between a provider and members eligible for Optum Salt Lake County Medicaid must include the following statement:

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

Providers whose current fee agreement does not include the required language indicated above must update their form immediately.

Documentation requirements

Outreach documentation in the medical record

Gaps in service such as sickness, vacation, incarceration, home visits, no shows and cancellations are expected to be documented in the clinical record. If using UWITS, please enter as a “Miscellaneous Note”.

When members have unexpected gaps in service, documentation explaining the circumstances of each case (e.g., illness, scheduling conflicts, transportation or childcare-related barriers, etc.) and outreach efforts should be documented in the clinical record. If gaps in service persist, evidence of outreach to re-engage the member shall be documented in the clinical record.

Group services

Per the Utah Medicaid Behavioral Health Services Manual and the Optum Provider Manual for Medicaid services, documentation for group services should contain the following information for each member:

1. The date, start and stop time, and duration of the service.
2. The setting in which the service was rendered (for telehealth this includes the provider’s setting with a notation the service was telehealth).
3. The specific service rendered.
4. A per session clinical note that documents:
    a. the focus of the group psychotherapy session and
    b. treatment goal(s) addressed in the session and
    c. progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers, or
    d. support of the ongoing clinical need and the level of care provided
5. The signature and licensure or credentials of the individual who rendered the service. If a co-provider is present for the group psychotherapy session, the note must contain the co-provider’s name and licensure or credentials.
6. The staff to member ratio. Utah Medicaid defines the allowable ratios based on type of group. Please see the Utah Medicaid Behavioral Health Services Manual for these ratios. The clinical documentation for the group shall include the number of group members present.

If you have any questions regarding these documentation standards, please visit the Utah Medicaid Behavioral Health Services Manual at Utah Medicaid Official Publications or contact the QAPI Department at slcoquality@optum.com.

Suspected or reported abuse

Providers are expected to follow state and federal laws governing the reporting of potential or suspected child (Utah Code 80-2-602) or elder (Utah Code 62A-3-305) neglect/abuse as well those governing the duty to warn. If you are faced with a potential need to report to state protection agencies or to warn a potential victim but are uncertain about your obligations, it is incumbent upon you to seek appropriate and immediate clinical and/or legal counsel.

In addition, information regarding reports to the appropriate authorities must be documented in the clinical record. Documentation should include:

1. Date and time information was received
2. Date, time of report to CPS, APS and/or law enforcement.
3. Name of the individual who took the report
4. Case number if the report was accepted or disposition of the case if not accepted.

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

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

Please use the following numbers for reporting suspected abuse:
Child and Family Services
1-855-323-DCFS(3237)

Adult Protective Services
1-800-371-7897