Optum

January **2024**

Optum Idaho

Provider Manual

optumidaho.com

Optum Idaho Provider Services: **1-855-202-0983**

Table of Contents

Table of Contents *(continued)*

Table of Contents *(continued)*

Table of Contents *(continued)*

Table of Contents *(continued)*

Table of Contents *(continued)*

Table of Contents *(continued)*

Table of Contents *(continued)*

Table of Contents *(continued)*

Section **1**

Welcome to Optum

1.1 Introduction

Thank you for becoming a part of our network. We are happy to welcome you and have you as a partner. Optum is dedicated to helping people live healthier lives and making the health system work better for everyone. We connect people to an extensive network of QUALITY providers and offer innovative tools that help members access care, at the right time, in the setting of their choice. Our focus is on driving better overall health outcomes for members while making the care they receive more affordable, improving the provider experience and generating insights that drive high-impact, integrated behavioral health services.

We encourage you to utilize our industry-leading website, ***Provider Express*** where you will find access to resources, relevant news, and can conduct a variety of secure transactions at your preferred time and pace. We continuously expand our online functionality to better support your day-to-day operations, so be sure to check back regularly for updates.

Please take time to familiarize yourself with all aspects of the Provider Manual. We've included an easy reference Resource Guide and FAQs to help get you started.

Optum is confident that together we can tackle the challenges facing the behavioral health industry and bring greater precision, speed and ease to how people obtain behavioral health services. Your voice is important, and we encourage you to reach out with feedback, ideas or questions. We'd love to hear from you.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

1.2 About United Behavioral Health and Optum

United Behavioral Health (UBH) was officially formed on February 2, 1997, via the merger of U.S. Behavioral Health, Inc. (USBH) and United Behavioral Systems, Inc. (UBS). Our company is a wholly owned subsidiary of UnitedHealth Group. We have been operating under the brand Optum since 2012.

We are one of the nation's largest accredited managed behavioral health care organizations, supported by an extensive behavioral provider network of more than 210,000 practitioners. We offer a comprehensive array of innovative and effective behavioral health care programs, as well as tools and additional support that inspire people to be invested in their own wellness.

Today, our customers include small businesses, Fortune 100 companies, school districts, health plans, and disability carriers. Optum Behavioral Health provides coverage/services for approximately 37 million members.

Optum

All of us at Optum are dedicated to helping people live healthier lives and helping make the health system work better for everyone. Optum is a health services innovation company pushing the boundaries of what health care can be. People are at the center of everything we do. We are focused on giving everyone great experiences, lower costs and the best possible results. We do this by connecting people, technology, clinical insights, data and analytics to find a smarter way for every person to live their healthiest life.

By connecting people, clinical insights, data and technology we can make whole person care a reality and enable business breakthroughs that lower costs. We help deliver bold new health experiences to drive better outcomes and empower all to live their healthiest life.

Optum supports population health management solutions that address the physical, mental and financial needs of organizations and individuals. We provide health information and services to over 127 million consumers, including military, Veterans, Medicare and Medicaid beneficiaries—educating them about their symptoms, conditions and treatments; helping them to navigate the system, finance their health care needs and stay on track with their health goals.

We serve people throughout the entire health system allowing us to bring a uniquely broad, yet experienced, perspective. We have the ability and scale to help our clients both envision and implement new approaches that drive meaningful, enduring and positive change.

Optum delivers simple, effective and comprehensive solutions to organizations and consumers across the whole health system through our three business units: OptumHealth, OptumInsight and OptumRx®.

Optum Idaho

Effective September 1, 2013, Optum Idaho manages outpatient mental health and substance use disorder services, hereby referred to as behavioral health services, to help adults and children enrolled in Idaho Medicaid access the most effective treatment for their needs.

Optum Idaho is working closely with the state of Idaho, consumers, family members, providers and community stakeholders to develop, implement and maintain a utilization management program for the Idaho Behavioral Health Plan (IBHP) to monitor the appropriate utilization of covered services and to:

- Simplify the administrative processes for providers, enabling them to devote more staff time to treating members
- Encourage members to access services at the time they first recognize symptoms in themselves or in a family
- Ensure that all services provided are medically necessary, are focused on measurable outcomes, and are supporting the member's recovery and/or the family's resiliency

Our focus is on improving access to treatment, expanding the array of covered service, enhancing quality of care and improving treatment outcomes. Our goal is to enhance the statewide behavioral health system and make it easier for people to access care.

In addition to adding more behavioral health care providers and new community-based programs, wherever possible, Optum is increasing services available in rural areas to ensure that people throughout Idaho are able to get the care they need close to home.

Optum is committed to recovery, resiliency and person-centered care. This includes assisting and supporting people in learning to manage their behavioral health and wellness challenges. Our practices are anchored in the belief that people with mental illness are able to live, work and participate productively in their communities despite their behavioral health challenges, and are resilient and able to rebound from trauma, stigma and other stresses.

We look forward to an active partnership as we all work together to improve the lives of consumers in Idaho.

Mission

Our Mission is helping people live healthier lives and helping make the health system work better for everyone.

Core Values

Integrity – We adhere to the highest forms and standards of ethical behavior, including making honest commitments and consistently honoring those commitments.

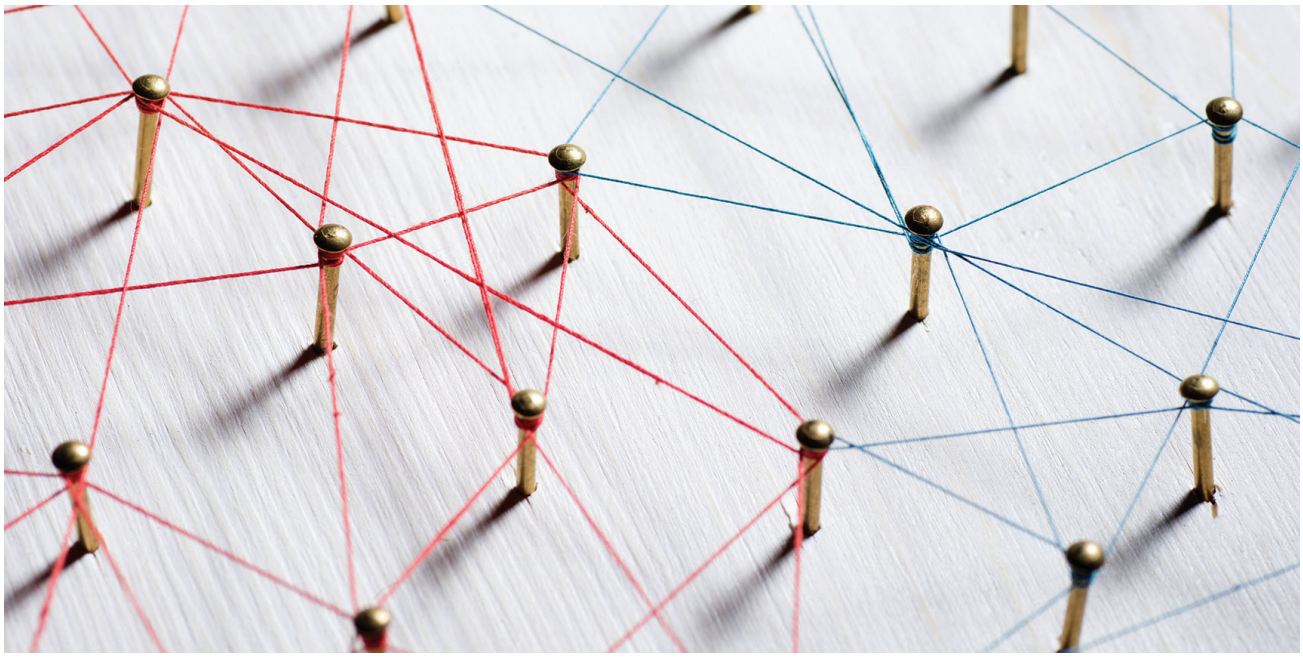
Compassion – We celebrate our role in serving people and society in an area as vitally human as their health. Approaching situations with compassion and strive to genuinely understand, feel and identify with their needs.

Relationships – We build trust through collaboration in order to take action and find solutions. Trust is earned and preserved through integrity and active engagement with our colleagues and clients.

Innovation – We draw on experiences of the past and use those insights to invent a better future to make the health care environment work and serve everyone more fairly, productively, and consistently.

Performance – We are committed to delivering and demonstrating excellence in everything we do, which means constantly challenging ourselves to strive for even better outcomes in key performance areas.

CLICK HERE TO RETURN TO TABLE OF CONTENTS



Section **2**

Provider Resource Guide

2.1 Optum Idaho Network Management

Your Optum Idaho Network Management team is here to support you in the provision of quality care to all Idaho Behavioral Health Plan (IBHP) members. The team consists of seven, full-time employees dedicated to ensuring the Optum Idaho network meets the needs of the IBHP membership statewide. Their primary location of operations is at the Optum Idaho office in the Boise area at:

Optum Idaho
322 E. Front Street, 4th Floor
Boise, ID 83702

Provider Relations Director – Responsible for overseeing the development and management of the Optum Idaho network to ensure that the IBHP membership has optimal access to quality care for all IBHP covered services.

Provider Relations Advocate – Responsible for ongoing development and management of the Optum Idaho network

Community Agency Liaisons – Responsible for coordinating the interface between the Optum Idaho clinical team and all IDHW partners (including the courts, juvenile justice, department of corrections, as well as child and family services).

This team can be reached during regular business hours by calling the Optum Idaho Provider Services line at **1-855-202-0983**.

Optum Idaho Provider Services: **1-855-202-0983**

2.2 Optum Idaho Website – optumidaho.com

Optum Idaho providers have access to a host of web-based information and resources through our Idaho website ***optumidaho.com***, which is designed to reduce their administrative burden and increase their effectiveness. The foundation of this is easily accessible information such as Provider forms, Provider Manual, Optum Idaho Level of Care Guidelines, policies and procedures, relevant news articles, and on-line training, including Continuing Education Units (CEUs) to maintain licensure. We provide secure tools to reduce the administrative tasks, such as online verification of member eligibility and benefits, treatment authorization request and verification, submission of behavioral health claims online, EDI support so that providers can easily get their claims processed, status of submitted claims (in accordance with national standards), and the ability to register online to receive electronic payments directly into their bank account.

Resources available on Optum Idaho include:

- Optum Idaho ***Provider Manual***
- Optum Idaho ***Level of Care Guidelines***
- Link to Online ***Verification of Member Eligibility and Benefits***
- Link to Online ***Treatment Authorization Request and Verification***
- Link to Online ***EDI Support***
- Link to additional provider training resources:
  - ***Relias Learning***
  - ***Optum Health Education***
- Access to Standard Tools for primary care physicians

The Optum Idaho portal contains direct links to all resources available on the Optum primary provider portal at ***Provider Express***.

2.3 Provider Express – providerexpress.com

Our industry-leading provider website ***Provider Express*** includes both public and secure pages. Public pages include general updates and useful information. Secure pages require registration. Both in-network and out-of-network individual providers are eligible to register for secure access. Group practices and facility providers must be in-network to register. The password-protected secure "Transactions" gives you access to member and provider specific information.

To Register for Access: Select the "First-time User" link in the upper right-hand corner of the home page and follow the prompts.

Secure Transactions

Provider Express offers a range of secure transactions including:

- Submit initial credentialing application and check status of initial credentialing
- Check eligibility and view benefit information, including authorization requirements
- Obtain initial authorization or notification requests, if applicable
- Create and maintain "My Patients" list
- Submit professional claims and view claim status
- Make claim adjustment requests
- Make claim or clinical appeal requests
- Access Provider Remittance Advice statements

- Update practice information:
  - Add NPI
  - Add Taxonomy Code(s)
  - Update languages spoken
  - Update email address
  - Update gender
  - Add Medicaid/Medicare numbers
  - Update non-attested expertise
  - Update ethnicity
  - Manage address locations, including practice, remit, 1099 and credentialing
  - Update phone and fax numbers
  - Availability status for accepting new patients
  - Office conditions, including weekend or evening practice hours, wheelchair accessibility, public transportation, etc.
- Attest to provider directory information
- Send secure messages to several internal departments using the "message center" without having to hold on the phone
- Admin-level users can add and manage other user' access
- View Achievements in Clinical Excellence (ACE) and the Wellness Assessment Dashboard
- Obtain pre-populated Wellness Assessments
- Link to clinician version of ***liveandworkwell.com*** to obtain patient education resources in English and Spanish (see "Live and Work Well" section below)

Public Pages

The ***Provider Express*** home page includes frequent updates about changes to administrative processes, state-specific news and other topics that help you work with Optum. In addition, we include "Quick Links" to frequently accessed pages:

- ACE Clinicians
- Behavioral Health Toolkits
- Claims Tips
- Clinicians Tax ID Add/Update Form (online form)
- ***Forms***
- Guidelines/Policies & Manuals
- Medication-Assisted Treatment
- Navigating Optum
- Optum Pay

Training Page

Information includes webinar offerings and ***Guided Tours*** of secure transaction features such as: Claim Entry, Eligibility & Benefits and Message Center. The Guided Tours provide quick overviews of key transactions.

Video Channel Page

View "how to" guides and walk-through videos that explain how to access and use many of the features available on ***Provider Express*** such as:

- Signing up for Electronic Payments & Statements

- Updating Your Practice Information
- Entering Claims on Provider Express
- Navigating Optum Webinar
- Becoming a Telehealth Provider
- Claim Inquiries and Adjustments

Live and Work Well

You may use this member site to:

- Get patient behavioral health education information (Access Clinician version of site from ***optumidaho.com*** and click on the Consumer tab, then the link to ***liveandworkwell.com***)
- Refer members to appropriate benefit specific online resources:
  - » Members may register and log in

Our primary member website makes it simple for members to:

- Manage behavioral health benefits:
  - » Check eligibility/benefits
  - » Submit/track claims
  - » View claim status
  - » Submit out-of-network claims
- Request services
- Identify network clinicians and agencies
- Take self-assessments
- Use computer-based trainings:
  - » Depression
  - » Anxiety
  - » Stress
  - » Screening, Brief Intervention, and Referrals to Treatment (SBIRT)
  - » Alcohol and Drugs
- Find articles on a variety of wellness and daily living topics
- Parent/Teen/Child Integrated medical/behavioral information on adolescent health
- Locate community resources

Members can explore topics by category:

- **Personal life:** Supportive information on caregiving, parenting, and relationships
- **Mind & body**: Find a variety of helpful articles, videos and assessments on mental health and substance use concerns
- **Crisis support**: Support for members and their families, available 24/7

The ***Liveandworkwell.com*** website provides resources and patient education in English and Spanish. Website content varies according to member benefit packages so advise members to link directly to their customized LAWW site by using the hyperlink located on the ***optumidaho.com*** > For Members page; registration allows access to additional content.

Optum Pay

For the latest information on electronic payment options through Optum Pay, go to:
optumhealthpaymentservices.com

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Frequently Used Forms and What You Need to Know

You may submit Service Requests electronically for services requiring prior authorization by going to ***Provider Express***.

Wellness Assessments

The one-page Wellness Assessment (WA) is a reliable, confidential, consumer-driven instrument used to help identify targeted risk factors in addition to establishing a baseline for tracking clinical change and outcomes. The WA is routinely administered at the beginning of the first session and then again at session three, four or five. The completed form is faxed to Optum. Detailed instructions and copies of the WA are available at ***Provider Express***. Wellness Assessments are also available in Spanish.

- Adult Wellness Assessment – The adult seeking treatment completes this form
- Youth Wellness Assessment – The parent or guardian completes this form when the individual you are seeing is a minor

For questions and/or comments about the Wellness Assessments, e-mail us at: *WellnessAssessmentDashboard@optum.com*

Claims and Customer Service

Claim Entry through Provider Express

Providers should file Optum claims at Provider Express. This secured, HIPAA-compliant transaction feature is designed to streamline the claim submission process. It performs well on all connection speeds and submitting claims on Provider Express closely mirrors the process of completing a Form 1500. In order to use this feature, you must be a network clinician or group practice and have a registered user ID and password for Provider Express. To obtain a user ID, call toll-free **1-866-209-9320**. We strongly encourage you to use this no-cost claims entry feature for claims submission at Provider Express, which allows claims to be paid quickly and accurately. For more information about fast and efficient electronic claims submission, please see ***Provider Express*** "Improve the Speed of Processing", on the Claim Tips page.

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 practitioner (physician, psychologist, social worker) and a Payor (Optum). You may choose any clearinghouse vendor to submit claims through this route. Because Optum has multiple claims payment systems, it is important for you to know where to send claims. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. For Optum claims use Payer ID #87726.

Clinician Claim Forms

Paper claims can be submitted to Optum using the Form 1500. The claims should include all itemized information such as diagnosis (using the ICD code from the current DSM), units, member name, member date of birth, member identification number, dates of service, type and duration of service (described by Procedure Code), name of clinician (i.e., individual who actually provided the service), credentials, tax ID and NPI numbers. Additional information about outpatient claim submission is available on ***Provider Express***, Outpatient Service Claims.

Claims and Customer Service issues can be addressed by calling **1-855-202-0983**.

To ensure proper processing of claims, it is important to promptly contact your Provider Relations Advocate if you change your Tax ID number. You may make changes to your practice address online (see "Secure Transactions" section above).

2.4 Complaint Process

What is a complaint?

A complaint is an expression of dissatisfaction (other than an appeal) submitted by a member, a member's authorized representative or a provider (on behalf of a member, acting as the member's authorized representative) that cannot be resolved through a standard inquiry to Optum. In addition, a provider may file a complaint on his/her own regarding an issue unrelated to a specific member.

How are complaints classified by Optum?

Concerns regarding the Optum Idaho administration of the plan are classified as Quality of Service Complaints, while concerns about the services received by a member from a provider in the Optum network are considered Quality of Care Complaints.

What should I do if I have a complaint?

Those who wish to file a complaint related to Optum may do so by phone (informing staff that the purpose of the call is to register a complaint). Any Optum Idaho employee can accept a complaint and is trained to properly send it to the correct person. Complaints may also be sent by email, by fax, or by mail:

- Phone: Optum Idaho Customer Support Services or Provider Services at **1-855-202-0983** weekdays from 8am to 6pm MT
- Email: *optum.idaho.complaints@optum.com*
- Fax: 1-877-220-7330
- Mail: You may also send your complaint in writing to:
  Optum Idaho
  322 E. Front Street, 4th Floor
  Boise, ID 83702

How long will it take to process my complaint?

We will send a letter within five business days from when we received your complaint, to let you know that we received it. If the complaint filed is a general complaint, and not a Quality of Care Concern, we will send a letter with a resolution within 10 business days after initial receipt of your complaint. The process for Quality Care Concerns is described below.

What does Optum Idaho do when there is a possible Quality of Care issue reported?

A member, representative or provider may file a complaint about a potential Quality of Care issue. A Quality of Care issue means the quality of care provided to a member by a provider may be unsatisfactory. Quality of Care complaints should be filed the same way as other complaints. Based on the severity of the complaint, our Quality Department will determine how to escalate it appropriately. Quality of Care concerns are resolved within 30 days.

If the complaint is escalated, the Quality Department and Chief Medical Officer will review and investigate the Quality of Care incident reported. The complaint may be forwarded to the Peer Review Committee for additional investigation and corrective action if needed. The actions taken by Optum Idaho to address the complaint may not be released to you; this is dependent on your role in the case. This means that Optum Idaho will advise the person filing the complaint that it has been referred as a Quality of Care complaint, and is being investigated, but details are not normally provided due to privacy issues.

Complaints are not Adverse Benefit Determinations, Internal Appeals, nor Provider Disputes; which are all described elsewhere in this manual.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

2.5 Glossary of Terms

These definitions are general definitions applied for purposes of this manual. State law, certain practitioner agreements and individual benefit contracts define some of these terms differently. In such cases, the definitions contained in the applicable law or contract will supersede these definitions. In the definitions below, and throughout this manual, "we", "us" and "our" refer to Optum Idaho.

Abuse

Unsound business practice resulting in undue remuneration.

Adverse Benefit Determination

Adverse Benefit Determination (ABD) means the denial or limited authorization of a requested service; termination, suspension, or reduction of a previously authorized service, the denial in whole or in part of a payment for service; or the failure to act upon a request for services in a timely manner.

Affiliate

Each and every entity or business concern with which we, directly or indirectly, in whole or in part, either: owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Agency

A non-facility-based outpatient provider meeting specific criteria. Examples include, but are not limited to, Federally Qualified Health Centers (FQHC), Community-based Rehabilitative Service Agencies, Substance Use Disorder Agencies and Case Management Agencies. Agencies require clinical oversight by an independently licensed clinician of any staff members who are not independently licensed.

Agreement

A contract describing the terms and conditions of the contractual relationship between us and a provider under which behavioral health services are provided to members.

Algorithm

A set of decision rules we apply to member-specific data to determine whether there are any targeted clinical issues or risks.

Appeal

A request for reconsideration by a member or member's authorized representative, following an Adverse Benefit Determination by the contractor

The ASAM Criteria®

Optum Idaho and the provider network use, "The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition" to guide service delivery, level of care placement for Substance Use Disorder (SUD) Services.

Per ASAM, The ASAM Criteria were developed through an interdisciplinary consensus process and were designed to help clinicians, counselors, and care managers develop patient centered service plans, and make objective

decisions about patient admission, continuing care, and transfer/discharge for individuals with addictive, substance related, and co-occurring conditions.

For more information regarding The ASAM Criteria®, go to: ***asam.org***

Authorization

The number of days or non-routine outpatient visits/units for which benefits have been applied as part of the member benefit plan for payment (formerly known as Certification). Authorizations are not a guarantee of payment. Final determinations will be made based on member eligibility and the terms and conditions of the member's benefit plan at the time the service is delivered.

Balance Billing

The practice of a provider requesting payment from a member for the difference between the UBH contracted rate and the clinician or facility's usual charge for that service.

Behavioral Health Care

Assessment and treatment of mental health and/or substance use disorders (MH/SUD).

Care Advocate

An Optum employee who is a licensed clinical professional (e.g., nurse, doctor, psychologist, social worker, or professional counselor) who works with members, health care professionals, physicians, and insurers to maximize benefits available under a member's benefit plan. The Care Advocate has obtained clinical endorsement, and is specifically licensed with that designation, and has experience in mental health and/or substance use disorder services; primary responsibility is reviewing requests for service authorizations.

Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII)

Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18.

For additional information, please visit ***Provider Express*** > Clinical Resources > Guidelines and Policies > LOCUS CALOCUS-CASII ECSII.

Clean Claim

A UB-04 or a Form 1500 claim form, or their successors, submitted by a facility or clinician for MH/SUD health services rendered to a member which accurately contains all the following information: member's identifying information (name, date of birth, subscriber ID); facility or clinician information (name, address, tax ID); date(s) and place of service; valid ICD-10 code or its successor code; procedure narrative; valid CPT-4 or revenue code; services and supplies provided; facility charges; and such other information or attachments that may be mutually agreed upon by the parties in writing.

The primary avenue for clinician claims submissions is electronically through Provider Express via the ***optumidaho.com*** portal.

Coordinated Care Plan

A coordinated care plan is the result of coordinating care from all providers involved in treatment and may take

many forms depending on level of involvement. Examples may include person-centered service plans, Idaho WInS (Wraparound Intensive Services) plans, developmental disability plans, or court-ordered goals.

Complaint

An expression of dissatisfaction logged by a member, a member's authorized representative or a provider concerning the administration of the plan and/or services received. Actions subject to a general complaint include, at a minimum, dissatisfaction with the benefit plan, a provider, a member, or the way in which Optum Idaho administers the plan. Possible subjects for complaints include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

Credentialing

The process by which a provider is accepted into our network and by which that association is maintained on a regular basis.

Crisis (Mental Health)

A mental health crisis is a situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress due to psychiatric symptoms associated with mental illness or substance use disorder(s). These persons may be considering self-harm or harm to others, disoriented or out of touch with reality or have a compromised ability to function, or are otherwise agitated and unable to self-calm. An immediate response to their circumstances is needed.

Duplicate Claim

A duplicate claim is defined as a claim or procedure code detail that exactly matches a claim or procedure code detail that has been reimbursed to the same provider for the same member. Duplicate claims or details include the same date of service, procedure code, modifier and number of units. Duplicate claims or procedure code details will be denied.

NOTE: Modifiers must be used to identify separate services when medically necessary and provided on the same date of service to prevent the claims from denying.

Early Childhood Service Intensity Instrument (ECSII)

Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for children ages 0-5.

For additional information, please visit ***Provider Express*** > Clinical Resources > Guidelines and Policies > LOCUS CALOCUS-CASIII ECSII.

Early Periodic Screening Diagnosis and Treatment (EPSDT) for Children

EPSDT Services (Federal Medicaid definition): Federal Medicaid law at 42 U.S.C.§ 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered by the State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act].

EPSDT Services (Idaho state-specific definition): Idaho Administrative Code at IDAPA 16.03.09.880-883 defines Early Periodic Screening, Diagnosis and Treatment Services as medically necessary services for eligible Medicaid participants under 21 years of age. EPSDT services are health care, diagnostic service, treatment and other measures described in section 1905(a) of the Social Security Act (SSA) necessary to correct or ameliorate defects, physical

and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan. Services authorized must be considered, safe, effective, and meet acceptable standards of medical practice, and shall require prior authorization. Services are not covered for cosmetic, convenience, or comfort reasons. Services subject to prior authorization may be reviewed:

- On a case-by-case basis and, evaluating each person's needs individually
- To assess relative cost effectiveness of alternative treatments *(Note: Optum cannot deny services based on cost alone.)*
- To consider that the services being requested are of a quality that meets professionally recognized standards of health care

The goal of the EPSDT benefit is to ensure that children under 21 years of age who are enrolled in Medicaid receive medically necessary age-appropriate screening, preventive services, diagnostic and treatment services to correct, maintain or improve their current health condition and/or to prevent the development of additional health problems.

Electronic Health Record (EHR)

An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

An electronic version of a member's behavioral health history that is maintained by the provider over time and may include all of the key administrative clinical data relevant to the member's care under a particular provider, including demographics, treatment notes, problems, medications, diagnosis, and past behavioral healthcare history.

Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)]

For appointment access standards, see "Emergency – Life-threatening", "Emergency – Non-life-threatening" and "Urgent".

Emergency – Life Threatening

A situation requiring immediate appointment availability in which there is imminent risk of harm or death to self or others due to a medical or psychiatric condition.

Emergency – Non-Life Threatening

A situation requiring appointment availability within six hours or less or as mandated by state law or customer contract in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm or death to self or others.

Evidence-Based Practices

Interventions that have been shown through research to be effective in treating specific disorders or populations.

Exclusions

Specific conditions or circumstances listed in the member's Benefit Plan for which the policy or plan will not provide coverage reimbursement under any circumstances.

Family

The word "family" refers to birth parents, adoptive parents, guardians, extended family, family of choice, members of the family's support system, current caregivers and authorized representatives.

Field Care Coordination Manager

An Optum Idaho Field Care Coordination Manager, an independently licensed clinician who has obtained clinical endorsement, is specifically licensed with that designation and has experience in mental health and/or substance use disorder services. Their primary responsibility is managing the Field Care Coordinators and working with providers, affiliated delivery systems, regional behavioral health boards, regional IDHW staff and others in a designated IDHW region.

Field Care Coordinator

An Optum employee who is a licensed clinical professional (e.g., nurse, doctor, psychologist, social worker or professional counselor) and works with members, health care professionals and physicians in each of the seven Idaho regions and is responsible for intensive care coordination cases, routine care coordination cases and discharge coordination cases. Their primary responsibility is working with providers who are serving members identified as high need or high risk.

Federally Qualified Health Center

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 (PHS), certain tribal organizations and FQHC Look-Alikes. An FQHC Look-Alike is an organization that meets all the eligibility requirements of an organization that receives a PHS Section 330 grant but does not receive grant funding.

Fee Maximum

The maximum amount a participating provider may be paid for a specific health care service provided to a member under a specific contract. Reimbursement to clinicians is based upon licensure rather than degree.

Fraud

An intentional deception or misrepresentation made by a person 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. [42 CFR 438.2; 42 CFR 455.2]

Health Plan

A health maintenance organization, preferred provider organization, insured plan, self-funded plan, government agency, or other entity that covers health care services. This term also is used to refer to a plan of benefits.

HIPAA

The Health Insurance Portability and Accountability Act, by which a set of national standards are set for, among other topics, the protection of certain health care information. The standards address the use and disclosure of an individual's "Protected Health Information" (PHI) by organizations subject to the Privacy Rule ("covered entities"). These standards also include privacy rights for individuals to understand and control how their health information is used. For more information, please visit the ***Department of Health and Human Services*** website.

Independent Review Organization (IRO)

An independent entity/individual retained by a private health plan or government agency to review adverse

determinations (based on medical necessity) that have been appealed by, or on behalf of, a member (also sometimes known as External Review Organizations). In the case of the IBHP, the IDHW manages the IRO process for the second level (Fair Hearing) in the appeal process.

Independently Licensed Clinician

A licensed behavioral health professional whose clinical licensure allows for the independent provision of behavioral health care services without supervision by another licensed professional.

Least Restrictive Level of Care

The Level of Care (LOC) at which the member can be safely and effectively treated while maintaining maximum independence of living.

Legal Entity

United Behavioral Health (UBH) operating under the brand Optum.

Idaho Medicaid Supplemental Clinical Criteria – Optum Idaho Level of Care Guidelines (LOCG)

The Idaho Medicaid Supplemental Clinical Criteria (Optum Idaho Level of Care Guidelines) are a set of objective and evidence-based clinical criteria used to standardize coverage determinations, promote evidence-based practices, and support recovery, resiliency, and well-being.

The Optum Idaho Level of Care Guidelines are modeled after national standards and must be adopted by the Quality Assurance and Performance Improvement Committee to preserve integrity of the information. Clinical Criteria for Idaho are primarily state specific. When state specific criteria are not available or do not apply, the following criteria are used: ASAM Criteria®, Level of Care Utilization System-LOCUS, Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument-CALOCUS-CASII and or Early Childhood Service Intensity Instrument-ECSII. For additional information, please visit ***Provider Express*** > Clinical Resources > Guidelines and Policies > LOCUS CALOCUS-CASII ECSII.

Level of Care Utilization System (LOCUS)

Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for adults. For more information on LOCUS please visit ***Provider Express*** > Clinical Resources > Guidelines and Policies > LOCUS CALOCUS-CASII ECSII.

Live and Work Well (LAWW) Website

A member website which provides resources for wellness information, MH/SUD intervention, and network referrals.

Medical Necessity

- The State of Idaho's regulatory definition of medical necessity is located at: ***IDAPA 16.03.09.011.16 and 16.03.09.012.14***
- A service is medically necessary if:
  - » It is reasonably calculated to prevent, diagnose or treat conditions in the member that endanger life, cause pain or cause functionally significant deformity or malfunction; and
  - » There is no equally effective course of treatment available or suitable for the member requesting the service which is more conservative or substantially less costly
  - » Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality

- Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services:
  - » Medically necessary services for eligible Medicaid members under the age of twenty-one (21) are healthcare, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan
  - » Services must be considered safe, effective and meet acceptable standards of medical practice
- Location of definition: ***IDAPA 16.03.09 880***

Member

An individual who meets all eligibility requirements and for whom premium payments for specified benefits of the contractual agreement are paid. Such individuals may also be referred to as a plan member, enrollee or consumer.

Mental Health Center (MHC)

A behavioral health agency that offers mental health services by licensed clinicians whose licensure allows for independent practice. MHCs may utilize such licensed clinicians to provide clinical supervision to unlicensed staff, in the provision of services to members, under the Supervisory Protocol Addendum to the provider contract. The MHC array of services includes assessment and diagnosis, psychotherapy and pharmacological management. Additional services may include skills training, crisis intervention, case management, psychological testing and neuropsychological testing.

Mental Health Parity

Financial requirements and treatment limitations applied to mental health and substance use disorder benefits may be no more restrictive than those applied to medical/ surgical benefits, per the Mental Health Parity and Addiction Equity Act of 2008. For more information, please visit ***uhc.com***.

MH/SUD

Mental Health and/or Substance Use Disorder.

Notice of Adverse Benefit Determination

A written notification letter that explains the Adverse Benefit Determination taken, or intended to be taken, regarding denial or limit of authorization of a requested service; termination, suspension, or reduction of a previously authorized service; the denial, in whole or in part, of a payment for service; or the failure to act upon a request for services in a timely manner.

optumidaho.com

Optum Idaho-specific ***website*** providing resources for clinicians and agencies serving the Idaho Behavioral Health Plan membership.

Optum Pay (Electronic Fund Transfer)

Optum Pay is the standard method for receiving payments and provider remittance advice (PRA) from Optum. Optum Pay delivers electronic payments and provides 835 files for health care providers or facilities.

Paraprofessional

A qualified practitioner supervised by an independently licensed clinician.

Payor

The entity or person that has the financial responsibility for funding payment of covered services on behalf of a member who is authorized to access MH/SUD services in accordance with the Agreement.

Program Manager – UM (Utilization Management)

A licensed clinician with a master's or doctoral degree in psychology, social work, counseling or a related field, or registered psychiatric nurse and a current non-restricted and independent license in a behavioral health field or nursing. Primary responsibilities are to provide clinical supervision, training, oversight and direction to the Care Advocacy teams and ensure that department goals are communicated clearly, and that goals are met or exceeded through team effort. UM Program Manager schedules staff to provide adequate phone service coverage, including on-call after-hours support, monitors utilization and quality trends, audits files for appropriate documentation, conducts clinical case reviews, and is involved in committees and other meetings as necessary. UM Program Manager handles exceptions to policies and procedures, appeals, and problematic cases as needed.

Prospective Review

When future claims (not yet processed) that match suspected abusive patterns submitted by a provider go under investigation and trigger a request for medical records.

Provider Dispute

A contracted provider's written notice to Optum Idaho disputing or requesting reconsideration of a claim (or group of claims) that has been denied, adjusted or contested and for which the member has already received service. Under the provider Agreement, one level of dispute is available. For more information, see the "Member Appeal Process and Provider Disputes" sections of this manual.

Provider Express

Provider Express is a website providing resources for clinicians, agencies and group practices, general information, manuals, forms and newsletters are available to all providers. A variety of secure, self-service transactions including authorization inquiry and claim entry are available to network clinicians, agencies and group practices that obtain a registered "User ID".

Provider Quality Specialists

Optum Idaho Provider Quality Specialists are clinicians who conduct chart reviews to ensure the quality, appropriateness and clinical outcomes of all services provided through the Idaho Behavioral Health Plan, and who follow-up with providers as appropriate.

Provider Relations Department

Consists of Provider Relations Advocates and Associates who provide services and information to providers. In addition, they may act as liaisons with other departments such as Care Advocacy and Account Management to contract and retain experienced behavioral health professionals.

Quality Assurance

A formal set of activities to review and affect the quality of services provided. Quality Assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient services. Idaho has regulations for health plans to have quality assurance programs.

Quality Improvement

A continuous process that identifies opportunities for improvement in health care delivery, tests solutions, and routinely monitors solutions for effectiveness.

Relias and OptumHealth Education

Optum Idaho offers free training with the Relias Learning Management System as a resource for in network providers who are providing Behavioral Health Services directly to Medicaid Members. Relias is a resource that is offered to provide continuing education, specific training and knowledge for the purpose of delivering care and serving members within the Optum Idaho Behavioral Health plan. These online courses:

- Are designed to fit into a busy schedule
- Won't require travel time or cost
- Are free of charge within the Optum Network

Relias is an eLearning portal that provides a robust knowledge library of clinical and business courses to all types of clinical and administrative staff. Relias offers a variety of CEU based courses for master's level clinicians based on key learning areas. Network providers can register for a free Relias account on ***Relias***.

OptumHealth Education is an eLearning portal that is targeted towards medical professionals (MD, PhD, R.N., P.A.) and offers CME and CEU based courses in behavioral health and related learning areas. Network providers can register for a free account at ***Optum Health Education***.

Routine Access

A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others.

Telehealth

The provision of behavioral health services by a behavioral health provider via a secure two-way, real-time, interactive audio/video telecommunication system.

Urgent Access

A situation in which immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation. Availability should be within 48 hours or less or as mandated by state law.

Waste

Any unnecessary consumption of health care resources.

Wellness Assessment (WA)

A reliable, confidential, member-driven instrument used to help identify targeted risk factors in addition to establishing a baseline for tracking clinical change and outcomes.

Wraparound Intensive Services (Idaho WInS)

Wraparound Intensive Services (Idaho WInS) is a Wraparound model provided with quality and fidelity as defined by the National Wraparound Initiative. Idaho WInS is a type of Intensive Care Coordination in the YES system of care.

Section **3**

Network Requirements

3.1 Clinical Network Development and Maintenance

Optum Idaho is responsible for arranging for the provision of a comprehensive spectrum of behavioral health services. To fulfill this responsibility, we administer a provider network which includes, but is not limited to, licensed qualified professionals, community-based rehabilitative services, case management services and agencies providing mental health and substance use disorder treatment. This network represents an array of clinical and cultural specialties offering a wide variety of services. The diversity of our network allows us to meet the clinical, cultural, linguistic and geographic needs of the Idaho Behavioral Health Plan membership.

Non-Discrimination

Optum Idaho does not deny or limit the participation of any provider in the network, and/or otherwise discriminate against any provider, based solely on any characteristic protected under state or federal discrimination laws.

Furthermore, Optum has never had a policy of terminating any provider because the provider or provider representative: (1) advocated on behalf of a member; (2) filed a complaint against Optum; (3) appealed a decision of Optum; or (4) requested a review of a termination decision or challenged a termination decision of Optum. Moreover, consistent with the terms of the Settlement Agreement entered into in Holstein v. Magellan Behavioral Health, Optum has adhered to this practice both before and since the Settlement Agreement was executed. Optum has not, and will not, terminate any provider from its network based on any of the four grounds enumerated above. Nothing in the Agreement should be read to contradict, or in any way modify, this long-standing policy and practice of Optum.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

3.2 Credentialing and Re-Credentialing

Agency/Group Credentialing and Re-Credentialing

Optum Idaho follows the guidelines of the National Committee for Quality Assurance (NCQA) for credentialing and re-credentialing unless otherwise required by law. As part of the credentialing and re-credentialing process, agencies 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 Idaho for the providers delivering services, including Idaho Medicaid credentialing reports.
- Current copy of accreditation certificate and/or letter from each accrediting body
- General and professional liability insurance coverage (a minimum of $1 million/$3 million)
- W-9 forms
- Disclosure of Ownership and Control Interest Statement
- Signed malpractice claims statement/history
- Staff roster
- Program description including services provided

In addition, documentation confirming completion of criminal background checks on agency employees, in accordance with Idaho Department of Health & Welfare requirements, may be reviewed during site audits. For more information, visit the ***Idaho Criminal History Unit*** Home Page. Please refer to Provider Manual Section 3.6 "Criminal History Background Checks" for information on Criminal History Background Check Waivers/Variances issued by IDHW for Peer Support and Recovery Coaching providers.

In the event that your agency is not accredited by an entity recognized by Optum, an on-site audit will be required prior to credentialing and again prior to re-credentialing (see "Audits of Sites and Records" in the "Quality Improvement" section of this manual for more information).

The Credentialing Plan addresses the requirements for participation, continued participation (maintaining unrestricted license, cooperating with complaints investigation, etc.), and information regarding disciplinary action up to and including termination of participation in the network. The Credentialing Plan is available at ***Provider Express***, or you may request that a paper copy be mailed to you by contacting your Provider Relations Advocate.

Individual Clinician Credentialing and Re-Credentialing

Optum Idaho uses ProView®, developed by CAQH, to obtain the data needed for credentialing and re-credentialing of individual network clinicians. The CAQH web-based credentialing tool streamlines the credentialing process by enabling you to complete your credentialing application online. This free service for healthcare professionals is available 24 hours a day, 365 days a year. The online application allows you to save your work and return later to finish the process. Once completed, CAQH stores the application online and enables you to make updates to your information as needed. By keeping your CAQH information current, future re-credentialing is quick and easy.

Once your application is completed with CAQH, Optum may utilize Aperture, an NCQA certified Credentials Verification Organization (CVO), to review the application packet for completeness and collect any missing or incomplete information.

Optum Idaho credentials clinicians 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, except as required by applicable state law
- License is in good standing and free from restriction and/or without probationary status
- Board Certification for psychiatrists (Board Eligibility for newly licensed psychiatrists, with requirement to complete Board Certification prior to re-credentialing)

- Current certification through the Federal Drug Enforcement Agency (DEA) for prescribing clinicians in each state in which they practice
- Professional Liability Coverage: a minimum of $1 million occurrence/$1 million aggregate for master's-level and doctoral-level clinicians, and a minimum of $1 million/$3 million for physicians
- Free from any exclusion from government programs
- Disclosure of Ownership and Control Interest Statement

In addition, documentation confirming completion of criminal background checks on agency employees, in accordance with Idaho Department of Health & Welfare requirements, may be reviewed during site audits. For more information, visit the ***Idaho Criminal History Unit*** Home Page. Please refer to Provider Manual Section 3.6 "Criminal History Background Checks" for information on Criminal History Background Check Waivers/Variances issued by IDHW for Peer Support and Recovery Coaching providers.

For a more specific list of criteria, please refer to the Credentialing Plan on ***providerexpress.com***.

You will be asked to sign a release of information granting Optum 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 may have information pertaining to your professional standing. Obtaining and reviewing this information is necessary to complete the credentialing process. Failure to provide such a release will preclude completion of your credentialing and prevent your participation in the network.

Optum has specific requirements for identified specialty areas. A comprehensive list of specialty areas is available on the Specialty Attestation form, which can be found in the "Forms" section on ***Provider Express***. If you request recognition of a specialty area, an attestation statement may be required documenting the specific criteria met for the identified specialty. Current competency of a designated specialty may be randomly audited to ensure that network clinicians remain active and up to date in their specialty field attestations.

The Credentialing Plan addresses the requirements for participation, continued participation (e.g., maintaining unrestricted license, cooperating with complaints investigation, etc.) and information regarding disciplinary action up to and including termination of participation in the network. The Credentialing Plan is available at Provider Express or you may request that a paper copy be mailed to you by contacting ***Network Management*** (*optum_idaho_network@optum.com*).

In accordance with our commitment to the highest quality of clinical treatment, Optum Idaho re-credentials clinicians every 36 months unless state law or client policies require a different re-credentialing cycle. During re-credentialing, we will access your information through your CAQH application, unless otherwise required by law. In addition, you will be required to provide your current copy of:

- Professional licensure and/or certification
- Federal Drug Enforcement Agency (DEA) certificate (if applicable) for each state in which you practice
- Controlled Dangerous Substances (CDS) certificate (if applicable)
- Professional and general liability insurance
- Curriculum vitae

You may also 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 a release will preclude completion of your re-credentialing and prevent your continued participation in the network

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

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Facility Credentialing and Re-Credentialing

Optum follows the guidelines of NCQA for credentialing and re-credentialing unless otherwise required by law. As part of the credentialing and re-credentialing process, facilities and agencies 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 copy of accreditation certificate and/or letter from each accrediting body
- General and professional liability insurance certificates

For Facilities

- With an acute inpatient component, professional/general liability $5 million/$5 million minimum coverage
- Without an acute inpatient component, professional liability $1 million/$3 million minimum coverage
- Comprehensive general liability $1 million/$3 million minimum coverage

For Agencies

- Professional liability – $1 million/$3 million minimum coverage
- Comprehensive general liability – $1 million/$3 million minimum coverage
- Peer Run Organization – $1 million/$1 million minimum coverage (professional liability); $1 million/$1 million minimum coverage (general liability)
- W-9 forms
- Staff roster, including attending physicians, if applicable
- Daily program schedules
- Program description
- Facility Billing Information Form

Disclosure of Ownership

This form is a mandated requirement for Optum Idaho. It must be collected as part of new recruitment or continued participation process.

If your facility/agency is not accredited by an entity recognized by Optum, an on-site audit will be required prior to credentialing and again prior to re-credentialing (refer to "Audits of Sites and Records" in the Quality Improvement section of this manual for more information).

The Credentialing Plan addresses the requirements for participation, continued participation (maintaining unrestricted license, cooperating with complaints investigation, etc.), and information regarding disciplinary action up to and including termination of participation in the network. The Credentialing Plan is available at ***Provider Express***, or you may request that a paper copy be mailed to you by contacting your Facility Contract Manager.

Roster Maintenance

Credentialed agencies that are contractually required to provide a roster of their independently licensed clinicians must maintain the accuracy of that roster, including timely reporting of the addition of new clinicians and removal of clinicians who have left the agency. Roster management can be completed through "My Practice Info" on Provider Express or by submitting the "Agency Roster Update Form" to Provider Relations. The "Agency Roster Update Form" can be found in the "Optum Forms – Administrative" section under "Forms" on ***Provider Express***.

Credentialing and Re-Credentialing Rights and Responsibilities

As an applicant to the Optum Idaho network, or as a network provider in the process of 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, excluding personal or professional references, internal Optum documents, or other information that is peer-review protected or restricted by law
- Make corrections to erroneous information identified by Optum in review of credentialing or re-credentialing application

In addition to the above rights, you have the responsibility to submit any corrections to your credentialing or re-credentialing application in writing within 10 business days of your notification by Optum.

3.3 Contractual Obligation of Written Notification of Status Changes

You are contractually obligated to notify Optum in writing within 10 days, unless otherwise required by state or federal law or your Agreement, of any changes to your practice demographic information. In accordance with CMS regulations, and consistent with the Consolidated Appropriations Act (CAA), we will verify information in our provider directories on a regular basis.

Registered users of ***Provider Express***, except Facilities, are strongly encouraged to use the "My Practice Info" function to update this information. The "My Practice Info" function is fast, efficient, and very easy to use. If the My Practice Info function is unavailable, you may submit changes in writing at *updatemyinfo@optum.com* or by fax (1-844-397-5312). Facilities should submit their changes to their Contracting Manager.

PLEASE NOTE: We may remove providers and facilities from our provider directories if we are unable to verify provider demographic information. Therefore, it is important our network providers maintain accurate information within our directories and respond to inquiries from us when they are received.

It is imperative our network providers notify us immediately if there are any changes to the following:

- The participating status of the practice including changes in practice location, billing address, appointment phone or secure fax number
- Accepting New Patient status for each practice location
- Changes in Facility, Agency or Group ownership
- The status of professional licensure and/or certification such as revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, debarment from any government program, monitoring 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)

Directory Attestations: Consistent with the Consolidated Appropriations Act, we will verify information in our provider directory. You will provide accurate information to us and will respond to inquiries from us when they are received by you. You will respond to our inquiries within any time period that is listed in the communication that we send to you. We may remove providers and facilities from the provider directory if we have been unable to verify information.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

3.4 Practice Locations and Contract Status

Individually Contracted Clinician

Your Agreement is between you and UBH operating under the brand Optum. It is an agreement for you to see all members eligible to access this Agreement. Your Agreement with UBH/Optum is not specific to a single location or Tax Identification Number (TIN). It is important to provide us with all practice locations and the TIN(s) under which you may bill to facilitate proper reimbursement.

Facility/Agency Contracts

The Agreement is between the facility/agency and UBH. It is an agreement for the facility/agency to see all members eligible to access this Agreement. The Agreement with UBH is specific to a single TIN but may include multiple practice locations. It is important to provide us with all practice locations and the TIN under which you may bill to facilitate proper reimbursement.

3.5 Provider Initiated Unavailable Status

Individual clinicians may request to be made unavailable for new referrals at one or more of your practice locations for up to six months. You are required to notify Optum Idaho Network Management within 10 calendar days of your lack of availability for new referrals. You may make this notification through "Secure Transactions" on ***Provider Express***, or by contacting ***Network Management***. You will receive an electronic confirmation or be sent a letter confirming that your request has been processed.

When you have been on unavailable status for five consecutive months, we will send you a letter reminding you that you will be returned to active status within 30 calendar days. You may update your status on Provider Express or contact Network Management to request an extension of your unavailable status. Should you decide that you want to return to active status sooner than expected; you may update your status on Provider Express or notify ***Network Management***.

Some common reasons for requesting unavailable status are extended illness, vacation or leave plans, or lack of available appointments. Practice addresses that are hospital-based/inpatient-only or where appointments are not routinely available to new Members should also be made unavailable indefinitely for one of several available reasons.

Please note that your agreement remains in effect while on unavailable status.

Group Practices and Facilities/Agencies that wish to be made unavailable should contact ***Network Management***.

3.6 Criminal History Background Checks

For dates of service July 1, 2021, and later, IDHW's administrative rule in ***IDAPA 16.03.09*** Medicaid Basic Plan Benefits Section 009 Criminal History and Background Check Requirements made a Medicaid variance option available to providers who have applied for but have been denied criminal history check clearance, as set forth in ***IDAPA 16.05.06***, Criminal History and Background Checks. A Medicaid variance allows the provider to deliver Peer Support and Recovery Coaching services only.

All other ***Criminal History Unit (CHU)*** requirements for prospective providers remain in place, including rules that prohibit enrollment of providers that appear on the Office of the Inspector General's (OIG) List of Excluded Individuals/Entities, the Idaho Medicaid Provider Outstanding Debt/Termination List, and the Idaho Medicaid Exclusion List.

Providers having an existing Background Check Waiver approval letter from the Division of Behavioral Health dated

before July 1, 2021, should contact Medicaid at **1-866-681-7062** if they are interested in providing Peer Support and Recovery Coaching services reimbursed through Medicaid.

Providers whose applications for waivers/variances are approved will receive an approval letter from the Division of Behavioral Health documenting their eligibility to provide Peer Support and Recovery Coaching services to Medicaid enrollees. Agencies employing Peer Support Specialists or Recovery Coaches should include Background Check Waiver/Variance documentation in the employee's personnel file, as outlined in the Peer Support Site Audit Tool and the Organizational Provider Site Audit Tool.

To learn more about background check waivers/variances and how to apply, please visit the Behavioral Health Service Providers page on the ***Idaho Department of Health and Welfare*** website.

3.7 Access to Outpatient Mental Health and Substance Use Disorder Services

As part of our Quality Improvement Program, and to ensure that all members have access to appropriate treatment as needed, we develop, maintain, and monitor a network with adequate numbers and types of clinicians and outpatient programs. We require that the network adhere to specific access standards, which are outlined as follows:

- Respond within 24 hours to a member request for routine outpatient care
- An initial MH/SUD appointment must be offered within 10 business days of the request
- Urgent appointments must be offered within required timeframes (MH/SUD – 48 hours)
- Non-life-threatening emergency appointments must be offered within 6 hours
- An immediate appointment must be offered for any life-threatening emergencies
- An MH/SUD outpatient appointment must be offered within 7 days of an acute inpatient discharge

Optum expects that members will generally have no more than a 15-minute wait time for their appointment in your office. In addition, any rescheduling of an appointment must occur in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice. In cases where a member is being discharged from acute inpatient care, Optum expects a follow-up outpatient appointment to occur within seven (7) days from the discharge date. This appointment should be included in the facility discharge plan.

If you are unable to take a referral, immediately direct the member to contact Optum Idaho at **1-855-202-0973** so that he or she can obtain a new referral.

3.8 On-Call and After-Hours Coverage

You must provide or arrange for the provision of assistance to members in emergency situations 24 hours a day, seven days a week. You should inform members about your hours of operation and how to reach you after-hours in case of an emergency. Each member's treatment plan must also include a crisis plan that informs the member what to do in the case of an emergency. In addition, any after-hours message or answering service must provide instructions to the members regarding what to do in an emergency situation.

When you are not available, coverage for emergencies should be arranged with another participating clinician.

3.9 Supervisory Protocol

In accordance with the Agreement, the services you provide must be provided directly by you for all members unless your agency is the contracting entity and your Optum contract includes the Supervisory Protocol Addendum.

Licensed supervising clinicians within the agency may submit claims in their name for treatment services provided by bachelor's level paraprofessional employees within the agency who are under the direct supervision of the licensed clinicians.

3.10 Termination or Restriction of Network Participation

A provider's participation with Optum Idaho can end for a variety of reasons. Both parties have the right to terminate the Agreement upon written notice, pursuant to the terms of the Agreement.

If you need clarification on how to terminate your Agreement, you may email ***Network Management***.

In some cases, you may be eligible to request an appeal of an Optum-initiated termination or restriction of your participation. If you are eligible for an appeal, we will notify you of this in writing within 10 calendar days of the adverse action. The written request for appeal must be received by Optum within 30 calendar days of the date on the letter which notified you of any adverse action decision. Failure to request the appeal within this timeframe constitutes a waiver of all rights to appeal and acceptance of the adverse action.

The appeal process includes a formal hearing before at least three (3) clinicians, appointed by Optum. The Appeal Committee members are not in direct economic competition with you, and have not acted as accuser, investigator, factfinder, or initial decision-maker in the matter. You may be represented by a person of your choice at the appeal hearing, including legal counsel. At the conclusion of the hearing you have five business days to submit further documentation for consideration.

The Appeal Committee's decision is by a majority vote of the members. The decision of the Appeal Committee is final, and may uphold, overturn, or modify the recommendation of the Optum Credentialing Committee. Correspondence regarding the decision is sent to the clinician or Facility/Agency within 30 calendar day of the hearing date.

Continuation of Services after Termination

Network Clinicians and Agencies who withdraw from the Optum Idaho network are required to notify us, in writing in accordance with your Agreement, 90 calendar days prior to the effective date of termination, unless otherwise stated in your Agreement or required by state law. The timeline for continued treatment is up to 90 calendar days from the effective date of the contract termination, or as outlined in your Agreement or until one of the following conditions is met, whichever is shortest:

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

To ensure continuity of care, Optum will notify members affected by the termination of a clinician or agency at least 15 calendar days prior to the effective date of the termination whenever feasible. Optum will assist these members in selecting a new clinician, group or agency. You are also expected to clearly inform members of your impending non-participation status earlier than the member's next appointment or prior to the effective termination date, in compliance with your Agreement.

Quality-related issues, suspected fraud, waste or abuse, change in license status or change in ability to participate in federal programs, clinicians are obligated to continue to provide treatment for all members under their care. Under these circumstances, Optum Idaho will assist the member with transitioning services as soon as possible.

Abandonment and Member Neglect

It is the responsibility of all network providers not to abandon or neglect members who are receiving their services. The provider is responsible to assist in making appropriate arrangements for the continuation of services, when necessary, during interruptions such as vacations, illness and following termination to ensure continuity of care for

the member. If the provider terminates services with the member, they are responsible to assist the member to receive ongoing medically necessary services.

3.11 Treatment Record Documentation Requirements

In accordance with your Agreement, you are required to maintain high-quality medical, financial and administrative records (including appointment or scheduling books) related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community, and conform to all applicable laws and regulations including, but not limited to, state licensing, Centers for Medicare and Medicaid Services (CMS) and/or national certification board standards.

In order to perform required utilization management, practice management and quality improvement activities, we may request access to such records, including, but not limited to, claims records and treatment record documentation. You are permitted under HIPAA Treatment, Payment or Healthcare Operations to provide requested records as contractually required. In accordance with HIPAA and the definition of Treatment, Payment or Healthcare Operations, you must provide such records upon request.

- We may review your records during a scheduled On-Site Audit or may ask you to submit copies of the records to Optum for review. An On-Site Audit and/or Treatment Record Review may occur for several reasons, including, but not limited to:
  - Reviews of agencies without national accreditation such as The Joint Commission, CARF or other agencies approved by Optum
  - Audits of high-volume providers
  - Audits of providers who offer Skills Building/Community Based Rehabilitation Services (CBRS) for adults and/or youth
  - Routine random audits
  - Audits related to claims, coding or billing issues
  - Audits concerning quality of care issues
  - Audits related to a member complaint regarding the physical environment of an office or agency

The audits may focus on the physical environment (including safety issues), policies and procedures, and/or thoroughness and quality of documentation within treatment records and/or accuracy of billing and coding. We have established a passing performance goal of 85% for both the Treatment Record Review and On-Site Audit. On-Site Audit or Treatment Record Review scores under 85% will require a written Corrective Action Plan (CAP). Scores under 80% require submission of a written CAP and a re-audit within six months of the implementation of the CAP. However, in some cases, a requesting committee may require a CAP and/or re-audit regardless of the scores on the audit tools.

Billing records should reflect the member who was treated, the rendering and supervising providers, and the modality of care. Audits related to claims, coding or billing issues may require corrective action.

The regional Provider Quality Specialists will play a role in supporting system transformation through provider monitoring and education; this process will support ongoing improvements to the quality of care provided to members:

- The audit process assesses several aspects related to documentation:
  - Documentation of medical necessity (appropriateness of care)
  - Compliance with clinical standards and Optum documentation expectations
  - Clear documentation of which services were rendered by the Provider Quality Specialists
- Request Corrective Action Plans (CAPs) and conduct re-audits based on the initial audit outcome
- Promote understanding and use of best practices
- Participate on provider training teams. These are comprised of the regional Provider Quality Specialist, Field Care Coordinator and the Provider Relations Advocate. These teams will provide technical assistance, coordination and support to providers in their location
- Investigate Quality of Care (QoC) issues
- Link audit data to improvement activities

Treatment Record – Content Standards

Optum requires that all non-electronic treatment records are written legibly in blue or black ink. All treatment records must include the following:

- Each member receiving treatment will have an individual treatment record.
- Each record contains the member's name, address, phone numbers, employer or school information, emergency contact information, relationship and legal status, and guardianship information (when relevant).
- All entries in the treatment record are dated and include the rendering provider's name, professional degree and license information (when applicable); each entry must include a signature.
- Appropriate consent for treatment form(s) must be present in the record.
- Documentation of a DSM-V diagnosis consistent with the presenting problem(s), history, mental status examination, and other assessment data:
  - » List medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of the member's mental health condition.
- The presenting problems and conditions must be documented.
- A behavioral health history, including previous treatment dates and providers, therapeutic interventions and responses, previous medication history, and relevant family history information must be documented as obtained during the initial diagnostic assessment.
- A medical history and/or physical exam (appropriate to the level of care) must be documented.
- A medical health history, including known medical conditions, any drug allergies, previous treatment dates and providers, previous medication history, current treating clinicians, current therapeutic interventions and responses, and relevant family history must be documented.
- Each record indicates what medications have been prescribed, the dosages of each, and dates of initial prescriptions or refills. Informed consent for each medication must be present in the record.
- When a member is prescribed medication, the progress notes must include evidence of medication monitoring.
- A complete mental status exam must be documented.
- A risk assessment including the presence or absence of suicidal or homicidal risk and any behaviors that could present a danger towards self or others must be documented. This includes any previous history of risk behaviors.
- The record must include an assessment of any abuse the member has experienced or perpetrated.
- The record must include an assessment of the following elements: trauma the member has experienced; spiritual and cultural variables impacting treatment; educational status (appropriate to the member's age); legal issues; and identification of community resources the member and member's family are currently accessing.
- For children and adolescents, prenatal and perinatal events must be documented, along with a complete developmental history (physical, psychological, social, intellectual, and academic). For adolescents only, a sexual behavioral history must be documented.
- The initial assessment must include an assessment for depression.
- For members 10 and older, a substance use screening, including alcohol, drugs, prescription and over the counter medications, and nicotine must be present.
- When a substance use disorder issue is identified, the ASAM six-dimensional assessment and/or Global Appraisal of Individual Needs (GAIN) must be completed. An intervention to address the substance issue must be documented.
- On an annual basis, the member is reassessed. The reassessment includes the member's current status and a new mental status exam.
- Coordination of care between the provider and other medical or behavioral providers and institutions must be documented in the record.
- The treatment plan must be geared towards the individual member's needs and include treatment goals in the member's own words.
- There must be documentation that the member or legal guardian has agreed to the treatment plan. Member and, when applicable, family involvement in treatment must be documented.

- The treatment plan must be consistent with the diagnosis, member strengths and functional needs, as well as include objective and measurable short and long-term goals with time frames for goal attainment. The plan must also include an initial discharge plan.
- Treatment plan updates occur when goals are achieved, or new problems are identified.
- Progress notes document the start and stop time for each session.
- Progress notes document who attends each session.
- Progress notes document the billing code that was submitted for the session.
- Progress notes identify the type of intervention used during the session.
- Progress notes reflect reassessments, including ongoing risk assessments.
- Progress notes document progress or lack of progress towards treatment goals.
- Progress notes include identification of member strengths and weaknesses and how those impact treatments.
- Progress notes document the use of any preventive services and referrals to other providers or services.
- When lab work is ordered, the documentation must include evidence that the provider reviewed the lab results and educated the member about the lab results.
- When the member is discharged, a discharge summary must be completed that includes the reason for discharge, the extent to which treatment goals were met, and any recommended follow-up activities.
- The dates of follow-up appointments must be documented.
- If a member misses an appointment, there is documentation indicating why the appointment was missed (if this is known) and what efforts were made to reengage the member in treatment.
- The record must include documentation supporting medical necessity for services that are rendered. This includes identification of functional deficits the member is experiencing and how the services that are rendered will address these deficits. The treatment that is provided should be at the lowest level of care necessary to prevent decompensation and the need for a higher level of care.
- The record must include documentation of any education provided to the member related to treatment options, participation in treatment, coping with behavioral health issues, prognosis and outcomes of treatment, and risks of not participating in treatment.
- If the member has limited English proficiency, there must be documentation indicating that interpreter services were offered and whether the member accepted or declined the services.
- During the chart review process, reviewers will assess the improvement of the member's level of functioning and overall symptom reduction.

Guidelines for Storing Member Records

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

- Practice sites and agencies must have an organized system of filing information in treatment records.
- Treatment records including electronic health records must be stored in a secure area and the site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable laws and regulations, including HIPAA.
- The 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 a minimum period of seven years from the date of service, or in accordance with applicable state or federal laws or regulations, whichever is longer. Termination of the Agreement has no bearing on this requirement.
- Financial records concerning covered services rendered are required to be maintained from the date of service for ten (10) years, or the period required by applicable state or federal law, whichever is longer. Termination of the Agreement has no bearing on this requirement.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Member Access to Medical/Behavioral Health Records

A member, upon written request and with proper identification, may access his/her records that are in the possession of Optum. Before a member is granted access to his/her records, the record will first be reviewed to ensure that it contains only information about the member. Confidential information about other family members that is in the record will be redacted.

Driven by Centers for Medicare & Medicaid (CMS) Interoperability and Patient Access Rules, Medicaid members can access their behavioral health care information by downloading an application on their smart phone, desktop, laptop or tablet.

Information on the application and instructions for use are available to members in their Member Handbook.

Electronic Health Record (EHR) Signatures

Description: This section defines valid member and provider electronic signatures on behavioral healthcare member documents to demonstrate that services have been accurately and fully documented, reviewed, and authenticated.

Guidelines: A signature is considered valid when the following criteria are met:

- Signatures are handwritten or electronic
- Provider credentials are on the behavioral healthcare record, either appended to the signature or on a group practice's stationery

A signature serves three main purposes:

1. Provide authentication of the signatory individual
2. Provide integrity of document's content
3. Provide strong and substantial evidence that will make it difficult for the signer to claim that the documentation is not valid

The individual whose name is on the electronic signature and the provider bear the responsibility for authenticity.

Provider Responsibilities

Electronic Health Record (EHR): An electronic behavioral healthcare record (EHR) that utilizes electronic signatures must meet the following requirements: meet the certification and standard criteria defined in the Health Information Technology Initial Set of Standards; Implementation Specifications; Certification Criteria for Electronic Health Record Technology Final Rule (45 CFR Part 170); and any revisions including, but not limited to, the following:

- Assign a unique name and/or number for identifying, tracking user identity, and establishing controls that permit only authorized users to access electronic health information
- Record actions related to electronic health information according to the standard set forth in 45 CFR § 170.210
- Enable a user to generate an audit log for a specific time period. The audit log must also have the ability to sort entries according to any of the elements specified in the standard 45 CFR § 170.210
- Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information
- Record the date, time, member identification, and user identification when electronic health information is created, modified, accessed, or deleted. An indication of which action(s) occurred and by whom must also be recorded

Ensure the EHR provides:

- Nonrepudiation – assurance that the signer cannot deny signing the document in the future
- User authentication – verification of the signer's identity at the time the signature was generated

- Integrity of electronically signed documents – retention of data so that each record can be authenticated and attributed to the signer
- Message integrity – certainty that the document has not been altered since it was signed
- Capability to convert electronic documents to paper copy – the paper copy must indicate the name of the individual who electronically signed the form as well as the date electronically signed

Ensure electronically signed records created by the EHR have the same back-up and record retention requirements as paper records.

Signature Requirements

Electronic/Digital Signatures: All electronic and digital signatures are required to be dated and time stamped. Acceptable methods for digital and electronic signature capture include but are not limited to the following:

Acceptable methods of digital/electronic signatures for **members**:

- Electronically signed by member
- Digitized signature: Handwritten and scanned into the computer
  - The member could sign a paper document that is scanned and placed into the member's electronic file
  - The member could sign a touchpad signature device similar to when a person makes a credit card purchase. The use of the signature pad produces a graphic image of the person's signature.
  - The member could independently access his/her electronic record using a unique user ID and password via a sequence of entries and enter a mark that she/he adopts as his/her signature.
  - The member could send a picture of a signed document, which can be saved to the member's electronic file.
- ******Email cannot be accepted as a form of electronic signature for members at this time***

Acceptable methods of digital/electronic signatures for **providers**:

- Electronically signed by provider's name and credentials
- Digitized signature: Handwritten with credentials and scanned into the computer
- Attestation with provider's name and credentials. Provider must document explicitly what is being attested to and the parties involved in the attestation.
- Providers can submit email as a form of electronic signature

As required by HIPAA-covered entities, the provider must ensure that the software program used is set up so that the signer cannot deny having signed the document in the future, the signer's identity is guaranteed at the time the signature was generated, and that the document has not been altered since it was signed.

Signature to Scribed Information: Information entered into the healthcare record by a Scribe must be signed by the behavioral healthcare provider and behavioral healthcare provider must authenticate the entry by signing, dating and timing it (for deemed status purposes).

- The role and identity of the Scribe should be clearly noted and distinguishable from that of the behavioral healthcare provider, and the Scribe cannot enter the date and time for the behavioral healthcare provider.

Entries Made on Behalf of Another: When behavioral healthcare providers cannot or do not attest a document because they are no longer available to sign (generally, due to resignation or death), the individual signing the document must be identified as a qualified alternative signer for purpose of record closure.

- A qualified alternate signer is one who is able to uphold the purpose of attestation, is familiar with the clinical case, and can validate the accuracy of the documentation.
- A qualified alternate signer is one who is directly involved in the care of the patient or is a peer physician reviewer within the practice that performs routine clinical reviews, within the past six months.

When entries must be left unsigned because there is not a qualified alternate signer, explanatory documentation should be included in the record to indicate the reason.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Additional Information

EHR systems help providers better manage care for members and provide better behavioral health care by:

- Providing accurate, up-to-date, and complete information about members at the point of care
- Enabling quick access to member records for more coordinated, efficient care
- Securely sharing electronic information with members and other clinicians
- Helping providers more effectively diagnose members, reduce errors, and provide safer care
- Improving member and provider interaction and communication, as well as behavioral health care convenience

3.12 Communication with Providers

Obtaining Clinical Information to Support Utilization Management Decision Making

Optum obtains relevant clinical information and consults with the treating providers when making a determination of medical necessity. All clinicians who make utilization management decisions are trained to use Optum Idaho Level of Care Guidelines, the ASAM Criteria®, LOCUS/CALOCUS-CASII/ ESCII and always to follow their professional judgment in authorizing services.

Providers are to complete the Service Request Forms in their entirety when requesting a service that requires prior authorization. When a Care Advocate is unable to authorize a service request based on the information provided, the Care Advocate may request additional information from the treating provider. If the services cannot be authorized, the Care Advocate refers the request to the Chief Medical Officer or a Peer Reviewer. The Chief Medical Officer or Peer Reviewer makes the decision using clinical judgment and a review of the case against Optum Idaho Level of Care Guidelines, ASAM Criteria®, LOCUS, CALOCUS-CASII, ESCII, the availability of community resources, and the member's individual needs.

If the case is not approved due to not meeting medical necessity, the provider may request a Peer to Peer Conversation with rendering Peer Reviewer, the instructions for which are provided with the Adverse Benefit Determination letter. To facilitate the decision-making process, Optum uses the Optum Idaho Level of Care Guidelines (LOCGs), ASAM Criteria® and LOCUS/CALOCUS-CASII/ESCII. LOCGs are reviewed by Optum on an annual basis.

Insufficient Information

Should a Care Advocate require additional clinical information, the Care Advocate may contact the requesting provider to explain the additional information needed in order to make a determination about the medical necessity of the treatment requested. Providers are afforded two reach-out calls over 48 hours to respond to the Care Advocate request for additional information. If the Care Advocate does not get a response within 48 hours of requesting the additional information, then the Care Advocate cannot render an authorization and at that time forwards the case for Peer Review. The Peer Reviewer (who is a doctorate level and above professional) will review the case information as originally submitted. The Peer Reviewer may render an authorization or a denial determination on the case based on insufficient information to make a determination.

Provider Guidance for using Utilization Management Criteria

Utilization Management criteria for the IBHP is available to providers in this Provider Manual, and in posted Optum Idaho LOCG documents for each benefit offered. These materials are referenced and reviewed routinely over the course of time during various provider trainings. In general, providers may locate and utilize the following guidance offered by Optum:

- Comprehensive information, including the level of care (utilization management) criteria are available for providers on the ***Optum Idaho*** website under Guidelines and Policies.

- The Provider Manual includes links to the criteria and is posted at the ***Optum Idaho*** website. A hard copy of the manual can also be provided upon request.

Optum Idaho Level of Care Guidelines

Our ***Optum Idaho Level of Care Guidelines*** are intended to promote optimal clinical outcomes and consistency in the authorization of benefits by Care Advocacy staff and Peer Reviewers. They are available at ***optumidaho.com*** or you may request a paper copy by contacting Network Management at **1-855-202-0983**.

Best Practice Guidelines

We have adopted ***Best Practice Guidelines*** from external nationally recognized organizations. The guidelines provide information about evidence-based treatment of common behavioral health conditions. Two aspects of each Supplemental and Measurable Guideline are measured annually, and the data is then used to identify opportunity for improvement. Links to these guidelines may be found on ***Provider Express***.

Evidence-Based Practice Resource Library

Optum Idaho has developed a resource list of evidence-based practices (EBPs) to promote the use of scientifically established behavioral health interventions. Training and education in these EBPs will increase the expertise needed to provide effective interventions to members receiving services.

Optum Idaho is not mandating use of specific evidence-based practices but is providing a clearinghouse of resources for providers to access based on their specific need and clinical judgment. The recommendations for external EBP resources are based on research done through SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

For information please visit optumidaho.com > For Network Providers > ***Provider Trainings***.

Assisting with Recovery

We encourage you to assist IBHP members with their recovery by providing information about their condition, its treatment, and self-care resources. Members have the right to information that will inform decision-making, promote participation in treatment, enhance self-management, and support broader recovery goals.

We encourage you to discuss all treatment options and the associated risks and benefits and solicit members' input about their treatment preferences. Nothing in this manual is intended to interfere with your relationship with members as patients.

Assessment Requirements

Thorough clinical assessments are required and should be included in the clinical record. The initial diagnostic assessment, also known as the comprehensive diagnostic assessment (CDA), includes a biopsychosocial history that provides information on previous medical and behavioral health conditions, interventions, outcomes, and lists current and previous medical and behavioral health providers. The mental status exam includes an evaluation of suicidal or homicidal
risk. A substance use screening should occur for members over the age of ten (10) years, noting any substances abused and treatment interventions.

Other areas to be covered in the assessment are developmental history, education, legal issues, social support, as well as cultural and spiritual considerations. A note should also be made of any community resources accessed by the member. A culmination of these assessment aspects, including negative findings, will yield a DSM diagnosis or ICD equivalent.

For routine outpatient services, a Wellness Assessment is to be part of every new treatment episode. Providers should encourage and facilitate their members to complete this assessment.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

This tool contributes to comprehensive treatment planning (see the "Idaho Behavioral Health Plan Benefits, Authorization Requirements and Access to Care" section of this manual).

Technology Review

Technology is reviewed on an as-needed basis with professionals who are actively working with the technology under review and/or clinical issue(s) that may be impacted by the technology under review.

Services of Interpreters

It is typically the provider's responsibility to arrange for the services of interpreters, when indicated, for members under their own care. Interpreter services are covered under the IBHP and the appropriate service codes for billing are included on the Optum Idaho Medicaid fee schedule.

3.13 Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing rules are federal laws enacted to ensure privacy and security of a member's Protected Health Information (PHI). PHI is basically defined as individually identifiable health information that is transmitted or maintained in any form or medium.

Optum's operations are compliant with the required HIPAA privacy practices as well as other applicable state and federal laws. Below are some of the highlights of Optum's privacy practices.

Uses and Disclosure of PHI

We have 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 used and/or disclosed to accomplish the purpose of the disclosure or request.

Request of Information

It is our policy to release information only to the individual, or to other parties designated in writing by the individual, unless otherwise required or allowed by law. For each party that the individual designates permission to access his or her PHI, he or she must sign and date a legally compliant Release of Information (ROI) specifying what information may be disclosed, to whom, for what purpose(s) and during what period of time. An individual's authorization for ROI is not required when PHI is being exchanged with a network clinician, facility or other entity for the purposes of Treatment, Payment, or Health Care Operations as enumerated in HIPAA (and consistent with applicable state and other Federal law).[1]

Identification and Authentication

We require that anyone requesting access to PHI be appropriately identified and authenticated. Members and personal representatives, for example, are required to provide the member identification number and other information (such as the member's date of birth). You or your administrative staff are identified and authenticated in several ways and may be asked for your federal tax identification number or physical address, and patient/member information as part of this verification process.

[1]*"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.*

Internal Protection of Verbal, Written and Electronic PHI

Optum works with UnitedHealth Group, our parent organization, to ensure that all physical and logical safeguards are in place to protect against the unauthorized use, disclosure, modification, and destruction of PHI across all media (e.g., paper records and electronic files). All employees of Optum receive privacy and security training and are familiar with the privacy practices relevant to their job duties and responsibilities.

National Provider Identifier

The purpose of a National Provider Identifier (NPI) is to improve the efficiency and effectiveness of the electronic transmission of health information. We require the billing clinician to include NPI information on all electronic claims. In addition to all electronically submitted claims, Idaho mandates that the NPI be used on all claims (whether paper or electronic submission is used). For more information about obtaining an NPI, you may contact the ***Centers for Medicare and Medicaid Services*** (CMS). For additional information about claims processing, visit Provider Express: Home page > Admin Resources > ***Claim Tips***.

3.14 Manual Updates and Governing Law

This manual may be updated periodically as procedures are modified and enhanced. Providers will be notified a minimum of thirty (30) calendar days prior to any material change to the manual unless otherwise required by regulatory or accreditation bodies. The current version of the manual is always available on ***optumidaho.com***. You can view the manual online or download a complete copy from your computer. If you do not have internet access or printing capabilities, you may request a paper copy by contacting Network Management at **1-855-202-0983**.

Governing Law and Contract

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual conflict with 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.

3.15 Anti-Fraud, Waste and Abuse

Optum Idaho is committed to addressing and correcting known offenses, recovering lost funds, improving overall anti-Fraud, Waste and Abuse (FWA) ability and partnering with state and federal agencies to pursue and prosecute violators to the fullest extent of the law.

Program Introduction

The Provider Network Integrity Program (PNI) Program incorporates multiple components leveraging technology, expertise and collaboration in a proactive way. Program components include but are not limited to the following: education and awareness, prevention, detection, investigation, system enhancement and capability, corrective action and recovery and resolution. The PNI team consists of clinicians, investigators, pre-payment intervention specialists, data analytics staff, certified coders and executive leadership.

Potential fraud, waste and/or abuse practices include, but are not limited to, filing fraudulent claims, fraudulent authorization of claims, misrepresentation of services provided, abuse of services in order to obtain a benefit (including personal or commercial gain) from a Payor to which an individual or entity is not entitled. The identification process includes, but is not limited to, examining claims of providers to identify outlier practice patterns.

In the event potential fraud, waste and/or abuse is identified, appropriate interventions are implemented. Possible interventions may include but are not limited to outreach meetings and/or written correspondence to providers, records review and/or site audit, individual case peer-to-peer reviews, and referral for further investigation. You are

contractually required to cooperate in this process and participate in any activities related to the identification and correction of potential fraud, waste, and abuse. Once an intervention has occurred, we continue to monitor to ensure that providers adhere to all requirements for payment.

Education, Awareness & Compliance Training

All providers and affiliates working on Medicare Advantage, Part D or Medicaid programs must provide compliance program training and anti-Fraud, Waste, and Abuse (FWA) training within 90 days of employment and annually thereafter (by the end of the year) to their employees and/or contractors. The training is subject to certain requirements and may be obtained through OptumHealth or another source.

All providers and affiliates meeting the FWA certification requirements through enrollment in the fee-for-service Medicare program are deemed by CMS rules to have met the training and education requirements. It is your responsibility to ensure that your organization is provided with appropriate training for your employees and applicable subcontractors. To facilitate that, we provide training and educational materials via ***Provider Express***: Home page > Admin Resources > Fraud, Waste Abuse, and Error and Payment Integrity.

In compliance with federal regulations, you are required to administer the compliance and FWA training materials to your employees and/or contractors. If your organization has already completed a compliance and FWA training program—either on your own or through a Medicare plan—that meets CMS requirements, we will accept documentation of that training. You must maintain records of the training (e.g., sign-in sheets, materials, etc.) in compliance with CMS requirements. Documentation of the training may be requested at any time for verification that training was completed.

Prevention, Detection and Pre-Payment Process

Among the ways we address prevention are education, use of rigorous credentialing standards, and proper contracting.

We have a pre-payment program that leverages technology to search through real-time claims data to alert us to anything unusual in that data in order to make a determination to pay or to investigate further. The FWA look back period is normally determined by state and federal regulation and is generally unlimited in scope.

Overpayment Process

Providers are required to notify Optum when they become aware of an overpayment, return the overpayment within 60 days after the overpayment was identified and provide in writing the reason for the overpayment. [***42 CFR 438.608(d)(2)***].

Post-Payment Investigations and Corrective Action Plan (CAP)

When potential fraud, waste and abuse is reported or detected, we conduct an investigation to determine potential corrective action. A sample of retrospective FWA investigation actions may include, but is not limited to, contacting providers to obtain and review medical and billing records; reviewing providers' disciplinary activity, civil or criminal litigation, and financial records; educating providers on errors in their billing and negotiating with providers on corrective action plan and settlement of overpayment. Following investigation, timely payment is made or, in the event that a claim denial is issued, the denial notification includes the provider's standard appeal rights.

Findings of billing inconsistent with our policies by in-network providers may result in such actions as clarification of proper procedure, a Corrective Action Plan (CAP), a change in network availability status, or may result in termination of your Agreement. In the case of retrospective review, Optum and our Payors reserve the right to pursue recoupment of funds paid. The Credentialing Committee may recommend termination. In that event, the provider is notified in writing and provided with information about appeal rights, if applicable, and in compliance with state and federal laws. A provider's voluntary termination from the network does not suspend or stop fraud, waste and/or abuse investigations or reviews, which may still be required by law.

Regulatory Reporting

Optum works closely with state and federal agencies in combating fraud, waste and abuse and periodically refers suspected and/or confirmed cases of fraud, waste and abuse to these agencies as required by regulation and contract.

Cooperation with State and Federal Agencies

Optum is committed to working with and cooperating fully with state and federal agencies in battling FWA. Optum will work diligently to fulfill all requests for investigative assistance, subpoenas and/or other investigative information requests. This includes but is not limited to providing information pursuant to civil and/or criminal proceedings, as well as providing expert opinion or fact testimony at depositions and trials.

Optum will participate with and contribute to information sharing sessions, working groups, task forces and communication efforts to enhance the overall national anti-FWA effort. Optum will retain all records pursuant to these activities and may be required to produce those records upon request in accordance with applicable laws and regulations.

As warranted, providers will be reported to the Idaho Department of Health and Welfare, Idaho licensing board(s), and any other regulatory agencies based on the outcome of the investigation and as required by contract and/or state and federal laws. Throughout this process, we adhere to state law, ERISA guidelines, and confidentiality standards.

Code of Conduct and Conflict of Interest Policy Awareness

All providers and affiliates working on Medicare Advantage, Part D or Medicaid programs—including contracted providers— must provide a copy of our Code of Conduct to employees and contractors.

You can obtain and review our ***Code of Conduct*** at ***unitedhealthgroup.com***.

Exclusion/Sanction/Debarment Checks

All providers and affiliates must review federal exclusion lists (HHS-OIG and GSA) at the time of hire/contracting with their current employees/contractors, health care professionals, or vendors that work on Medicare Advantage, Part D or Medicaid programs to ensure that none are excluded from participating in Federal health care programs. For more information or access to the publicly accessible excluded party online databases, please see the following links:

- Health and Human Services – ***Office of the Inspector General*** (HHS-OIG) List of Excluded Individuals / Entities: Office of Inspector General
- General Services Administration (GSA) Excluded Parties List System (EPLS) is accessible through the ***System for Award Management (SAM)*** site: System for Award Management.

What You Need to Do:

Review applicable exclusion/sanction/debarment lists to ensure that none of your employees or contractors are excluded from participation in federal health care programs.

We have guidelines to address suspected fraud, waste and/or abuse by providers. In accordance with your Agreement, you are required to cooperate with the review process to include any requests for medical records.

You can report potential violations using the "Tip Referral Form" located at the IDHW website link below or by calling the Fraud Tip Hotline at **1-866-242-7727**.

The Medicaid Program Integrity Unit's contact information can be found on the ***Idaho Department of Health and Welfare's*** website.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

3.16 Compensation and Claims Processing

The network rate for eligible outpatient visits is reimbursed to you at the lesser of (1) your customary charge, or (2) the Optum Idaho fee maximum.

Financial records concerning covered services rendered are required to be maintained from the date of service for the greater of 10 years, or the period required by applicable state or federal law, whichever is longer. Any termination of the Agreement has no bearing on this legal obligation.

Balance Billing for Covered Services Is Prohibited

Under the terms of the Agreement, you may not balance bill members for covered services provided during eligible visits, which means you may not charge members the difference between your billed usual and customary charges and the aggregate amount reimbursed by Optum. Additionally, if a claim denies correctly there will be no balance billing of members for that amount.

Claims Submission

The provider shall submit claims using current (CMS) Form 1500 (its equivalent or successor) with applicable coding including, but not limited to, ICD-10 (or its successor), CPT, and HCPCS coding.

The provider shall include in a claim the member number, provider's Federal Tax ID number, National Provider Identifier (NPI) and/or other identifiers requested by Optum.

In addition, you are responsible for billing of all members in accordance with the nationally recognized CMS Correct Coding Initiative (CCI) standards. Please visit the ***CMS*** website for additional information on CCI billing standards.

Claims are reimbursed based on the Optum Idaho Medicaid network fee schedule for services covered by the IBHP.

For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes.

Claim Entry through Provider Express

You should file Optum claims at ***Provider Express***. This secured, HIPAA-compliant transaction feature is designed to streamline the claim submission process. It performs well on all connection speeds and submitting claims on Provider Express closely mirrors the process of completing a Form 1500. In order to use this feature, you must be a network clinician or group practice and have a registered user One Healthcare ID and password for Provider Express. To obtain a One Healthcare ID, click on the "First-time User" link in the upper right-hand corner of the home page and follow the prompts.

We strongly encourage you to use this no-cost claims entry feature for claims submission at Provider Express, which allows claims to be paid quickly and accurately. For more information about fast and efficient electronic claims submission, please see Provider Express "***Improve the Speed of Processing—Tips for Claims Filing***."

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 practitioner (physician, psychologist, social worker) and a Payor (Optum). You may choose any clearinghouse vendor to submit claims through this route. Because Optum has multiple claims payment systems, it is important for you to know where to send claims. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. For Optum claims use Payer ID #87726. Additional information regarding EDI is available on Provider Express "***Claim Tips***."

Clinician Claim Forms

Paper claims can be submitted to Optum using the Form 1500. The claims should include all itemized information such as diagnosis (from current version of DSM), length of session, member name, member date of birth, member identification number, dates of service, type and duration of service, name of rendering provider (i.e., individual who actually provided the service), credentials, tax ID and NPI numbers.

Paper claims submitted via U.S. Postal Service should be mailed to:

Optum
P. O. Box 30760
Salt Lake City, UT 84130-0760

Online Claims Help

Contact information for Claims and Customer Service issues can be found in the "***Contact Us***" section of Provider Express.

To ensure proper processing of claims, it is important to promptly contact Network Management if you change your Tax ID number. You may make changes to your practice address online at ***Provider Express***.

Customer Service Claims Help

Optum Idaho has a dedicated customer service department with staff available five days a week during regular business hours to assist our network with questions related to general information, eligibility verification or the status of a claim payment.

The Optum Idaho customer service phone number is: **1-855-202-0983**.

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 the 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.

If the IBHP is a secondary plan, you will be paid up to the Optum contracted rate according to "lessor of" logic. 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.

In general, if the member has dual coverage, submit to Medicare first as Medicaid is always 'the Payor of last resort'; when the service is not covered by Medicare, the provider should submit directly to Optum first. If the member is covered by another form of insurance, submit to Optum Idaho with evidence of how or whether any portion was covered by the other insurer.

Use the following formula to calculate the coordination amount:

Eligible/Contracted amount minus Primary paid amount = X

Situation	Action
X is less than or equal to patient responsibility	Pay up to X.
X is greater than or equal to patient responsibility	Pay up to patient responsibility.
X is less than or equal to 0	Pay nothing.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Processing and Payment of Claims

All information necessary to process claims must be received by Optum Idaho no more than 90 calendar days from the date of service. Claims received after this time period may be rejected for payment at the discretion of Optum and/or the Payor. You may not bill the member for claim submissions that fall outside these established timelines. Any corrections or additions to a claim should be made within 90 days of receipt of the initial claim.

Claims should be submitted as directed by Optum. We strongly recommend that you keep copies of all claims for your own records. You permit Optum, on behalf of the Payor, to bill and process forms for third-party claims or for third-party Payors and execute any documents reasonably required or appropriate for this purpose. In the event of insolvency of the IBHP or Optum, your sole redress is against the assets of Optum or IDHW, not the member. You must agree to continue to provide services to members. Any termination of the Agreement has no bearing on this requirement.

Claims that contain all of the required information and match the authorization, if applicable, will be paid to the following standard (for the entire network as a whole) per Optum Idaho contract requirements: pay 90% of clean claims within 30 days and 99% of clean claims within 90 days after receipt. This may exclude claims that require Coordination of Benefits (COB) determinations. Benefits are payable provided coverage is in force at the time expenses are incurred, and are subject to all limitations, provisions and exclusions of the plan. You will be paid for covered services by Optum and will not under any circumstances seek payment through Optum for plans for which Optum is not the Payor or administrator.

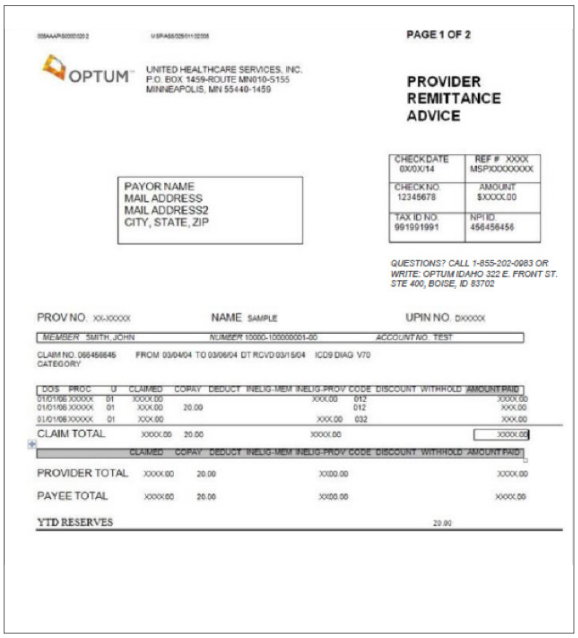
Optum may make corrective adjustments to any previous payments for services and may audit claims submissions and payments to ensure compliance with applicable policies, standards, procedures, including without limitation, the Manual, the Credentialing Plan, the Agreement, and state and federal law. Optum may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law.

Optum Idaho will use a check writing process two times per week to ensure network providers experience timely receipt of reimbursement for services rendered. Checks are issued with a Provider Remittance Advice (PRA).

The Provider Remittance Advice contains the following elements (an example mock-up is shown below):

- Member name
- Member number
- Claim number
- Rendering provider number
- Supervising provider number
- Check number
- Account number
- Check date
- Date of service
- Procedure code
- Amount billed
- Amount paid
- Provider Tax ID number
- Payee ID number
- Billing provider name
- Code descriptions (e.g., non-covered service)
- Optum Claims and Customer service phone number

Example Provider Remittance Advice:



PAGE 1 OF 2

OPTUM

UNITED HEALTHCARE SERVICES, INC.
P.O. BOX 1459-ROUTE MN010-5155
MINNEAPOLIS, MN 55440-1459

PROVIDER REMITTANCE ADVICE

CHECK DATE	REF # XXXX
0X/0X/14	MSPIXXXXXXXX
CHECK NO.	AMOUNT
12345678	$XXXX.00
TAX ID NO.	NPI ID
991991991	456456456

PAYOR NAME
MAIL ADDRESS
MAIL ADDRESS2
CITY, STATE, ZIP

QUESTIONS? CALL 1-855-202-0983 OR WRITE: OPTUM IDAHO 322 E. FRONT ST. STE 400, BOISE, ID 83702

PROV NO. XX-XXXXX NAME SAMPLE UPIN NO. DXXXXX

MEMBER SMITH, JOHN NUMBER 10000-100000001-00 ACCOUNT NO. TEST

CLAIM NO. 066456646 FROM 03/04/04 TO 03/06/04 DT RCVD 03/15/04 ICD9 DIAG V70
CATEGORY

DOS	PROC	U	CLAIMED	COPAY	DEDUCT	INELIG MEM	INELIG PROV	CODE	DISCOUNT	WITHHOLD	AMOUNT PAID
01/01/06	XXXXX	01	XXX.00				XXX.00	012			XXX.00
01/01/06	XXXXX	01	XXX.00	20.00				012			XXX.00
01/01/06	XXXXX	01	XXX.00				XXX.00	032			XXX.00
CLAIM TOTAL			XXXX.00	20.00			XXXX.00				XXXX.00
			CLAIMED	COPAY	DEDUCT	INELIG MEM	INELIG PROV	CODE	DISCOUNT	WITHHOLD	AMOUNT PAID
PROVIDER TOTAL			XXXX.00	20.00			XX00.00				XXXX.00
PAYEE TOTAL			XXXX.00	20.00			XX00.00				XXXX.00
YTD RESERVES											20.00

3.17 Provider Disputes

There are two distinct processes related to an Adverse Benefit Determination regarding requests for services or payment:

- Member Appeals
- Provider Disputes

An Adverse Benefit Determination for the purposes of this section is a decision by Optum to deny, in whole or in part, a request for authorization of treatment and/or of a request for payment. An Adverse Benefit Determination may be subject to the Appeal process (see below) or Provider Dispute process (see below) depending on the nature of the Adverse Benefit Determination, claims filed, member liability and your Agreement.

Care Advocacy decision-making is based on the appropriateness of care as defined by the Idaho Medicaid Supplemental Clinical Criteria Optum Idaho Level of Care Guidelines, LOCUS/CALOCUS-CASII/ESCII, The American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide, The ASAM Criteria®, as well as the terms and conditions of the member's Benefit Plan.

The Idaho Medicaid Supplemental Clinical Criteria Optum Idaho Level of Care Guidelines and the American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide for Optum Idaho are available on ***optumidaho.com*** and ***providerexpress.com***. To request a paper copy of the Idaho Medicaid Supplemental Clinical Criteria Optum Idaho Level of Care Guidelines, the American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide, and/or the applicable section of The ASAM Criteria®, please contact Provider Relations at **1-855-202-0983**. All treatment certified by Optum must be outcome-driven, clinically necessary, rational, evidence-based and provided in the least restrictive environment possible.

Optum offers no financial rewards or other incentives for providers, utilization reviewers or other individuals to reduce behavioral health services, limit the length of stay, withhold or deny benefit coverage.

Provider Dispute Process

You may dispute or request for reconsideration of a claim (or group of claims) that has been denied, adjusted or contested. Members cannot be held financially liable for services received and therefore, you cannot bill the member for these services beyond the applicable co-payments or deductibles. For all services requiring a prior authorization, a request must be made and approved prior to providing the requested service and submitting a claim.

The Provider Dispute process must be initiated by contacting Optum via one of the methods listed below and must include the following information:

- Member identifying information:
  - Name
  - Medicaid Identification number (MID)
  - Date of birth
  - Address
- The type of service
- Each applicable date of service and units
- Your identifying information:
  - Name
  - Tax identification number
  - Contact information
- Dollar amount in dispute, if applicable
- Any additional information you would like to have considered as part of the dispute process, including but not limited to, administrative records which dispute the reason for the denial of the claim, such as explanation of benefits from other insurance showing a trial of attempted claim submitted, proof of claim acceptance from Provider Express, prior authorization approval letter from Optum (where applicable)
- Your explanation as to why the adverse decision should be overturned

Where to submit a Provider Dispute:

- **Mail**: Optum Idaho, 322 E. Front Street, 4th Floor, Boise, ID 83702
- **Fax: 1-888-950-1182**
- **Email:** *optum.idaho.provider.dispute@optum.com*
- **Online**: ***providerexpress.com***

For questions or assistance, call **1-855-202-0983** and press prompt **4**.

The Provider Dispute process is available for post-service requests for which a claim has already been submitted. Disputes related to pre-service and other concurrent service requests are subject to the member appeal process previously described. Disputes related to post-service requests that, due to extenuating circumstances failed to obtain prior authorization, and no claim filed, are subject to the retrospective review process. To initiate a Provider Dispute, Optum must receive your request within 180 calendar days from the date you received the Provider Remittance Advice (PRA) from Optum.

Disputes received outside of this timeframe will not be processed. Optum will notify you or your authorized representative of the dispute resolution in writing within 30 calendar days of the receipt of your request.

Section **4**

Idaho Behavioral Health Plan

Optum Idaho establishes guidelines and requirements for providers. Where required by law, more stringent standards may be applied. However, if state law permits the application of less stringent standards, the Optum standards specified herein shall still be applied pursuant to the terms of your Agreement. In accordance with industry standards and best practices, Optum may review and modify authorization procedures.

4.1 Treatment Philosophy

We are committed to creating and maintaining relationships with Optum Idaho network providers. We believe that optimal treatment is attained when delivered in the setting that is both the least restrictive and the one with the greatest potential for a favorable outcome. We know it is the efforts of our clinical network that give IBHP members the best opportunity to achieve a level of functioning that supports their quest to live healthier lives. As a result, our priority is creating relationships with network providers that ensure appropriate, time-effective clinical treatment. Through this partnership we look to foster positive outcomes for IBHP members receiving behavioral health services.

In accordance with your Agreement, you are required to provide services to all IBHP members and their families in a manner that is consistent with professional and ethical standards as set forth by national certification and state licensing boards and applicable IDHW regulations. Resources are available to you which outline the expectations for Optum Idaho network
treatment quality.

This manual addresses assessments, treatment and discharge planning, coordination of care, and member rights and responsibilities (see also the “Treatment Record Documentation Requirements” section of this manual). Additional resources in these areas can be found at ***optumidaho.com*** as well as on ***Provider Express***: Home page > Clinical Resources > Guidelines/Policies. You will find the following guidelines, including but not limited to:

- Idaho Medicaid Supplemental Clinical Criteria Optum Idaho Level of Care Guidelines
- Best Practice Guidelines:
  - OH/OHBS-CA
  - The American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide

Optum utilizes ASAM Criteria® for SUD related services at ***asam.org***.

Optum participates with health plans in measuring performance on NCQA HEDIS® measures and incorporates these standards into our requirements and guidelines.

4.2 Member Rights and Responsibilities

Below you will find our Member Rights and Responsibilities. You may request a paper copy by contacting Network Management at **1-855-202-0983** (see "Provider Resources" section of this manual). These rights and responsibilities are in keeping with industry standards. All members benefit from reviewing these standards in the treatment setting. We request that you display the Rights and Responsibilities in your waiting room or have some other means of documenting that these standards have been communicated to Optum members.

In the course of care, a member has both rights and responsibilities.

Member Rights

Optum Idaho believes and supports the proposition that every member has the right to:

- Receive information about Optum's services, network practitioners and member's rights and responsibilities
- Be treated with respect and recognition of his or her dignity and right to privacy
- Participate with network practitioners in making decisions about his or her health care:
  - Provider disputes should not interfere with the professional relationship between you and the member
- A candid discussion of appropriate or medically necessary treatment options for his or her condition
- Voice complaints or appeals about Optum for the services provided by Optum
- Make recommendations regarding Optum's members' rights and responsibilities policies
- Care that is considerate and that respects his or her personal values and belief system
- Personal privacy and confidentiality of information
- Reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability
- Have family members participate in treatment planning. Members over 12 years old have the right to participate in such planning
- Individualized treatment, including:
  - Adequate and humane services regardless of the source(s) of financial support
  - Provision of services within the least restrictive environment possible
  - An individualized treatment or program plan
  - Periodic review of the treatment or program plan
  - An adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment or program plan
- Participate in the consideration of ethical issues that may arise in the provision of care and services, including:
  - Resolving conflict
  - Withholding resuscitative services
  - Forgoing or withdrawing life-sustaining treatment
  - Participating in investigational studies or clinical trials

- Designate a surrogate decision-maker if he or she is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care
- Be informed, along with his or her family, of his or her Optum rights in a language they understand
- Choose not to comply with recommended care, treatment, or procedures and be informed of the potential consequences of not complying with the treatment recommendations
- Be informed of rules and regulations concerning his or her own conduct
- Be informed of the reason for any non-coverage determination, including the specific criteria or benefits provisions used in the determination
- Have decisions about the management based on behavioral health benefits; Optum does not reward network practitioners or other individuals for issuing non-coverage determinations
- Inspect and copy their protected health information (PHI) and in addition:
  - » Request to amend their PHI
  - » Request an accounting of non-routine disclosures of PHI
  - » Request limitations on the use or disclosure of PHI
  - » Request confidential communications of PHI to be sent to an alternate address or by alternate means
  - » Make a complaint regarding use or disclosure of PHI
  - » Receive a Privacy Notice
- Receive information about Optum's clinical guidelines and Quality Assurance and Performance Improvement (QAPI) program

Member Responsibilities

In addition to the rights listed above, every member has the responsibility to:

- Supply information (to the extent possible), that Optum and its network practitioners need in order to provide care
- Follow plans and instructions for care that they have agreed on with his or her network practitioner
- Understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- Keep scheduled appointments and actively participate in treatment

Member Education

We offer a variety of Health and Wellness tip sheets for members. These are educational materials, written in common, everyday language. Topics include, but are not limited to, general therapy issues, self-help, mood and anxiety disorders, and substance use disorders. Tip sheets address child, adult and elderly populations. As a provider, you are encouraged to distribute these to members as appropriate. Health and Wellness Tips are available at ***optumidaho.com*** via the ***liveandworkwell.com*** link under the "External Optum Sites" section, or you can request paper copies by contacting Network Management at **1-855-202-0983**.

4.3 Prior Authorization Requirements

Authorization Requirements Categories

The authorization process for services covered by the IBHP vary depending on the category the requested service falls within. For purposes of authorization, Optum Idaho covered benefits are divided into four categories:

- **No Authorization Required**
  Basic services which require no authorization
- **Prior Authorization Required**
  Specialized outpatient services, which are authorized to the specific provider typically for no more than 90 calendar days based on criteria focused directly on each separate service in that category. Services in this

CLICK HERE TO RETURN TO TABLE OF CONTENTS

category require provider-specific authorization and, in some cases, submission of additional information and documentation. The provider must request the authorization for most services using the Service Request links on ***optumidaho.com*** in advance of the provision of the service.

- **Threshold Authorizations (no authorization required until established threshold is reached)**
  Select specialized outpatient services that can be performed up to a certain established threshold before a provider-specific authorization is needed. The units for these services are provided per member and per calendar year: thresholds will be renewed annually. These services, like all services, should be provided only when medically necessary. When additional services are required, they must be requested in advance of the provision of the services.
- **Guidelines**
  Some services, such as the CANS, have a specified number of hours per year that are indicated on the fee schedule. The hours per member on these services are guidelines. Optum will analyze claims information to identify outlier cases that may benefit from a clinical review when utilization exceeds the guidelines. These guidelines do not indicate there is a hard limit and there is no requirement for an authorization to exceed the indicated hours. Please see the fee schedule for a complete listing of services that have a guideline indicated.

Optum recognizes that some substance use disorder (SUD) and other services are court related, and that when the member is Medicaid eligible, the SUD and other providers for these services need to follow the required authorization process. Optum will work closely with the courts and SUD providers to facilitate compliance with this process. Optum also recognizes that not all court-ordered services will meet medical necessity, in which case Optum will work with the provider and court to help the member receive the appropriate services.

Services Requiring Prior Authorization

The following services require prior authorization:

CPT Code	Service
97151-97158; 0362T; 0373T	Behavioral Modification and Consultation
H0036	Intensive Home and Community Based Services – Functional Family Therapy, Multidimensional Family Therapy, and other modalities
H2033	Intensive Home and Community Based Services – Multisystemic Therapy
H2012	Child Day Treatment
H0035; 912, 913	Partial Hospitalization Programs (PHP) MH/SUD

Prior Authorization Not Required

These outpatient services will be reimbursed by Optum Idaho when they are provided by a network provider to a member. The claim will be paid based on verification of member eligibility and provider contract status. For services that do not require prior authorization, Optum will analyze claims information to identify outlier cases that may benefit from a clinical review.

An Optum Idaho network provider can initiate services not requiring prior authorization to a member of the Idaho Behavioral Health Plan without contacting Optum Idaho. After the network provider provides any of these outpatient services to a member of the Idaho Behavioral Health Plan, the provider must submit the claim to Optum Idaho and the claim is paid after verification through the claims system of the member's plan enrollment on the date of enrollment and the provider's network status.

Providers of outpatient services are also expected to submit the member's Optum Wellness Assessment.

All services provided to IBHP members (whether a prior authorization is required or not) must be medically necessary.

Mental Health

CPT Code	Service
90791	**Comprehensive Diagnostic Assessment** (including treatment plan)
90792	**Comprehensive Diagnostic Assessment by Prescribing Professional** (including treatment plan)
90832-90838	**Individual Psychotherapy**
90839-90840	**Individual Crisis Psychotherapy**
90846-90847	**Family Psychotherapy**
90853	**Group Psychotherapy**
99201-99205; 99211-99215	**Medication Management**
96130-96139	**Psychological Testing**
96116-96139	**Neuropsychological Testing**
G9007	**Child and Family Team (CFT) Interdisciplinary Team Meeting**
S5150	**Respite Services**
H2027	**Family Psychoeducation**
H0032	**Individualized BH Treatment Plan –** teaming between clinician and paraprofessional
H2014	**Skills Training and Development (STAD)**
S9485	**Crisis Center**
H2011	**Crisis Intervention**
H0030	**Crisis Response**
S9480	**IOP-Intensive Outpatient Program – MH**
T1013	**Language Interpretative Services**
Q3014	**Telehealth Originating Site Facility Fee**
T2002	**Mileage Reimbursement**

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Substance Use Disorder Services

CPT Code	Service
H0001	**Substance Use Disorder Assessment**
H0004	**Substance Use Disorder Individual**
H0005	**Substance Use Disorder Group**
H0015	**IOP-Intensive Outpatient Program – SUD**

Threshold Authorizations

No prior authorization is needed up to a pre-determined threshold for these services. After this threshold is met, a provider-specific prior authorization is needed.

Like other services, this category of outpatient services will be reimbursed by Optum Idaho when they are provided by a network provider to an enrolled member of the Idaho Behavioral Health Plan and are indicated as medically necessary. The claim will be paid based on verification of member eligibility and provider contract status with reference to the thresholds noted below:

T1017	**Case Management – Behavioral Health –** Threshold is 240 units per member, per calendar year. Additional services must be prior authorized by submitting a Case Management service request form in advance of the provision of services via ***Optum Idaho*** or ***Provider Express***.
H2017	**Skills Building/Community Based Rehabilitative Services (CBRS) –** Threshold is 308 units per member, per calendar year. Additional services must be prior authorized by submitting a Skills Building/Community Based Rehabilitative Services (CBRS) service request form in advance of the provision of services via ***Optum Idaho*** or ***Provider Express***.
80305, 80306, 80307	**Drug Testing –** Threshold is 24 units/tests (combination of 80305, 80306, 80307) per member per calendar year, additional services must be prior authorized.
96156, 96158, 96159, 96164, 96165, 96167, 96168	**Health Behavior Assessment and Intervention** – Threshold is 60 units for all codes combined per member, per calendar year. Each visit shall not exceed one hour in duration. Additional services must be prior authorized by submitting a Health Behavior Assessment and Intervention service request form in advance of the provision of services via ***Optum Idaho*** or ***Provider Express***.

Optum expects that paraprofessionals are appropriately supervised by a qualified clinician in this activity. For further information, please review the supervisory protocol in your Optum Network Agreement.

Peer Services

H0038	**Adult Peer Support by a qualified Peer Support Specialist –** Threshold is 416 units per member, per calendar year. This service is provided to members age 18 and older. Additional services must be prior authorized via ***Optum Idaho*** or ***Provider Express***.

(Continued on next page)

H0038	**Youth Support by a qualified Youth Support provider. –** Threshold is 416 units per member, per calendar year which includes both individual and group. This service is provided to members ages 12 to 17. Additional services must be prior authorized via ***Optum Idaho*** or ***Provider Express***.
H0038 HF	**Recovery Coaching by a qualified Recovery Coach –** Threshold is 416 units per member, per calendar year. This service is provided to members age 18 and older. Additional services must be prior authorized via ***Optum Idaho*** or ***Provider Express***.
H0046	**Family Support Services by a qualified Family Support Partner** – Threshold is 416 units per calendar year. This service is provided to members under the age of 18 years of age and their families. Additional services must be prior authorized via ***Optum Idaho*** or ***Provider Express***.

4.4 IBHP Available Services

Optum Idaho administers outpatient behavioral health managed care benefits for Idaho Behavioral Health Plan (IBHP) members. All IBHP members shall be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other patients of the provider. Providers should reference the Optum Idaho Level of Care Guidelines (LOCGs), Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), Early Childhood Service Intensity Instrument (ECSII), for service definitions and for more detail regarding the appropriate provision of these benefits. These documents are located at optumidaho.com in the "***For Network Providers***" section and Optum ***Provider Express*** website. For substance use disorder (SUD) services, providers utilize the ASAM Criteria®. For more information regarding the ASAM Criteria®, please visit the following link: ***asam.org***.

The following are available and accessible to all IBHP members when determined to be medically necessary:

4.5 Outpatient Mental Health Services

Individual Psychotherapy

Description

Psychotherapy is the practice of a trained professional clinician applying clinical techniques that originate from the principles of psychology in order to help members adjust to situations in their lives, manage or change how they think, manage or change how they feel, alter certain behaviors, or bring about change in other areas of their lives. Interventions are designed to build on and/or develop member's strengths, address identified needs, and improve and/or stabilize functioning of the member.

Outpatient individual psychotherapy services are in-person, non-electronic services (except when Telehealth is provided in accordance with board regulations) and are used to treat mental health conditions. Individual Psychotherapy may be delivered in a home or community-based setting.

Provider Qualifications

Providers will be licensed clinicians as defined per licensure by the Idaho Division of Occupational and Professional Licenses and IDAPA; and/or practicing under the Optum Idaho supervisory protocol.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Provider Responsibilities

Individual psychotherapy is provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment care needs.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
90832	*See below*	Psychotherapy, 30 minutes ***	1 unit = 1 visit
90833	*See below*	Psychotherapy, 30 minutes with evaluation and mgmt. services ***	1 unit = 1 visit
90834	*See below*	Psychotherapy, 45 minutes ***	1 unit = 1 visit
90836	*See below*	Psychotherapy, 45 minutes with evaluation and mgmt. services ***	1 unit = 1 visit
90837	*See below*	Psychotherapy, 60 minutes with patient and/or family member; when appropriate may report interactive complexity add-on code 90785	1 unit = 1 visit
90838	*See below*	Psychotherapy, 60 minutes with patient and/or family member with an evaluation and management service; when appropriate may report interactive complexity add-on code 90785; use in conjunction with 99201-99215	1 unit = 1 visit

Psychotherapy, 30 or 45 minutes with patient, when appropriate may report with interactive complexity add on code 90785. Do not report psychotherapy of less than 16 minutes duration.

Modifier	Professional Level of Provider
U1	Prescribers under supervision
HO	Master's level provider under supervisory protocol
GT	Service rendered via Telehealth.

Applicable modifiers based on credentialed level of the professional providing the services as below:

****Note: Psychotherapy services may be provided as part of the Therapeutic After School and Summer Programs (TASSP). The UC modifier is used to indicate that the service was rendered as a TASSP service.*

There are certain license types who do not have an NPI number in order to bill and therefore must use the NPI of a supervising clinician and the appropriate modifier (HO, U1) in order for the claim to pay.

Additional Information

Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.

This service may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.

Crisis Psychotherapy

Description

Crisis Psychotherapy is provided when a member is experiencing an acute crisis, is not at imminent risk of harm to self or others, and psychotherapy for crisis is appropriate for providing rapid and time-limited assessment and stabilization.

Provider Qualifications

Providers will be licensed clinicians as defined per licensure by the Idaho Bureau of Licenses and IDAPA; and/or practicing under the Optum Idaho supervisory protocol.

Provider Responsibilities

Crisis psychotherapy is provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
90839	*See below*	Psychotherapy for Crisis - first 60 min.	1 unit = 1 visit
90840	*See below*	Psychotherapy for Crisis - each add. 30 min.	1 unit = 1 visit

Applicable modifiers based on credentialed level of the professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescribers under supervision
HO	Master's level provider under supervisory protocol
GT	Service rendered via Telehealth.

Additional Information

This service may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.

Family Psychotherapy

Description

Family psychotherapy is a form of psychotherapy that focuses on the improvement of interfamilial relationships and behavioral patterns of the family unit, as well as among individual members and groupings, or subsystems, within the family. Interventions are designed to build on and/or develop member and member's family's strengths, address identified needs, and improve and/or stabilize functioning of the member and the member's family.

CPT Code	Modifier	Description	Unit
90846	*See below*	Family psychotherapy, without the patient present ***	1 unit = 1 visit
90847	*See below*	Family psychotherapy, with patient present ***	1 unit = 1 visit

Applicable modifiers based on credentialed level of the professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescribers under supervision
HO	Master's level provider under supervisory protocol
GT	Service rendered via Telehealth.

Outpatient family psychotherapy services are in-person, non-electronic services (except when Telehealth is provided in accordance with board regulations) and is used to treat mental health conditions and substance use disorders. Family Psychotherapy may be delivered in a home or community-based setting.

Provider Qualifications

Providers will be licensed clinicians as defined per licensure by the Idaho Division of Occupational and Professional Licenses and IDAPA; and/or practicing under the Optum Idaho supervisory protocol.

Provider Responsibilities

Family psychotherapy is provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

Authorization Type

No prior authorization is required.

Payment Methodology

Family Psychotherapy, without patient present or conjoint psychotherapy with patient present.

Additional Information

Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.

This service may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.

Group Psychotherapy

Description

Group psychotherapy is the treatment of psychological problems in which three or more members interact with each other on both an emotional and a cognitive level in the presence of a clinician who serves as a catalyst, facilitator, or interpreter. Group psychotherapy approaches vary, but in general groups aim to provide an environment in which problems and concerns can be shared in an atmosphere of mutual respect and understanding. Group psychotherapy seeks to enhance self-respect, deepen self-understanding, and improve interpersonal relationships.

Outpatient group psychotherapy services are in-person, non-electronic services (except when Telehealth is provided in accordance with board regulations) and are used to treat mental health conditions.

Provider Qualifications

Providers will be licensed clinicians as defined per licensure by the Idaho Division of Occupational and Professional Licenses and IDAPA; and/or practicing under the Optum Idaho supervisory protocol.

Provider Responsibilities

Group psychotherapy services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial developmental and treatment needs.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
90853	*See below*	Group psychotherapy, when appropriate may report with interactive complexity add-on code 90785 ***	1 unit = 1 visit

****Note: Group Psychotherapy services may be provided as part of the Therapeutic After School and Summer Programs (TASSP). The UC modifier is used to indicate that the service was rendered as a TASSP service.*

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Applicable modifiers based on credentialed level of the professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescribers under supervision
HO	Master's level provider under supervisory protocol

Group Psychotherapy, other than multiple-family group; when appropriate may report with interactive complexity add-on code 90785.

Medication Management

Description

Medication Management includes a clinical assessment of the member to determine the need for psychotropic medications and monitoring of the medications once they are prescribed. The prescription of medication and follow-up reviews are included as part of the member's individualized treatment plan. Medication Management is also used to evaluate the effectiveness and side effects of the medication by medical personnel monitoring of medications that a member takes to confirm that he or she is complying with a medication regimen, while also ensuring the member is avoiding potentially dangerous drug interactions and other complications.

Provider Qualifications

Psychiatrists, Psychologists with prescriptive authority and prescribing APRNs (including Psychiatric Nurse Practitioners and/or Psychiatric Physician Assistants)

Provider Responsibilities

Psychiatrists, Psychologists with prescriptive authority and prescribing APRNs (including Psychiatric Nurse Practitioners and/or Psychiatric Nurse Practitioners) are not required to obtain prior authorization for the initial consult, routine medication management sessions and other routine outpatient services, such as the 90792, 90833, 90836, and 90838 and evaluation and management codes 96372, 99201-99205, 99211-99215 as applicable.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
90792	*See below*	Psychiatric Diagnostic Evaluation	1 unit = 1 visit
90833	*See below*	Psychotherapy, 30 minutes	1 unit = 1 visit
90836	*See below*	Psychotherapy, 45 minutes	1 unit = 1 visit
90838	*See below*	Psychotherapy, 60 minutes	1 unit = 1 visit
96372	*See below*	Therapeutic injection	1 unit = 1 injection
99201	*See below*	Office OP-New Pt	1 unit = 10 min.
99202	*See below*	Office OP-New Pt	1 unit = 20 min.
99203	*See below*	Office OP-New Pt	1 unit = 30 min.
99204	*See below*	Office OP-New Pt	1 unit = 45 min.
99205	*See below*	Office OP-New Pt	1 unit = 60 min.
99211	*See below*	Office OP-Est. Pt	1 unit = 5 min.
99212	*See below*	Office OP-Est. Pt	1 unit = 10 min.
99213	*See below*	Office OP-Est. Pt	1 unit = 15 min.
99214	*See below*	Office OP-Est. Pt	1 unit = 25 min.
99215	*See below*	Office OP-Est. Pt	1 unit = 40 min.

Applicable modifiers based on credentialed level of the professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescribers under supervision
GT	Service rendered via Telehealth.

Additional Information

Medication management services may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Therapeutic Injection

Description

Therapeutic injection given subcutaneously or intramuscularly means that a drug is given by injection under the skin or in the muscle.

In some cases, therapeutic injections create better outcomes and compliance with chronic medication administration. In other cases, therapeutic injections are the preferred method for the application of medications.

Provider Qualifications

Psychiatrists, Psychologists with prescriptive authority and prescribing APRNs (including Psychiatric Nurse Practitioners and/or Psychiatric Physician Assistants)

Provider Responsibilities

Psychiatrists, Psychologists with prescriptive authority and prescribing APRNs (including Psychiatric Nurse Practitioners and/or Psychiatric Nurse Practitioners) are not required to obtain prior authorization for the therapeutic injections.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
96372	*See below*	Therapeutic, injection (specify substance or drug); subcutaneous or intramuscular.	1 unit = 1 injection

Applicable modifiers based on credentialed level of the professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescribers under supervision

4.6 Substance Use Treatment Services

Substance Use Assessment

Description

The Department of Health and Welfare (DHW) established the standard of using the American Society of Addiction Medicine (ASAM) Criteria® for substance use disorder assessments. The previous requirement was the Global Appraisal of Individual Needs (GAIN), which can still be used by GAIN-certified providers to meet the substance use assessment requirement. For those who are not using the GAIN to meet the substance use assessment requirement, a provider must include the six ASAM dimensions in the Comprehensive Diagnostic Assessment (CDA):

- **Dimension 1** – Acute Intoxication and/or Withdrawal Potential
- **Dimension 2** – Biomedical Conditions and Complications
- **Dimension 3** – Emotional, Behavioral, or Cognitive Conditions and Complications
- **Dimension 4** – Readiness to Change
- **Dimension 5** – Relapse, Continued Use, or Continued Problem Potential
- **Dimension 6** – Recovery/Living Environment.

Trainings meeting this standard include:

- Web-based or in person trainings, ASAM Criteria®, multidimensional assessment process and level of care placement decision-making from the American Society of Addiction Medicine (ASAM) or an ASAM-approved training entity (ex. The Change Companies)
- Web-based or in-person trainings through conferences, workshops, seminars, certification programs, or accredited college/university courses with required documentation via certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in the ASAM is also acceptable.

Note: A provider must demonstrate evidence of training in the ASAM Criteria® multidimensional assessment process and level of care placement decision-making. Licensure, certification or degrees without the documented training is not sufficient evidence of meeting this training requirement.

Provider Qualifications

SUD Providers will be licensed clinicians and paraprofessionals as defined per licensure by the Division of Occupational and Professional Licenses, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), Northwest Indian Alcohol/Drug Certification Board (NWIADCB), the Idaho Department of Health and Welfare Division of Behavioral Health (DBH per IDAPA); and practicing under the Optum Idaho supervisory protocol. Paraprofessionals (defined as individuals who are not independently licensed) providing outpatient substance use disorder treatment services within the IBHP may not be required to have a bachelor's degree; however, they must meet the minimum relevant certification available for the service rendered (e.g., CADC).

Substance use disorder providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.

It is important to ensure that services provided are within the scope of practice based on education/training and certification/designation of the substance use disorder provider. State-approved certification/designation entities are IBADCC, NWIADCB, DBH per IDAPA.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Provider Responsibilities

When a substance use concern is present, the six ASAM dimensions must be included in the member's Comprehensive Diagnostic Assessment (CDA). GAIN-certified providers have the option to use the Global Appraisal of Individual Need (GAIN) to meet this requirement. Other assessment tools may also meet this requirement. To search for an in-network SUD provider, please utilize the provider search tool on ***liveandworkwell.com***.

Authorization Type

No prior authorization is required.

Payment Methodology

Additional Information

For additional information about the standard substance use assessment decision from the Idaho Department of Health and Welfare, you may access the Behavioral Health Standards eManual on ***HealthandWelfare.idaho.gov***.

CPT Code	Modifier	Description	Unit
H0001	*N/A*	Individual assessment and treatment plan for substance use including administration of the GAIN ***	1 unit = 15 minutes

****Note = Substance Use Disorder Group Counseling services may be provided as part of the Therapeutic After School and Summer Programs (TASSP). The UC modifier is used to indicate that the service was rendered as a TASSP service.*

Substance Use Disorder Group Therapy

Description

Substance use disorder (SUD) treatment providers employ a variety of group treatment models to meet member needs during the multiphase process of recovery. A combination of group goals and methodology is the primary way to define the types of groups used. SUD groups:

- Help members learn to cope with their substance use disorders and other problems by allowing them to see how others deal with similar problems.
- Reduce the sense of isolation that most individuals who have substance use disorders experience.
- Enable members who have substance use disorders to witness the recovery of others.
- Encourage, coach, support, and reinforce as members undertake difficult or anxiety-provoking tasks.
- Offer members the opportunity to learn or relearn the social skills they need to cope with everyday life instead of resorting to substance use.
- May add needed structure and discipline to the lives of members struggling with substance use disorders.

Provider Qualifications

SUD Providers will be licensed clinicians and paraprofessionals as defined per licensure by the Division of Occupational and Professional Licenses, Idaho Board of Alcohol/Drug Counselor Certification, Inc (IBADCC), Northwest Indian Alcohol/Drug Certification Board (NWIADCB), the Idaho Department of Health and Welfare Division of Behavioral Health (DBH per IDAPA); and practicing under the Optum Idaho supervisory protocol. Paraprofessionals (defined as individuals who are not independently licensed) providing outpatient substance use disorder treatment services within the IBHP may not be required to have a bachelor's degree; however, they must meet the minimum relevant certification available for the service rendered (e.g., CADC).

Substance use disorder providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.

It is important to ensure that services provided are within the scope of practice based on education/training and certification/designation of the substance use disorder provider. State-approved certification/designation entities are IBADCC, NWIADCB, DBH per IDAPA.

Provider Responsibilities

Optum Idaho and the provider network use, "The ASAM Criteria®: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition" to guide service delivery, level of care placement for Substance Use Disorder (SUD) Services.

All providers will deliver services in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment needs.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
H0005	*N/A*	Group Counseling – substance use***	1 unit = 15 minutes

****Note = Substance Use Disorder Group Counseling services may be provided as part of the Therapeutic After School and Summer Programs (TASSP). The UC modifier is used to indicate that the service was rendered as a TASSP service.*

Additional Information

For additional information about the standard substance use assessment decision from the Idaho Department of Health and Welfare, you may access the Behavioral Health Standards eManual on ***HealthandWelfare.idaho.gov***.

Substance Use Disorder Individual Therapy

Description

Individual substance use disorder counseling generally focuses on motivating the member to stop using substances. Treatment then shifts to helping the member stay substance free. The clinician uses therapeutic interventions to help the member see the problem and become motivated to change, change their behavior, repair damaged relationships with family and friends, build new friendships with individuals who do not use substances and create a recovery lifestyle.

Outpatient psychotherapy services are in-person, non-electronic services (except when Tele-health is provided in accordance with board regulations) and are used to treat substance use disorders. Individual Psychotherapy may be delivered in a home or community-based setting.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Provider Qualifications

SUD Providers will be licensed clinicians and paraprofessionals as defined per licensure by the Division of Occupational and Professional Licenses, Idaho Board of Alcohol/Drug Counselor Certification, Inc (IBADCC), Northwest Indian Alcohol/Drug Certification Board (NWIADCB), the Idaho Department of Health and Welfare Division of Behavioral Health (DBH per IDAPA); and practicing under the Optum Idaho supervisory protocol. Paraprofessionals (defined as individuals who are not independently licensed) providing outpatient substance use disorder treatment services within the IBHP may not be required to have a bachelor's degree; however, they must meet the minimum relevant certification available for the service rendered (e.g., CADC).

Substance use disorder providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.

It is important to ensure that services provided are within the scope of practice based on education/training and certification/designation of the substance use provider. State-approved certification/designation entities are IBADCC, NWIADCB, DBH per IDAPA.

Provider Responsibilities

Optum Idaho and the provider network use, "The ASAM Criteria®: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition" to guide service delivery, level of care placement for Substance Use Disorder (SUD) Services.

All providers will deliver services in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
H0004	*N/A*	Individual counseling - substance use ***	1 unit = 15 minutes

****Note: Substance Use Individual Counseling services may be provided as part of the Therapeutic After School and Summer Programs (TASSP). The UC modifier is used to indicate that the service was rendered as a TASSP service.*

4.7 Psychological/Neuropsychological Testing

Psychological Testing

Description

Psychological Test Evaluation Services is a set of formal procedures utilizing reliable and validated tests designed to measure areas of intellectual, cognitive, emotional, and behavioral functioning, in addition to identifying psychopathology, personality style, interpersonal processes, and adaptive skills.

Provider Qualifications

Providers will be licensed psychologist or psychology extenders as defined per licensure by the Idaho Division of Occupational and Professional Licenses and IDAPA; and practicing under the Optum Idaho supervisory protocol.

The provider's professional training and licensure must include any of the following:

- A doctoral-level psychologist who is licensed to practice independently and demonstrates sufficient training and experience.
- A psychometrist or psychometrician who administers and scores psychological tests under the supervision of a licensed, doctoral-level psychologist, and whose services are billed by the supervising psychologist.
- The supervising psychologist must have face-to-face contact with the participant at intake and during the feedback session.
- The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval.

Provider Responsibilities

Psychological testing providers will deliver services in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

Please refer to the American Psychological Association (APA) Psychological and Neuropsychological Testing Billing and Coding Guide for provider responsibilities on ***providerexpress.com*** > Guidelines/Policies and Manuals.

Authorization Type

This service does not require prior authorization and may be subject to retrospective review to address outliers in utilization. Generally, psychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered.

Payment Methodology

CPT Code	Modifier	Description	Unit
96130	*N/A*	Psychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	1 unit = first hour

(Continued on next page)

CPT Code	Modifier	Description	Unit
96131	*N/A*	Each additional hour (list separately in addition to code for primary procedure)	Unit = each additional hour
96136	*N/A*	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method, first 30 minutes.	1 unit = first 30 minutes
96137	*N/A*	Each additional 30 minutes (list separately in addition to code for primary procedure)	Unit = each additional 30 minutes
96138	*N/A*	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method, first 30 minutes.	1 unit = first 30 minutes
96139	*N/A*	Each additional 30 minutes (list separately in addition to code for primary procedure)	Unit = each additional 30 minutes
96146	*N/A*	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only	1 unit = 1 visit

Additional Information

- Providers of Psychological Testing must follow the Psychological and Neuropsychological Testing Billing and Coding Guide, developed by the American Psychological Association (APA) for guidance on clinical criteria used to make coverage decisions on testing services.
- Optum Idaho utilizes the American Psychological Association (APA) Psychological and Neuropsychological Testing Billing and Coding Guide for these reasons:
- Externally validated: APA criteria were created and updated based on the changing landscape of evidence informed care, market and regulatory considerations, and feedback from stakeholders across the care system.
- Common language drives improved care: The use of these guidelines creates a common language for providers with payers, regulators, and other stakeholders of the care system, which results in a clearer understanding of member needs.
- For additional information please refer to: APA Psychological and Neuropsychological Testing Billing and Coding Guide and other resources on ***providerexpress.com*** > Guidelines/Policies and Manuals

Neuropsychological Testing

Description

Neuropsychological Test Evaluation Services is a set of formal procedures utilizing reliable and valid tests specifically focused on identifying the presence of brain damage, injury, or dysfunction and any associated functional deficits.

Provider Qualifications

Providers will be licensed psychologists or psychology extenders as defined per licensure by the Division of Occupational and Professional License and IDAPA; and/or practicing under the Optum Idaho supervisory protocol.

The provider's professional training and licensure must include any of the following:

- A doctoral-level psychologist who is licensed to practice independently and demonstrates sufficient training and experience.
- A psychometrist or psychometrician who administers and scores neuropsychological tests under the supervision of a licensed, doctoral-level psychologist, and whose services are billed by the supervising psychologist.
- The supervising psychologist must have face-to-face contact with the participant at intake and during the feedback session.
- The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval.

Provider Responsibilities

Neuropsychological testing providers will deliver services in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment needs.

Please refer to the American Psychological Association (APA) Psychological and Neuropsychological Testing Billing and Coding Guide for provider responsibilities on ***providerexpress.com*** > Guidelines/Policies and Manuals.

Authorization Type

This service does not require prior authorization and may be subject to retrospective review to address outliers in utilization. Neuropsychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered.

Payment Methodology

CPT Code	Modifier	Description	Unit
96116	*N/A*	Neurobehavioral status exam by professional; first hour	1 unit = first hour
96121	*N/A*	Neurobehavioral status exam by professional; each additional hour.	Unit = each additional hour
96132	*N/A*	Neuropsychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	1 unit = first hour
96133	*N/A*	Each additional hour (list separately in addition to code for primary procedure)	Unit = each additional hour
96136	*N/A*	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method, first 30 minutes.	1 unit = first 30 minutes
96137	*N/A*	Each additional 30 minutes (list separately in addition to code for primary procedure)	Unit = each additional 30 minutes

(Payment Methodology continued on following page.)

CLICK HERE TO RETURN TO TABLE OF CONTENTS

CPT Code	Modifier	Description	Unit
96138	*N/A*	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method, first 30 minutes.	1 unit = first 30 minutes
96139	*N/A*	Each additional 30 minutes (list separately in addition to code for primary procedure)	Unit = each additional 30 minutes

Applicable modifiers based on credentialed level of professional providing the services.

Additional Information

- Providers of Neuropsychological Testing must follow the Psychological and Neuropsychological Testing Billing and Coding Guide, developed by the American Psychological Association (APA) for guidance on clinical criteria used to make coverage decisions on testing services.
- Optum Idaho utilizes the American Psychological Association (APA) Psychological and Neuropsychological Testing Billing and Coding Guide for these reasons:
  - » Externally validated: APA criteria were created and updated based on the changing landscape of evidence informed care, market and regulatory considerations, and feedback from stakeholders across the care system.
  - » Common language drives improved care: The use of these guidelines creates a common language for providers with payers, regulators, and other stakeholders of the care system, which results in a clearer understanding of member needs.
- For additional information, please refer to: APA Psychological and Neuropsychological Testing Billing and Coding Guide and other resources on ***providerexpress.com*** > Guidelines/Policies and Manuals.

4.8 Children's Services

Child and Adolescent Needs and Strengths (CANS) Functional Assessment

Description

The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose functional assessment tool developed for children's services to support decision making, including recommendations for an array of services based on the severity and complexity of the member's symptoms and needs; treatment planning; to facilitate quality improvement initiatives; and to allow for the monitoring of outcomes of services. The CANS involves youth, families, caregivers, and relevant natural and formal supports. Youth and their families are regarded as the experts on their experience and the CANS motivates them to recognize their own strengths, needs and resources. Through active engagement in the CANS, youth and families are empowered to make choices and give their opinions about the care they receive.

The CANS is designed to follow the course of the youth and family from system access to goal attainment and transition. This functional assessment tool is used to communicate the shared vision throughout the system.

The CANS is required prior to a youth receiving any outpatient behavioral health services except those services that do not address a functional need. Services that do not require a CANS are as follows: Health Behavior Assessment and Interventions (HBAI), Neuro/Psychological Testing, Medication Management, and Crisis Services. All treatment plans that address a functional need (i.e. Psychotherapy) must be based on the CANS.

The results of the CANS entered into the ICANS platform guides person-centered service plan development and additional specific treatment plans. Therefore, each member should only have one CANS and one person-centered service plan that follows the member through the system of care.

Provider Qualifications

- Optum network providers who are independently licensed clinicians Independently Licensed Clinicians (or master's level clinicians working under supervisory protocol) who are certified in the CANS can bill for the initial/annual CANS (if one has not yet been completed) and CANS updates
- A CANS-certified paraprofessional with a bachelor's degree in a human services field can complete CANS assessments (initial/annual and updates), if they are involved in the member's care and providing other services to the member. In some cases, a bachelor's level paraprofessional may need to refer some more difficult applications to a CANS-certified master's level clinician.
- For information on upcoming CANS certification trainings, please visit the ***Idaho Transformation Collaboration Outcomes Management (TCOM) Institute***. Providers seeking to become certified to administer the CANS can register on the Praed Foundation website at ***Praedfoundation.org***.

All individuals below must be CANS certified and have access to the ICANS Platform:

	Staff Level		
	Master's level provider and bachelor's level paraprofessional working under supervisory protocol	**Targeted Care Coordinator with a minimum of a bachelor's degree who has completed the Optum Idaho TCC Endorsement**	**Administrator within an Optum network provider agency who has administrative access to the ICANS platform**
Enter CANS data into ICANS	N/A	Yes	Yes – requires the administering provider to Sign and Finalize
Enter CANS data into ICANS AND bill for CANS Updates (minimum every 90 days)	N/A	Yes	No
Enter CANS data into ICANS AND bill for Initial and Annual CANS	N/A	Yes	No

Provider Responsibilities

Providers should check to see if an ICANS record exists for the member or ask the family if a CANS has been completed. If the youth has an ICANS record, the provider should coordinate and update the existing CANS. Each member should only have one CANS that follows the member through the system of care.

- The CANS must be administered face-to-face with the youth and family present, or via Telehealth (when appropriate) See the Telehealth Services section of this manual for additional information.
- The CANS must be conducted in a manner that is strengths-based, culturally competent and responsive to each youth's individual psychosocial, developmental and treatment needs.
- The initial or annual updated CANS can be completed in conjunction with an initial or updated Comprehensive Diagnostic Assessment (CDA), by the Independent Assessor or the treating clinician. If the CANS is completed by a bachelor's level provider, an Independent Assessor or the treating clinician will need to conduct the CDA.
- The CANS should not be conducted in a standalone appointment. Best practice when completing the CANS initial, annual and 90-day updates is to align with other behavioral health appointments to better assist youth especially if a youth is receiving multiple behavioral health services. It is best practice to coordinate with the youth's other behavioral health providers in order to not duplicate CANS assessments for the member.

- The CANS must be entered into the ICANS system by any individual who has access to the ICANS system. The CANS assessment must be signed and finalized by the provider who administered the CANS.
- The CANS should be administered with youth and family engagement, and family choice is the primary driver of how the CANS is conducted.
- The results of the CANS must be reviewed with the youth and family and the youth and family should receive a copy of the completed CANS including the narrative.
- Treating providers, with youth and family engagement, will use the CANS to create individualized treatment plans. CANS updates will be used to modify treatment plans to achieve identified treatment goals.
- The CANS must be completed comprehensively as indicated in the CANS manual.
- All available clinical information must be integrated in the CANS assessment process, which may include psychiatric findings, psychological testing, other assessments, medical information, etc.
- With appropriate releases of information, it is expected that this assessment will be shared with other professionals involved in the youth's assessment and treatment.
- CANS updates must be completed at least every 90 days or more frequently as necessary based on the youth's needs, the request of the family, or whenever there is a change in condition.
- The provider who is completing or updating the CANS should be working with the youth and the family. If a youth's treatment would be delayed due to the inability of the youth's family to be physically present with the youth for a CANS assessment or update, the family input may be collected via Telehealth (See the Telehealth Services section of this manual for additional information).
- When a CANS update identifies that changes in treatment are necessary, the youth's person-centered service plan and specific treatment plans must be modified.
- The provider delegated to update the CANS may vary (see CANS provider qualifications above). For example, for one youth, the assigned targeted care coordinator will update the CANS and for another member, it may be the treating clinician. The member's team should collaborate to identify what works best for the member and member's family being served.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
H0031	*See below*	CANS Assessment for adolescent under the age of 18; (10 hours per year per member) ***	1 unit = 15 minutes

*****Note = Hours per member are guidelines. Optum will analyze claims information to identify outlier cases that may benefit from a clinical review when utilization exceeds the guidelines. These guidelines do not indicate there is a hard limit and there is no requirement for an authorization to exceed the indicated hours.*

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider	Modifier	Professional Level of Provider
U1	Prescribers under supervision	**HN**	Bachelor's level provider under supervisory protocol
HO	Master's level provider under supervisory protocol	**GT**	Service rendered via Telehealth.

Additional Information

Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.

This service may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.

- The parent/guardian does not have to be present during the CANS assessment, as long as they give their informed consent for the CANS to be completed.
- The CANS is only reimbursable when entered into the ICANS platform, which is owned and operated by the Division of Behavioral Health. For more information on ICANS, visit: ***icans.dhw.idaho.gov***.
- CANS-certified master's level clinicians and CANS-certified bachelor's level paraprofessionals can be reimbursed for mileage when completing the CANS assessment whether initial, update, or annual in the member's home. If providing multiple CANS assessments to different family members during the trip, best practices are to claim the mileage code one time.
- The time to complete a CANS assessment will vary depending on factors such as the child's/youth's and family's presentation, current risk factors, and complexity of the strengths and needs of the child's/youth's and family, and the provider's experience in administering the CANS.
- The CANS can be used to monitor outcomes. This can be accomplished in two ways. First, items that are initially rated a '2' or '3' are monitored over time to determine the percent of youth who move to a rating of '0' or '1' (resolved need, build strength). Secondly, dimension scores can also be generated by summing items within each of the dimensions (Problems, Risk Behaviors, Functioning, etc.). These scores can be compared over the course of treatment. CANS dimension scores have been shown to be valid outcome measures in behavioral health treatment.

DC: 0-5

Description

The Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood (DC: 0-5) provides a mechanism similar to the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 but is specifically designed for children under the age of six (6). DC:0-5 is a multiaxial diagnostic framework.

Provider Qualifications

Optum will reimburse for master's level clinicians (and higher) who have the current Infant Mental Health endorsement (IMH-E®) in infant and toddler behavioral health care from the Idaho Association for Infant Mental Health (***aimearlyidaho.org***), or who have received the training hours required to sit for this examination, and who are qualified to diagnose as part of their clinical licensure.

Provider Responsibilities

Providers will deliver services in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs. Providers are still required to do a CDA and CANS for all children, even if the DC:0-5 is used. The CDA can be used to determine whether the DC:0-5 is appropriate for the child.

Authorization Type

This service does not require prior authorization but will be managed via outlier management.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

DC: 0-5 Payment Methodology

CPT Code	Modifier	Description	Unit
H1011	**HA**	DC: 0-5 Functional Assessment	1 unit = 15 minutes

In order to bill for DC: 0-5, the HA modifier must be used with H1011, as that unique code/modifier combination was set up for the DC: 0-5 only.

Recommended guidelines are that DC: 0-5 may take up to 3-5 hours per assessment interval. This would equate to 12-20 units (4 units = 1 hour per diagnostic episode).

Child and Family Team (CFT) Interdisciplinary Team Meeting

Description

Child and Family Team (CFT) is a group of individuals the youth and family select to help and support them while receiving treatment. These individuals selected by the youth and their family are individuals the youth/family believe should be involved with the development and implementation of their person-centered service plan. For example, the member and member's family may request that extended family, teachers, friends and other supports participate in the CFT. The Child and Family Team (CFT) Interdisciplinary Team Meeting is intended to be an in-person meeting which is facilitated by a Targeted Care Coordinator to develop, monitor or modify a person-centered service plan that includes both formal and informal supports. The CFT Interdisciplinary Team Meeting is scheduled by the assigned Targeted Care Coordinator who is chosen by the family (See "Targeted Care Coordination").

Attendance Guidelines

- At a minimum, the CFT interdisciplinary team meeting will include the Targeted Care Coordinator, the member, the member's family, the member's independently licensed clinician (or a master's level clinician under supervisory protocol).
- Those required to attend in person are: Targeted Care Coordinator, member and member's family.
  - In-person requirements:
    - Targeted Care Coordinator
    - At least one parent or legal guardian must be present
    - Member (to ensure the member agrees with the PCSP)
      - Exceptions are permitted for member attendance and must be documented with rationale
  - The clinician may participate in person, virtually, or telephonically (see provider qualifications)
- The clinician providing individual therapy must attend the CFT for the member they are treating.
  - If the member is not receiving individual or family therapy, the clinician with the supervisory involvement over the member's services must attend the CFT meeting.
  - An agency cannot have one clinician attend all CFTs for the agency.
  - If the member's Comprehensive Diagnostic Assessment (CDA) was completed by a clinician from a different agency, the clinician with supervisory involvement over the member's services must attend the CFT meeting.
  - It is an expectation that all Idaho Behavioral Health Plan (IBHP) network providers chosen by the family for the CFT attend the CFT meeting. If unable to attend CFT meeting, a signature is still required on the PCSP form confirming the IBHP network provider agrees to work on the goals identified in the PCSP plan in the specific service(s) recommended within the PCSP and intends to render the service to the member.

Child and Family Team (CFT) Interdisciplinary Team Meetings may include other provider attendance either in-person. virtually or telephonically. (See provider qualifications).

The CFT meeting is conducted in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs. The CFT team members work together

to recognize and encourage the youth and family's strengths, identify the youth and family's needs, learn what the youth and family want to accomplish, set realistic short and long-term goals and find solutions that build on the family's strengths that lead to necessary changes. The youth's treatment goals should align with the youth's PCSP.

Provider Qualifications

Master's level clinicians or above, and bachelor's level paraprofessionals and other qualified paraprofessionals directly involved in the member's care (regardless of certification/endorsement requirement).

Provider Responsibilities

- The Child and Family Team (CFT) interdisciplinary meetings understand and apply the core Principles of Care and the Practice Model of the Idaho Youth Empowerment Services (YES) system of care.
- Participants of the CFT empower youth and family to use their voices and participate in all aspects of treatment and recovery.
- The CFT team reviews the strengths and needs indicated on the CANS and works with the youth and family to develop and adopt a strengths-based person-centered-service plan that includes both formal and informal services and supports.
- Providers attending in a CFT interdisciplinary team meeting should document the reasons for their participation, and the resulting recommendations and agreed-upon actions.
- The CFT recognizes the member and member's family voice and choice of what they want the team to focus on. CFT meeting participants identify action items accordingly.
- The CFT meeting is used to review services, progress towards goals and objectives identified on the member's person-centered service plan and to review/discuss CANS assessment.
- CFT meetings can occur in any setting identified by the member and the member's family.
- CFT meetings may occur when a member or member's family requests a meeting, the identified strengths and needs change, the existing services and supports are not effective, new resources are available, the progress towards a goal is not as expected, goals are met, and new goals are identified, and/or there is a decrease in safety or a risk of crisis.
- CFT meetings may occur more frequently during the initial phases, when there are changes in needs, and during transitions.
- The CFT Team will deliver services in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment care needs.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
G9007	*See below*	Child and Family Interdisciplinary Team Meeting (CFT); scheduled and facilitated by a Targeted Care Coordinator to develop or monitor a person-centered service plan.	1 unit = 15 minutes

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescribers under supervision
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol
HM	Provider with less than bachelor's degree under supervisory protocol
GT	Service rendered via Telehealth

Additional Information

- Treatment planning activities that occur outside of a planned CFT Interdisciplinary Team Meeting are not billable activities using the procedure code for CFT Interdisciplinary Team Meeting.
- This service may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.
- Completed PCSPs developed through the Child and Family Interdisciplinary Team Meetings for YES members are submitted to Optum via Optum Supports and Services Manager (OSSM) for review of compliance with the Code of Federal Regulations (CFR).

Person-centered service plans must be facilitated by a Targeted Care Coordinator chosen by the family or an IDHW Case Manager. Families who are working with a case manager with IDHW's Children's Developmental Disabilities Program or CMH for Wraparound or 20-511A do not need a TCC to create their PCSP to remain eligible for YES. If a family has already developed a PCSP or Plan of Service and is actively working with an IDHW Case Manager, they will not need an additional plan developed and are not required to work with a TCC, as it may be considered a duplication of services. However, families working with a Case Manager through IDHW's Child Protection Services (CPS) may also receive TCC, as it is not considered a duplication of services. Families have the same access to services, regardless of whether their PCSP or Plan of Service was developed by an Optum TCC or an IDHW case manager. If you are unsure if a family is working with an IDHW Case Manager, you can contact Medicaid for more information at **1-866-681-7062**.

Intensive Home and Community-Based Services (FFT, MDFT, MST and Other Modalities)

Description

Intensive Home and Community-Based Services (IHCBS) programs are provided to children and adolescent members who are experiencing social, emotional and behavioral difficulties and need more intensive services to increase stability across settings and help prevent out-of-home placement. IHCBS include a flexible array of services to meet the assessed needs, including crisis response and intervention. Delivery of services can be centered on, but not limited to, one of the following therapeutic approaches: Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT), or Multi-Systemic Therapy (MST). All treatment, care and support services must be provided in a context that is individualized, family-centered, strengths-based, culturally competent and responsive to each child and adolescents' psychosocial, developmental and treatment care needs.

Functional Family Therapy (FFT)

Functional Family Therapy (FFT) is a prevention/intervention program for youth who have demonstrated a range of maladaptive, acting out behaviors and related syndromes.

- Provider agencies are required to have an FFT site certification from FFT, LLC and follow the guidelines as set by FFT, LLC.

For additional information on FFT, please visit ***fftllc.com***.

Multidimensional Family Therapy (MDFT)

Multidimensional Family Therapy (MDFT) is an integrated, comprehensive, family-centered treatment for adolescents. MDFT simultaneously addresses substance use, delinquency, antisocial and aggressive behaviors, mental health symptoms, and school problems.

- Providers are required to have a MDFT certification from MDFT International and follow the guidelines as set by MDFT International.

For additional information on MDFT, please visit ***mdft.org***

Multisystemic Therapy (MST)

Multisystemic Therapy (MST) is a time-limited, intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior in juvenile offenders. MST addresses the factors associated with delinquency across Member's key settings, or systems (e.g., family, peers, school, neighborhood). Using the strengths of each system to foster positive change, MST promotes behavior change in the Member's natural environment.

MST is not appropriate in the following circumstances:

- Member meets criteria for out-of- home placement due to suicidal, homicidal, or psychotic behavior or are those Members whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems.
- Member living independently, or Member for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
- Referral problem is limited to serious sexual misbehavior
- Member has an autism spectrum diagnosis

For additional information on MST, please visit ***mst.com***

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Therapeutic Behavior Services (TBS)

Therapeutic Behavioral Services (TBS) is a collaborative, one-to-one behavior modification and cognitive-behavioral therapy intervention for children and youth with serious emotional disturbances. TBS engages the parent/caregiver in helping the child or youth to identify the underlying needs met by maladaptive behaviors and teaches them to successfully meet their needs using more suitable replacement or alternative behaviors.

Provider Qualifications

Provider qualifications may vary according to the specific IHCBS EBP program credentialing and certifications.

Provider Responsibilities

Provider responsibilities may vary according to the specific IHCBS EBP and ensuring the fidelity of the program requirements. All providers must practice within their scope of practice/training/education, IHCBS EBP program certification, IHCBS EBP qualifications and meeting supervisory protocol requirements.

Optional services that can be billed outside of bundled rate:

- Case Management
- Targeted Care Coordination
- Respite
- Peer Support
- Youth Support
- Family Support
- Recovery Coaching
- Child and Family Team
- Psychological/Neuropsychological Testing
- Medication Management
- Psychiatric Evaluation

Authorization Type

All Intensive Home and Community Based Services require prior authorization.

- Clinical documentation should support the number of units requested and length of stay for the program.
- Online request form: ***optumidaho.com*** > For Network Providers > Forms
- The request form and/or relevant additional clinical documentation can be sent via secure email or fax.
- Fax: **1-855-708-9282**
- Email: *optum.idaho.IHCBS_dt@optum.com*
- Intensive Home and Community-Based Services are authorized per 15-minute increments

Payment Methodology

CPT Code	Modifier	Description	Unit
H0036	*See below*	Intensive Home and Community Based Service-FFT, MDFT and other evidence-based practice modalities.	1 unit = 15 minutes
H2033	*See below*	Intensive Home and Community Based Services-Multisystemic Therapy; rendered by provider(s) with MST certification from MST Incorporated	1 unit = 15 minutes

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescribers under supervision
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol
U5	Therapeutic Behavioral Services (TBS) intervention

Additional Information

Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.

The service request form and fee schedule include "other" for IHCBS to allow for additional Evidence Based Practices (EBPs) that are IHCBS programs. Providers interested in offering additional EBPs through their agency must provide justification of how the program serves the needs of high-risk members and helps prevent out-of-home placement or hospitalization.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT) and Multisystemic Therapy (SMT) Modalities

Functional Family Therapy (FFT)	Multidimensional Family Therapy (MDFT)	Multisystemic Therapy (MST)
Member age requirement: **11 to 18**	Member age requirement: **6 to 17**	Member age requirement: **12 to 17**
Functional Family Therapy (FFT) Family counseling approach is an evidenced based intervention to help at-risk youth and families overcome behavior problems, conduct disorder, substance abuse, and delinquency.	**Multidimensional Family Therapy** (MDFT) addresses a range of youth behavior challenges including: substance use, mental health, crime and delinquency, antisocial and aggressive behaviors, school and family problems, and emotional difficulties.	**Multisystemic Therapy (MST)** Program is an intensive evidence-based program designed to serve children and youth who are at risk of out-of-home placement or who are currently in an out-of-home placement, addressing the multiple influences that contribute to growing antisocial or illegal behavior.
Mental Health/SUDS/ Co-Occurring	**Mental Health/SUDS/ Co-Occurring**	**Mental Health/SUDS/ Co-Occurring**
Common Treatment Duration: 3-5 months	**Common Treatment Duration**: 3-6 months	**Common Treatment Duration**: 3-5 months
Required* Program Components Included in Rate: • Skills Building/CBRS • Crisis Intervention • Crisis Response • Therapy Services (Individual, Family and Group)	**Required* Program Components Included in Rate**: • Skills Building/CBRS • Crisis Intervention • Crisis Response • Therapy Services (Individual, Family and Group)	**Required* Program Components Included in Rate**: • Skills Building/CBRS • Crisis Intervention • Crisis Response • Therapy Services (Individual, Family and Group)
Optional Services that can be Billed Outside of the Bundled Rate: • Case Management • Targeted Care Coordination • Respite • Peer Support • Youth Support • Family Support • Recovery Coaching • Child and Family Team • Psychological & Neurological Testing • Medication Management • Psychiatric Evaluation	**Optional Services that can be Billed Outside of the Bundled Rate**: • Case Management • Targeted Care Coordination • Respite • Peer Support • Youth Support • Family Support • Recovery Coaching • Child and Family Team • Psychological & Neurological Testing • Medication Management • Psychiatric Evaluation	**Optional Services that can be Billed Outside of the Bundled Rate**: • Case Management • Targeted Care Coordination • Respite • Peer Support • Youth Support • Family Support • Recovery Coaching • Child and Family Team • Psychological & Neurological Testing • Medication Management • Psychiatric Evaluation

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Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT) and Multisystemic Therapy (SMT) Modalities

Functional Family Therapy (FFT)	Multidimensional Family Therapy (MDFT)	Multisystemic Therapy (MST)
Services that CANNOT be provided while receiving IHCBS: • Intensive Outpatient Program (IOP) • Partial Hospitalization Program (PHP) • Day Treatment	**Services that CANNOT be provided while receiving IHCBS**: • Intensive Outpatient Program (IOP) • Partial Hospitalization Program (PHP) • Day Treatment	**Services that CANNOT be provided while receiving IHCBS**: • Intensive Outpatient Program (IOP) • Partial Hospitalization Program (PHP) • Day Treatment
Prior Authorization	**Prior Authorization**	**Prior Authorization**
Training Requirements: Please visit **www.fftllc.com** for requirements	**Training Requirements**: Please visit **www.mdft.org/how-does-mdft-work** for requirements	**Training Requirements**: Please visit **www.mstservices.com** for requirements
Mileage reimbursement available	Mileage reimbursement available	Mileage reimbursement available
Average Case Load (if full time): 10-12 members	**Average Case Load (if full time)**: 6 members	**Average Case Load (if full time)**: 4-6 members

Therapeutic Behavior Services (TBS) and Family Program Modalities

Therapeutic Behavior Services (TBS)	Family Program
Member age requirement: **5 to 17**	Member age requirement: **4 to 18**
Therapeutic Behavioral Services (TBS) is a collaborative, one-to-one behavior modification and cognitive-behavioral therapy intervention for children and youth with serious social, emotional, and behavioral difficulties. TBS engages the parent/caregiver in helping the child or youth to identify the underlying needs met by maladaptive behaviors and teaches them to successfully meet their needs using more suitable replacement or alternative behaviors.	**Family Program** is an intensive in-home program that specializes in parent skill building, teaching co-regulation skills and promoting healthy relational skills that address behavior challenges in the home in order to help parents create safety in the home while addressing aggressive behaviors, family problems and emotional issues.
Mental Health/Co-Occurring	**Mental Health/Co-Occurring**
Common Treatment Duration: 6-10 months	**Common Treatment Duration**: 90 days

(Continued on following page.)

Therapeutic Behavior Services (TBS)	Family Program
Member age requirement: **5 to 17**	Member age requirement: **4 to 18**
Required* Program Components Included in Rate: • Skills Building/CBRS • Crisis Intervention • Crisis Response • Therapy Services (Individual, Family and Group)	**Required* Program Components Included in Rate**: • Skills Building/CBRS • Crisis Intervention • Crisis Response • Therapy Services (Individual, Family and Group) • Coaching parents and youth
Optional Services that can be Billed Outside of the Bundled Rate: • Case Management • Targeted Care Coordination • Respite • Peer Support • Youth Support • Family Support • Recovery Coaching • Child and Family Team • Psychological & Neurological Testing • Medication Management • Psychiatric Evaluation	**Optional Services that can be Billed Outside of the Bundled Rate**: • Case Management • Targeted Care Coordination • Respite • Peer Support • Youth Support • Family Support • Recovery Coaching • Child and Family Team • Psychological & Neurological Testing • Medication Management • Psychiatric Evaluation
Services that CANNOT be provided while receiving IHCBS: • Intensive Outpatient Program (IOP) • Partial Hospitalization Program (PHP) • Day Treatment	**Services that CANNOT be provided while receiving IHCBS**: • Intensive Outpatient Program (IOP) • Partial Hospitalization Program (PHP) • Day Treatment
Prior Authorization	**Prior Authorization**
Training Requirements: Please contact Debra Stace with Idaho Department of Health and Welfare at *debra.stace@dhw.idaho.gov* for a list of TBS trainers and/or requirements	**Training Requirements**: Please visit **www.healthyfoundations.co** for requirements
Mileage reimbursement available	Mileage reimbursement available
Average Case Load (if full time): 2-4 members	**Average Case Load (if full time)**: 3-5 members

Behavior Modification and Consultation

Description

Behavior modification and consultation (BMC) is the design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. These interventions are based on scientific research and the use of direct observation, measurement, and functional analysis. Behavioral strategies are used to teach the Member alternative skills to manage targeted behaviors across various environments. Behavior modification providers may provide this service at any time and any setting appropriate to meet the Member's needs, including home, school, and community. For successful outcomes, modified behaviors must be reinforced by the child/adolescent's parents, family, and other natural supports. All treatment, care and support services must be provided in a context that is child centered, family-focused, strengths based, culturally competent and responsive to each child's psychosocial, developmental, and treatment care needs.

Provider Qualifications and Responsibilities

Behavior Modification and Consultation will be delivered in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

Provider Qualifications – Psychologist Board Certified Behavior Analyst (BCBA)

A licensed psychologist provided that the services are rendered within the boundaries of the licensed psychologist's education, training, and competence and the provider has attested to having sufficient expertise with additional training in applied behavior analysis (ABA)/intensive behavior therapy, which includes six (6) months of supervised experience or training in the treatment of applied behavior analysis (ABA)/intensive behavior therapies.

Provider Responsibilities – Psychologist (Board Certified Behavior Analyst)

- Completes the behavior modification functional behavioral assessment
- Writes the behavior modification treatment plan
- Provides direct implementation of the behavior modification intervention
- Supervises the work of the Board-Certified Assistant Behavior Analysts (BCaBA) and the Behavior Technicians
- Advanced assessments

Provider Qualifications – BCaBA

A bachelor's level or higher provider certified as a Board-Certified Assistant Behavior Analyst (BCaBA) under the direct supervision of a BCBA or an independently licensed behavioral clinician who has attested to having sufficient expertise with additional training in applied behavior analysis (ABA)/intensive behavior therapy.

Provider Responsibilities – BCaBA

- Assists the BCBA, or independently licensed behavioral health clinician, in the initial or concurrent behavior modification functional behavioral assessment
- Assists the BCBA, or independently licensed behavioral health clinician, in writing the behavior modification treatment plan
- Provides direct implementation of the behavior modification intervention
- Supervises the work of the Behavior Technicians

Provider Qualifications – Behavior Technician (BT)

Behavior technician providers must be at least 18 years of age, have a high school diploma or equivalent, current registration as a Registered Behavior Technician (RBT) from the national Behavior Analyst Certification Board, or

CLICK HERE TO RETURN TO TABLE OF CONTENTS

alternative national board certification, and receive appropriate training and supervision by BCBAs, BCaBA or an independently licensed behavioral health clinician who has attested to having sufficient expertise with additional training in applied behavior analysis (ABA)/intensive behavior therapy.

Provider Responsibilities – Behavior Technician (BT)

- Responsible for the direct implementation of the behavior modification treatment plan
- It is the responsibility of the BT supervisor to determine which tasks a BT may perform as a function of his or her training, experience, and competence

Provider Qualifications – Behavior Technician (Psychologist Service Extender)

A master's level or higher behavior technician provider who is a service extender registered with the Idaho Division of Occupational and Professional Licenses to be working with a specified psychologist. A service extender delivers psychological services under the direct supervision of a licensed psychologist provided that the services provided are within the boundaries of the licensed psychologist's education, training, and competence.

Provider Responsibilities – Behavior Technician (Psychologist Service Extender)

- Responsible for the direct implementation of the behavior modification treatment plan
- It is the responsibility of the supervising psychologist to determine which tasks the service extender may perform as a function of his or her training, experience, and competence.

Authorization Type

Prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
97151	*See below*	Behavior identification assessment (Behavior Modification Functional Behavioral Assessment), administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other health professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	1 unit = 15 minutes
97152	*See below*	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes.	1 unit = 15 minutes

(Payment Methodology table continued on following page.)

CPT Code	Modifier	Description	Unit
97156	*See below*	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.	1 unit = 15 minutes
97157	*See below*	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardian(s)/caregiver(s), each 15 minutes.	1 unit = 15 minutes
97158	*See below*	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes.	1 unit = 15 minutes
0362T	*N/A*	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the physician or other qualified healthcare professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized to the patient's behavior.	1 unit = 15 minutes
97153	*See below*	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes.	1 unit = 15 minutes
0373T	*N/A*	Adaptive behavior treatment by protocol, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the physician or other qualified healthcare professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized to the patient's behavior.	1 unit = 15 minutes
97154	*See below*	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes.	1 unit = 15 minutes
97155	*See below*	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.	1 unit = 15 minutes

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
HP	Ph.D. level provider or higher
HN	Bachelor's level provider under supervisory protocol

Additional Information

The Member should not be actively engaged in Skills Building/Community-Based Rehabilitative Services (CBRS).

For more information on authorizations and how to join the network, please see ***providerexpress.com*** > Autism/ABA corner > ID Medicaid Behavior Modification and Consultation Program.

Respite

Description

Respite is in-person, short-term or temporary care for a youth with serious emotional disturbance (SED) provided in the least restrictive environment that provides relief for the usual caretaker and that is aimed at de-escalation of stressful situations.

Respite can be accessed through the 1915(i) State Plan Amendment. Please see Youth Empowerment Services (YES) section of this provider manual for additional information on the process to access Respite services through the 1915(i) State Plan Amendment.

Provider Qualifications

Individual Respite is provided by a credentialed agency in the member's home, another family's home, foster family home, a community-based setting and/or at the agency facility. Group Respite may only be provided at the credentialed agency facility, a community-based setting, or in the home for families with multiple children who have been determined to have SED. For additional information related to the provision of Respite, please see the Optum Idaho Level of Care Guidelines: Respite, on ***optumidaho.com***.

Qualified providers of Respite services must be employed by a credentialed Optum network provider, be at least 18 years of age, be at least a HS Graduate or have a GED, have a CPR certification, and have completed the required Optum Respite Training on ***Relias***. Providers of Respite must be no less than 36 months older than the member to which they are rendering Respite care.

Provider Responsibilities

Respite services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment needs.

- Respite providers should rely on the policies and procedures established by their agency, to ensure member safety and well-being are maintained. Appropriate provision of Respite and assignment of a Respite provider remains in the scope of accountability of the employing agency and the licensed, supervising clinician.
- Respite providers must follow agency policy and work with the clinical/agency supervisor to ensure they have a plan for managing and reporting increased risk situations such as crisis, intoxication, abuse, inappropriate sexual behavior, and/or violence in the respite setting.

Please see ***Optum Idaho Level of Care Guidelines*** for Children and Adolescent Services: Respite for additional information and provider responsibilities.

Authorization Type

No prior authorization is required for Respite up to a hard cap of 300 hours per year. For reimbursement, Respite must be included in the child/adolescent's person-centered service plan once the plan has been finalized.

Payment Methodology

CPT Code	Modifier	Description	Unit
S5150	*N/A*	Individual Respite care: for providers contracted to deliver the service; available to members eligible under the 1915(i) State Plan Amendment.	1 unit = 15 minutes
S5150	**HQ**	Group Respite care: for provider contracted to deliver the service; available to members eligible under the 1915(i) State Plan Amendment.	1 unit = 15 minutes

Additional Information

Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.

The following limitations apply to Respite:

- Payment cannot be made for room and board. Other Medicaid services cannot be provided at the same time Respite is being provided.
- Children and youth who go through the Liberty Healthcare independent assessment process, and have been determined to have SED, may access respite services immediately. However, once a child/youth has an approved person-centered service plan (PCSP), respite must be included on it.
- Respite cannot be provided on a continuous, long-term basis as a daily service to enable an unpaid caregiver to work.
- The Respite provider must not use restraints on the child, other than physical restraints in the case of an emergency.
- Physical restraints may only be used by staff with documented training in the use of restraints and in an emergency to prevent injury to the child or others and must be documented in the child's record.
- Only enrolled network providers from a credentialed agency may provide Respite for reimbursement under the Idaho Behavioral Health Plan.
- The duration of individual Respite care varies and may include an overnight stay in the member's home, as identified by the Child and Family Team (CFT) and cannot exceed a single episode of 72 hours. Individual Respite care provided in an agency or community setting cannot exceed a single episode of 10 hours.
- Individual Respite services shall be provided at a staff-to-participant ratio of 1:1.
- Group Respite may be provided at the credentialed agency facility, in the community setting or in the home for families with multiple Medicaid-eligible SED children. Group Respite services shall be provided at a staff-to-participant maximum ratio of 1:4. Group Respite does not allow for an overnight stay. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff-to-participant ratio must be adjusted accordingly.
- Respite services shall not be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.
- Members in the YES Program must receive a minimum of one (1) episode of a 1915(i)-specific service per plan

year in order to maintain eligibility under the 1915(i) State Plan Amendment. Currently, the only 1915(i)-specific service is Respite.

- If a member is eligible for Respite through the IBHP they may receive Respite through an Optum network provider, and their PCSP should include Respite as a service. However, if a family has already developed a PCSP or Plan of Service and is actively working with an IDHW Case Manager, they will not need an additional plan developed and are not required to work with a TCC, as it may be considered a duplication of services. In these situations, the member may still receive Respite, but their Plan of Care should include Respite as a service.
- The total annual limit for Respite (Respite group and individual combined) for a member is 300 hours per calendar year.

4.9 Children's and Adult Services

Comprehensive Diagnostic Assessment (CDA)

Description

The initial evaluation for treatment or comprehensive diagnostic assessment (CDA) includes a biopsychosocial assessment, as well as a description of the member's readiness and motivation to engage in treatment, participate in the development of the treatment plan and adhere to the treatment plan. The assessment will lead to a DSM diagnosis (or ICD equivalent) with recommendations for level of care, intensity and expected duration of treatment services. The CDA is completed by a clinician. No specific instrument is required for the diagnostic assessment; however, the assessment should include:

- Presenting problem
- Behavioral health treatment history and outcomes (noting current and previous providers), including family history
- Medical history, including family history
- Complete DSM-V diagnosis
- Mental status exam
- Risk assessment
  - A substance use screening should occur for members over the age of 10 years, noting any substance use and treatment interventions. When a substance use concern is identified during the assessment process, the provider must include the six ASAM dimensions in the CDA. Please note a GAIN can be used to fulfill this requirement. The ASAM assessment and placement determination must be completed by an individual trained in the ASAM Criteria® multidimensional assessment process and level of care placement decision making. The six ASAM dimensions are:
    - **Dimension 1:** Acute intoxication and/or withdrawal potential
    - **Dimension 2:** Biomedical conditions and complications
    - **Dimension 3:** Emotional, behavioral, or cognitive conditions and complications
    - **Dimension 4:** Readiness to change
    - **Dimension 5:** Relapse, continued use, or continued problem potential
    - **Dimension 6:** Recovery/living environment
- Education
- Legal Issues
- Social Support
- Assessment of spiritual and culture variables impacting treatment
- For children and adolescents, a developmental history is documented. For adolescents only, a sexual behavioral history must be documented.
- When applicable, medication information including prescriptions or refills, medication education and informed consent

- Recommendations
- For details on these requirements, see Treatment Record—Content Standards on pg. 39.

CDAs that are completed for members in mental health treatment without an identified SUD concern do not need to include the six ASAM dimensions.

A provider can use a CDA from any provider, including Liberty Healthcare, if it was completed in the last six months. The clinician is still required to do an independent clinical assessment/interview to verify that the information provided is accurate. If the CDA does not meet the requirements of the provider, the clinician needs to update it (billing either 90791 or 90834) with an addendum. An addendum is a way to add any additional relevant clinical information to the CDA. The auditors will consider both the initial CDA and the addendum in their review of the treatment records.

Newly eligible YES program members go through the independent assessment process and therefore will have a CANS and CDA from Liberty Healthcare. There should be no need to complete another CDA or CANS right away, unless the provider does not fully agree with the results. As a reminder, a completed CANS needs to be obtained with an initial CDA and updated every 90 days in the ICANSs system in order for a child to be eligible to receive most IBHP services (See the CANS section of this manual for additional information).

Provider Qualifications

Providers will be licensed clinicians as defined per licensure by the Idaho Division of Occupational and Professional Licenses and IDAPA; and/or practicing under the Optum Idaho supervisory protocol.

Provider Responsibilities

- A CDA is conducted face-to-face with the member and member's family present if applicable, or via Telehealth when appropriate. See the Telehealth Services section of this manual for additional information.
- A CDA is conducted at least every 365 days or when there are changes in the member's condition, needs, and preferences or at the request of the member, member's family or member's authorized representative.
- CDAs that are completed for members in mental health treatment without an identified SUD concern do not need to include the six ASAM dimensions. When a SUD concern is identified, referring for additional evaluation is the appropriate clinical intervention. (For more information regarding CDA incorporation of SUD assessment, please see Additional Information.)
- The provider supports engagement and involvement of the member, member's family.
- A CDA is conducted in a manner that is member centered, strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment needs.
- The provider will utilize the CDA and a functional assessment tool to guide individualized treatment planning.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
90791	*See next page*	Psychiatric Diagnostic Evaluation; Comprehensive Diagnostic Assessment; used for diagnostic assessment or reassessment, if required.	1 unit = 1 visit
90792	*See next page*	Psychiatric Diagnostic Evaluation with Medical Services	1 unit = 1 visit

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescriber under supervision
HO	Master's level provider under supervisory protocol
GT	Service rendered via Telehealth

Additional Information

No specific instrument is required for the Comprehensive Diagnostic Assessment (CDA). For children and adolescents, the initial or annual updated CANS can be completed in conjunction with an initial or updated CDA, by the Independent Assessor or the treating clinician. If the CANS is completed by a bachelor's level provider, an Independent Assessor or the treating clinician will need to conduct the CDA.

When a substance use concern is present, the six ASAM dimensions must be included in the member's Comprehensive Diagnostic Assessment (CDA). GAIN-certified providers have the option to use the Global Appraisal of Individual Need (GAIN) to meet this requirement. Other assessment tools may also meet this requirement. The ASAM assessment and dimensional placement determination must be completed by an individual trained in the ASAM Criteria® multidimensional assessment process along with level of care placement decision-making. This training must be documented in the individual's HR file through certificates, transcripts or CEU. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable. If the assessing provider is not qualified to complete the ASAM portion of the CDA, a referral must be made to an ASAM qualified professional for completion. To search for an in-network SUD provider, please utilize the provider search tool on ***liveandworkwell.com*** (see "Substance Use Assessment" for more information on ASAM dimensions).

Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.

Comprehensive diagnostic assessment services may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.

Family Psychoeducation

Description

Family Psychoeducation (FPE) is an approach for partnering with families and members with Serious and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED). Family Psychoeducation gives members and families information about mental illnesses, helps them build social supports, and enhances problem-solving, communication, and coping skills. Since Family Psychoeducation is a unique approach to mental health intervention, specialized sessions (joining sessions and an educational workshop) should be completed before beginning ongoing sessions and provider should ensure they are utilizing an Evidence-Based Practice. Providers may follow a different Evidence-Based Practice (EBP) Family Psychoeducation as fits the needs of the member, including EBPs where the member is not present with the family.

Provider Qualifications and Responsibilities

All family psychoeducation services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment needs.

Services may be provided by an independently licensed clinician or an individual with a master's degree who is able to provide psychotherapy. When a second facilitator is warranted, this may be a paraprofessional provider with a minimum of a bachelor's level operating in a group agency under Optum's supervisory protocol.

Multifamily Group Psychoeducation (2-5 families)

- Multifamily psychoeducation warrants two facilitators; at least one of these will be an independently licensed clinician or a master's-level provider qualified to deliver psychotherapy in a group agency under supervision. The second facilitator may be a bachelor's-level paraprofessional operating in a group agency under supervision.

OR

Single Family Psychoeducation

- Single-family psychoeducation requires a master's-level, independently licensed clinician or a master's-level provider qualified to deliver psychotherapy in a group agency under supervision. In cases where providers are working with a single family having many participants or complex issues, the family could benefit from the involvement of a second facilitator.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
H2027	*See below*	Family Psychoeducation; (26 sessions per member per year) * ***	1 unit = 15 minutes
H2027	**HQ** – *See below*	Multiple Family Group Psychoeducation; (26 sessions per member per year) * ***	1 unit = 15 minutes

**Note: Hours per member are guidelines. Optum will analyze claims information to identify outlier cases that may benefit from a clinical review when utilization exceeds the guidelines. These guidelines do not indicate there is a hard limit and there is no requirement for an authorization to exceed the indicated hours.*

****Note: Family Psychoeducation may be completed as part of the Therapeutic After School and Summer Programs (TASSP). The UC modifier is used to indicate that the service was rendered as a TASSP service as related to the clinical treatment plan goals.*

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescriber under supervision
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol
GT	Service rendered via Telehealth

Additional Information

Family psychoeducation services may be provided using Telehealth. See the Telehealth Services section of this manual for additional information. Additionally:

- Submit claims under the covered member's name regardless of the number of other family or group members participating.
- When more than one family member is a member in the Idaho Behavioral Health Plan (such as two or three siblings who also are eligible for Medicaid benefits), submit claims for the time spent conducting Family Psychoeducation for one member only.
- When two professionals facilitate multifamily groups (2-5 families), submit only one claim per service facilitator, per family.
- No more than two providers may bill for facilitating a Multiple Family Group Psychoeducation session.

Functional Assessment

Description

The provider shall utilize a functional assessment tool when appropriate to identify the member's strengths and needs and is used as part of the clinical record to create treatment plans with the member, member's family or member's authorized representative. Functional assessments are strengths-based evaluations of a member's functioning ability.

Provider Qualifications

The functional assessment tool can be administered by a provider who is certified/licensed to administer the specific assessment tool.

Provider Responsibilities

Assessment activities include face-to-face contact and the assessments should be member centered, culturally competent, and responsive to each member's psychosocial, developmental and treatment needs.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
H1011	*See below*	Functional Assessment Tool	1 unit = 15 minutes

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescriber under supervision
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol

Additional Information

There is no specific functional assessment tool mandated for adults, but one is required to be completed when appropriate to identify the member's strengths and needs.

Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.

The CANS is the state-required functional assessment for all Medicaid members under the age of 18. However, Optum does not mandate which additional assessments are appropriate for use. Rather, it's based on clinical discretion, as long as the CANS is used initially and updated every 90 days.

Individualized Skills Building Treatment Plan

Description

Teaming Approach (Skills Building/Community-Based Rehabilitative Services (CBRS)

The teaming approach is the process in which the independently licensed or master's level clinician under supervisory protocol, Skills Building paraprofessional, member, and family work together to develop an individualized Skills Building/CBRS treatment plan. The process is person-centered, strengths-based, collaborative, individualized and outcome-based.

Provider Qualifications

Providers qualified to provide Skills Building/CBRS and independently licensed or master's level clinicians under supervisory protocol (see Skills Building/CBRS provider qualifications).

Provider Responsibilities

- The Skills Building/CBRS teaming approach is a face-to-face meeting which is facilitated to develop, monitor, or modify a Skills Building/CBRS treatment plan.
- The providers support engagement and involvement of the member, member's family.
- The Skills Building/CBRS treatment plan should be developed as strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment needs.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

- Providers will use a functional assessment tool to identify the member-specific functional need(s) to be addressed with Skills Building/CBRS and use the results/measurements to develop the Skills Building/CBRS treatment plan.
  - » The Child and Adolescent Needs and Strengths (CANS) assessment is required for members under the age of 18 receiving Medicaid benefits. No specific functional assessment tool is mandated for adults, but one is required.
- Using the teaming approach, the Skills Building/CBRS treatment plan should be updated frequently enough to reflect changes in the member's condition, functional needs, goals, progress, preferences, and or at the request of the member/member's family.
  - » The period of time between treatment plan reviews shall not exceed ninety (90) calendar days.
  - » Treatment plan updates should reflect changes in the strengths and needs indicated from the 90-day functional assessment tool updates.
- The Skills Building/CBRS treatment plan is approved by the independently licensed clinician and must include their signature and title.
- The Skills Building/CBRS treatment plan must include the member/member's family signature on the document indicating their agreement with the treatment plan and their participation in its development.
- Please review the ***Skills Building/CBRS Optum Idaho Level of Care Guidelines*** for additional information.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
H0032	*See below*	Individualized Skills Building Treatment Plan – Billed by clinician and paraprofessional for teaming with patient present. (8 hours per member per year)***	1 unit = 15 minutes

****Note: Hours per member are guidelines. Optum will analyze claims information to identify outlier cases that may benefit from a clinical review when utilization exceeds the guidelines. These guidelines do not indicate there is a hard limit and there is no requirement for an authorization to exceed the indicated hours.*

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescriber under supervision
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol
GT	Service rendered via Telehealth

Additional Information

- Individualized Skills Building Treatment Plan services may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.
- Both individual providers (clinician and Skills Building/CBRS paraprofessional) may bill for teaming within the same agency.
- If a member is receiving therapy and Skills Building/CBRS at different agencies, the paraprofessional may also "team" with a treating clinician from another agency and both may bill for teaming. Clinical supervision under supervisory protocol still applies.

Skills Building/Community-Based Rehabilitation Services (CBRS)

Description

Skills Building/CBRS is a home or community-based service that utilizes psychiatric rehabilitation interventions designed to build and reinforce functional skills. Skills Building/CBRS modalities and interventions vary in intensity, frequency, and duration to support a member's ability to manage functional need independently. This service is available to youth diagnosed with Serious Emotional Disturbance (SED) and adults recovering from a Severe and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI). Skills Building/CBRS is driven by an individualized Skills Building treatment plan based on a member's specific needs and strengths identified from a comprehensive diagnostic and functional assessment. Services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, development, and treatment needs.

Provider Qualifications

Skills Building/CBRS specialists within the IBHP network must hold a minimum of a bachelor's level degree and be practicing under Optum Idaho supervisory protocol.

Provider Responsibilities

- The Skills Building/CBRS treatment plan must be developed and or updated using the teaming approach prior to submitting an Optum Idaho ***Skills Building/CBRS service request form***.
- The Skills Building/CBRS provider works with the member to develop and practice skills agreed upon with the treating clinician during the teaming process.
- Providers focus on behavioral, social, communication, rehabilitation, and/or basic living skills training which is designed to build a member's competency and confidence while increasing functioning and decreasing mental health and/or behavioral symptoms.
- Providers coordinate with other providers, agencies, systems or organizations serving the member and family to support the member's recovery and avoid duplication of services.
- For youth, the Skills Building/CBRS provider:
  - » May participate in the Child and Family Team (CFT) at the request of the youth and family who give consent.
  - » Ensures services are appropriate to the age and developmental stage of the child.
  - » Ensures that services provided result in demonstrated movement toward, or achievement of the member's treatment goals identified in the person-centered service plan, if applicable.

Authorization Type

Threshold is 308 units per member, per calendar year. Additional services must be prior authorized via ***Optum Idaho*** or ***Provider Express***.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Payment Methodology

CPT Code	Modifier	Description	Unit
H2017	*N/A*	Skills Building/Community Based Rehabilitation Services ***	1 unit = 15 minutes

****Note: Skills Building/Community Based Rehabilitation Services may be completed as part of the Therapeutic After School and Summer Programs (TASSP). The UC modifier is used to indicate that the service was rendered as a TASSP service as related to the clinical treatment plan goals.*

Additional Information

- Providers should rely on the policies and procedures established by their agency and any code of professional conduct that guides their certification or licensure to ensure appropriate boundaries are maintained with the member if providing other direct services.
- Skills Building/CBRS is not:
  - Provision of transportation, Respite, Case Management,or any other support or treatment service.
  - Daycare or a substitute for supervision.
  - Provided without involvement, communication, and coordination with the family of Members under the age of 18.
- Skills Building/CBRS Service Request Form
  - Providers should complete the Skills Building/CBRS service request form with information that demonstrates the member's current condition and how the member meets medical necessity criteria established by the Idaho Medicaid Supplemental Clinical Criteria (***Optum Idaho Level of Care Guidelines***).
  - Service request forms are only to be submitted when all 308 threshold units have been utilized for the year. Providers are responsible for tracking of units used and to only request services when additional units are needed.

Skills Training and Development (STAD)

Description

Skills Training and Development is treatment for members whose functioning is sufficiently disrupted to the extent that it interferes with their daily life as identified by a comprehensive diagnostic assessment and functional assessment tool.

Skills Training and Development is:

- Provided in a structured group environment within a mental health clinic or an appropriate group setting.
- Independent and/or group activities focusing on enhancing and/or developing social, communication, behavior, coping, and basic living skills. Activities can include each participant doing the same or similar tasks in the group or individuals doing independent tasks and bringing them back to the group.
- Used to treat mental health and co-occurring disorders.
- Offered separately for youth or adults.
- Provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

Provider Qualifications

Services may be provided by one of the following contracted professionals who meet the requirements of the Idaho Department of Health and Welfare and are within the scope of their practice:

- Licensed physician, Advanced Practice Registered Nurse, Physician Assistant, Licensed Social Worker (Licensed Clinical Social Worker, Licensed Master's Level Social Worker and Licensed Social Worker), Licensed Counselor, Licensed Marriage and Family Therapist.

- Bachelor's degree in a health and human services field and have completed the Optum Idaho general foundation and the Optum Idaho STAD training modules.
- Bachelor's degree in a health and human services field and 2 years' experience in health and human services field and have completed the Optum Idaho STAD training modules.
- Bachelor's degree in a health and human services field and licensed or certified in their field (i.e., certified as CPRP or CFRP by the Psychiatric Rehabilitation Association (PRA), and have completed the Optum Idaho STAD training modules.

For information on the required Optum Idaho general foundations and Optum Idaho STAD training modules, please go to ***optumidaho.com*** > For Network Providers > Provider Meetings & Trainings.

Provider Responsibilities

The group facilitator:

- Plans, guides and manages the group meetings to ensure that the group's objectives are met.
- Follows agency policy and works with the clinical/agency supervisor to ensure they have a plan for managing situations such as crisis, intoxication, abuse, inappropriate sexual behavior, and/or violence in the group setting.
- Works with the member and their treatment team to develop a STAD treatment plan and collaborates in monitoring the member's progress toward their goals.
- Updates the STAD treatment plan frequently enough to reflect changes in the member's condition, needs and preferences or at the request of the member or member's family (the period of time between reviews shall not exceed 90 calendar days).
- Selects appropriate curricula and interventions for the group.
- Works with the members of the group to set group expectations and consequences for not abiding by the rules.
- Sets group boundaries (structure, schedule, roles, etc.) and ensures that they remain intact.
- Educates group members about confidentiality, discussing confidentiality openly and often.
- Supports engagement and involvement of the member and member's family.
- Ensures that services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
H2014	*N/A*	Skills Training and Development***	1 unit = 15 minutes

****Note: Skills Training and Development may be completed as part of the Therapeutic After School and Summer Programs (TASSP). The UC modifier is used to indicate that the service was rendered as a TASSP service as related to the clinical treatment plan goals.*

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Additional Information

Providers should rely on the policies and procedures established by their agency and any code of professional conduct that guides their certification or licensure to ensure appropriate boundaries are maintained with the member if providing other direct services:

- When two or more providers facilitate a STAD group, only one provider can submit a claim for a member. Two or more providers facilitating the same group may not bill for the same members within the group.
- Skills training and development requires face-to-face contact with the member.
- Groups should be developmentally age appropriate; therefore, children and adolescent skills training groups should convene separately from adults.
- Service delivery should follow the member's individualized skills training and development treatment plan which is based on a member's specific needs and strengths identified from the comprehensive diagnostic (CDA) and functional assessment tool. Providers are encouraged to develop the skills training and development plan using the teaming approach. Treatment planning should be person-centered, collaborative, individualized and outcome based.
- While providers are encouraged to develop the skills training and development plan using the teaming approach, the teaming approach is not required as it is for Skills Building/CBRS. Therefore, the H0032 billing code for individualized Skills Building/CBRS treatment plan would not be applicable to STAD.
- **Group Size**
  - Group size can vary but is generally determined by the purpose of the group
  - Seven to nine group members is a guideline most often thought to be small enough to allow for open discussion and also allow individual attention to be given to each participant.
  - A group may consist of more than nine participants, although a general rule of thumb for facilitator to group member ratio is one facilitator for every 12 participants at most. However, this number can also vary greatly depending on the following member demographics:
    - **Ages of Group Members:** Children's groups may need a higher facilitator to group member ratio in order to support the needs of the group and to keep them engaged.
    - The safety and security needs for individuals and the group. Additional facilitators may be required.
    - **Purpose/topic of the group:** A group focusing on developing hygiene skills might need a lower ratio than a group focusing on social skills or other skills that benefit from high levels of group interaction.
    - **Diagnosis and needs of group members**: A group that has individuals needing support to engage in the discussion or are at risk for disruption may need a higher facilitator to group member ratio. Groups consisting of more than 12 participants may require an additional facilitator.
      - In all cases, it is crucial to consider the member's level of functioning and ensure milieu across the group. In some cases, when it is not possible for group functioning levels to be fully compatible, additional facilitators may be needed.
- The setting selected for a group should ensure privacy, safety, be related to the purpose of the group, provide appropriate boundaries, and meet the group's basic needs.
- A skills training and development group purpose can vary widely. Groups might focus on activities of daily living, cognitive, emotional or behavioral skills, social skills, health and wellness, and community integration.
- Selecting the appropriate curriculum or intervention for a group is critical to the success of the group and its members. The following factors should be taken into account when selecting the right curriculum or intervention.
  - **Relevance to the purpose of the group**: Before selecting a curriculum or intervention, the purpose and goals of the group should be clearly articulated, including clear objectives. The intervention should be able to meet those objectives and ensure that the necessary skills can be effectively gained by group members.
  - **Facilitator's ability to implement**: The strategies and modalities of a curriculum should first be reviewed by the provider to ensure that he or she has the basic competencies to implement the intervention.
  - Person-centeredness: A skills training and development curriculum must be person-centered, meaning that it focuses on the individuality of members, ensures dignity and respect of all members, and integrates member voice and choice in all aspects of implementation.
  - **Strengths-Focus**: A strengths-based approach focuses on finding solutions and emphasizing the strengths an individual already possesses. Group curricula or interventions should take into account the existing strengths of the member and build on those, rather than taking a needs-based approach.

- **Trauma-Informed Approach**: Trauma-informed means that an intervention considers the fact that trauma exists, recognizes the signs and symptoms of trauma, and responds by integrating practices to avoid re-traumatization.
- **Cultural relevance**: Any skills training and development curriculum or intervention should have an evidence-base showing effectiveness with the population being served. At the same time, the curriculum should be flexible enough to allow for the integration of culturally specific practices and concepts.
  - Members are expected to show benefit from skills training and development, with the understanding that improvement may be incremental.
  - Skills training and development must result in demonstrated movement toward, or achievement of, the member's treatment goals identified in the person-centered service plan, if applicable.

Skills Training and Development is not:

- Provision of transportation, respite, case management or any other support or treatment service.
- Daycare or a substitute for supervision.
- Provided to a group of children without involvement, communication and coordination with the family.

4.10 Crisis Services

A behavioral health crisis is a situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress due to psychiatric symptoms associated with mental illness or Substance Use Disorder(s). These persons may be considering self-harm or harm to others, be disoriented or out of touch with reality or have a compromised ability to function or are otherwise agitated and unable to self-calm. An immediate response to their circumstances is needed.

Crisis Centers

Description

A Behavioral Health Crisis is a situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress due to psychiatric symptoms associated with mental illness or Substance Use Disorder(s). Crisis Centers provide crisis services to adults in a behavioral health crisis for no more than twenty-three (23) hours and fifty-nine (59) minutes per single episode of care.

Optum Idaho uses the information from the Division of Behavioral Health Statement of Work that is part of their contract with the Crisis Centers to create guidelines, auditing tools and outcomes measures.

Provider Qualifications

Providers will be licensed clinicians as defined per licensure by the Idaho Division of Occupational and Professional Licenses and IDAPA; and/or practicing under the Optum Idaho supervisory protocol.

Bachelor's level paraprofessionals also must be trained and certified in Verbal Crisis Intervention by the Crisis Prevention Institute (CPI) to submit claims for the provision of all crisis services. To become certified, please visit ***optumidaho.com*** > For Network Providers > Provider Trainings. The bachelor's-level paraprofessional without CPI training can start work prior to completing CPI training; however, they must complete the CPI training at the next available opportunity. Crisis Center services are the only services allowed to be provided by the paraprofessional before completing the CPI training.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Provider Responsibilities

Crisis Centers are required to meet the following requirements:

- **Accreditation Requirements**
  - The Crisis Center must be either JCAHO- or CARF-accredited or pass an Optum Idaho Organizational Provider audit. This requirement serves to ensure the Crisis Center's facility, location and operations are consistent with the requirements to operate as a Crisis Center. The audits will comprise an on-site review. This will include site tour, review of policies and procedures, HR files and service records. Additional monitoring audits will occur within the recredentialing period. For all audits of Crisis Center Services, the audit team will use the Organizational Provider Audit Tool and the Community Crisis Center Record Tool.
- **Assessment and Evaluation Services**
  - **Intake Eligibility Assessment** – The intake eligibility assessment must be completed within thirty (30) minutes of the member seeking services at the Crisis Center. The intake eligibility assessment assists in determining whether the member is in a behavioral health crisis and whether the member, from a medical standpoint, needs treatment at the emergency department or inpatient facility. A mental status exam is required to be completed as part of the intake eligibility assessment as described in the ***Optum Level of Care Guidelines***.
  - **Medical Assessment** – A medical staff person licensed as a LPN, RN, EMT or paramedic will further evaluate the member for immediate medical needs. Additionally, the medical assessment will provide a health history for the member.
  - **Risk Assessment** – A licensed professional is required to complete a risk assessment of the member.
  - **Behavioral Health Assessment** – Each member shall have a behavioral health assessment completed. Best practice guidance is to complete the behavioral health assessment as soon as possible, with the understanding there may be times when the assessment will be completed several hours after the member is admitted to the Crisis Center. The behavioral health assessment is used to develop the plan of care, intervention services and referral services. Included in the behavioral health assessment are the following:
    - Presenting problem,
    - Treatment history,
    - Substance use history and
    - Recommendations.

The Crisis Center can use an updated behavioral health assessment for members who were assessed within the last three (3) months.

- **Plan of Care**
  - The Crisis Center is required to complete a plan of care based on the findings from the medical and behavioral health assessments for all members admitted to the Crisis Center. The plan of care needs to be individualized, person-centered, strengths-based, collaborative, family and community focused, culturally competent, utilize natural supports, and be outcomes-based.
  - The Crisis Center also shall utilize ongoing observation, assessment and evaluation to make changes to services while the member continues to receive treatment at the Crisis Center. This information, along with the member's strengths, needs and resources, shall be used to make referrals for ongoing services.
- **Intervention Services**
  - The Crisis Center is required to provide stage-wise treatment and intervention services based on the Dr. Kenneth Minkoff, M.D. five-stage model to address co-occurring psychiatric and substance use disorders.
  - The Crisis Center is required to provide services in the least restrictive manner and shall not utilize seclusion or restraints as part of its intervention services.
  - If it is determined the member requires a more restrictive setting, the Crisis Center is required to notify law enforcement to provide transportation as part of its intervention services.
  - The Crisis Center is required to incorporate the recovery model, to include the use of certified Peer Support Specialists and/or Recovery Coaches.
- **Referral Services**
  - The Crisis Center is required to make referrals based on identified functional needs of impairment (medical, vocational, financial, housing, family, social activities of daily living, transportation, legal and substance use).

- **Aftercare Plan**
  - The Crisis Center must provide a written aftercare plan to the member prior to their leaving the Crisis Center. The aftercare plan must include, at a minimum, connection to a Peer Support Specialist or Recovery Coach.
- **Admissions and Discharges**
  - Medicaid reimbursement requires that the medical record reflect the admission and discharge of a member with documentation supporting why they were admitted and discharged from the Crisis Center. If a member leaves the Crisis Center for whatever reason, there must a discharge note in the medical record with the reason for the discharge.
- **Readmissions**
  - If a member returns to the Crisis Center, the expectation is that the assessments that were completed for the previous admission would be updated to reflect the reason for the new admission, any changes that occurred since the discharge and any other pertinent information for the member at that time.

Authorization Type

No prior authorization is required.

Payment Methodology

Crisis Center Services

Although each center's plan for sustainability will be individualized, reimbursement from any insurer, including Medicaid, will be an important component. The Crisis Center will bill for the crisis center services using the HCPCS code S9485-Crisis Center which is an all-inclusive code. The Crisis Center cannot bill for other services while a member is in a Crisis Center. However, the provider will be reimbursed for medically necessary outpatient services if the member is seen in the clinic before being seen at the Crisis Center or after leaving it, even if those services are delivered on the same calendar day. The S9485 Crisis Center code can be billed only once per day for a member. A day is defined as from midnight to 11:59pm as opposed to 23 hours and 59 minutes after the member is admitted to the Crisis Center.

Crisis Center claims will use the Place of Service code of 20: Urgent Care Facility. In order to submit a Crisis Center claim, there must be a diagnosis on the claim form. Since there is not a CDA completed, the most appropriate diagnosis in most situations will be a Z-code-Other conditions that may be a focus of clinical attention. Z-codes identify conditions other than a disease or injury and are used to report significant factors that may influence present or future care. The Z codes to be used by Crisis Centers will be identified including and between Z55 (problems related to education and literacy) and Z73 (problems related to life management difficulty). The appropriate subcategory specifier should be selected to most closely reflect the member's presenting problem for obtaining Crisis Center services.

Crisis Center services include behavioral health assessment, medical evaluation, treatment/crisis planning, Case Management/Coordination, Crisis Services, Peer Support and/or Recovery Coaching and referrals.

Crisis Intervention Services

If after completing the Intake Eligibility Assessment it is determined the member doesn't meet the admission criteria for Crisis Center level of care, the Crisis Center should bill the Crisis Intervention code H2011 with the appropriate number of units instead of billing the Crisis Center code.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

CPT Code	Modifier	Description	Unit
S9485	*N/A*	Crisis Intervention-per diem rate that is all-inclusive of professional fees. Agencies may not bill other services while a member is in the Crisis Center.	1 unit = 1 visit
H2011	*See below*	Crisis Intervention	1 unit = 15 minutes

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescriber under supervision
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol

Additional Information

Crisis Center services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

- Although reimbursement and billing for care is a significant change for the Crisis Center, the underlying intent of Crisis Centers as a community resource for any adult experiencing a behavioral health crisis, regardless of ability to pay, will not change. Individuals without insurance will not be billed unless the individual center chooses this as part of their sustainability plan.
- If the member has another insurance primary, the Crisis Center would bill the primary insurance first. After the primary insurance has adjudicated the claim, the Crisis Center would then submit the Explanation of Benefits (EOB) from the primary insurance to Optum for processing of the claim.
- Crisis Centers can continue to use the WITS system as their electronic medical record; however, the WITS system will not be modified to support billing functions. The Crisis Centers continue to be required to submit the same data points to the Division of Behavioral Health's Automation/Data unit if they choose to use an alternative Electronic Health Record.
- Crisis Centers are required to update the Idaho Psychiatric Bed and Seat Registry (***IPBSR***) with their census numbers twice per day in order to support a statewide registry of crisis bed capacity and the number, availability, and demographic of those psychiatric beds and crisis seats across Idaho.
- The wellness assessment is not required to be completed for Crisis Center services.

Crisis Intervention

Description

Crisis Intervention services are available 24/7 and provide face-to-face intervention for members experiencing a mental health crisis. Crisis Intervention is provided in the location where the crisis is occurring. Crisis Intervention addresses the immediate safety and well-being of the member, family, and community. Crisis Intervention assesses, intervenes, and coordinates with the member's current behavioral health provider and/or provides referrals to behavioral health and/or emergency services.

Provider Qualifications

Up to two providers at any combination of license level (i.e., two CPI-certified paraprofessionals, two master's level clinicians, one CPI-certified paraprofessional and one Ph.D., etc.) may bill simultaneously for providing Crisis Intervention to a member.

Bachelor's-level paraprofessionals also must be trained and certified in Verbal Crisis Intervention by the Crisis Prevention Institute (CPI) to submit claims for the provision of all Crisis services. To become certified, please visit optumidaho.com > For Network Providers > ***Provider Trainings***.

Provider Responsibilities

Within the 24 hours following a behavioral health crisis, crisis service providers will follow up telephonically with the member/member's family to assess member stability and crisis follow-up needs.

- Crisis services are intended to stabilize the member during a behavioral health crisis.
- Crisis service providers practice only within their scope of practice and make referrals, as appropriate, based on the acuity of the crisis.
- Crisis services are not supervision of a member after the member is transferred to the appropriate level of care.

Providers of crisis services create and/or update the crisis/safety plan with the member and member's family.

Crisis Intervention services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment care needs.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
H2011	*See below*	Crisis Intervention	1 unit = 15 minutes

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescriber under supervision
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol

Crisis Response

Description

Crisis Response services are available 24/7 and provide telephonic intervention for members experiencing a behavioral health crisis. Crisis Response provides assessment and crisis stabilization through counseling, support, active listening or other telephonic interventions to alleviate the crisis and offer referrals to services and community providers.

Provider Qualifications

Providers will be licensed clinicians as defined per licensure by the Idaho Division of Occupational and Professional Licenses and IDAPA; and/or practicing under the Optum Idaho supervisory protocol.

Bachelor's-level paraprofessionals also must be trained and certified in Verbal Crisis Intervention by the Crisis Prevention Institute (CPI) to submit claims for the provision of all crisis services. To become certified, please visit optumidaho.com > For Network Providers > ***Provider Trainings***.

Provider Responsibilities

The goal of Crisis Response is to ensure the safety and emotional stability of the member to avoid further deterioration of his or her mental status.

If a member's behavioral health crisis cannot be resolved telephonically and a higher level of intervention is indicated, the member will be referred to Crisis Intervention services and/or Crisis Centers for adult members.

In the event of imminent risk of danger to self or others, or if no Crisis Intervention provider is available for immediate intervention, Emergency Services will be engaged.

In the 24 hours following a behavioral health crisis, it is best practice for providers to follow up telephonically with the member/member's family to assess member stability and crisis follow-up.

Crisis Response services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment care needs.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
H0030	*See below*	Crisis Response (Telephonic)	1 unit = 1 call

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
U1	Prescriber under supervision
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol

4.11 Peer Services

Defining Peer Services

Peer support workers are people who have been successful in the recovery process and choose to use their personal experience to help others navigate the process of recovery. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. (SAMHSA Substance Abuse and Mental Health Services Administration, 2020)

Peer Services include: Adult Peer Support, Family Support, Recovery Coaching and Youth Support. It is unlikely that these services would be delivered simultaneously. Best practice indicates that the member's primary diagnosis should determine which service is provided first. The treatment team should consider the member's individual circumstances and defer to their clinical supervisor for guidance on which services should be rendered.

Providers of Peer Services, in collaboration with the member, will complete an initial needs assessment inventory and recovery/service plan. As part of the assessment, the provider gives the member and/or family information about Peer Services and verifies that they want these services. If declined, the Peer Services provider offers information about obtaining services should their needs change. These should be completed within 15 calendar days of the initiation of services.

Peer Services Needs Assessment Inventory

1. The reasons for starting peer services (youth/adult/recovery coaching and family) are indicated and with Family Support services this would also include the name and relationship to the member for each family member expected to participate in services.
2. Inventory of the member's perception on their current family and/or social supports is included in the record.
3. An inventory of the member's/ family's self-identified strengths and other resilience factors such as the member's/family's support network.
4. An inventory of the member's behavioral health, medical and community support services.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

5. An inventory of what the member identifies as the barriers and risk factors which have undermined the member's participation in clinical and community support services or have otherwise prevented the member from achieving his/her broader recovery goals.

6. An inquiry about the member's need or desire to better understand of his/her condition, its treatment, and the role that community support services can play in the member's recovery.

7. An inquiry regarding actions plans, personal wellness plans and/or advanced directives are different based on the service as below:

   - Family Support Services – The service plan includes the development of an Action Plan for Recovery and/or plan for managing relapse (if desired by the member).
   - Peer Support/Recovery Coaching – An inquiry as to whether the member has a personal wellness plan, an advance directive, and/or a plan for managing relapse.
   - Youth Support – An inquiry as to whether the member has a personal wellness plan and/or a plan for managing relapse.
     - **§ The child's CANS should inform the inventory and Recovery Plan. If applicable a child's PCSP should be reflected in both the Needs Assessment and Recovery Plan.**

Peer Recovery/Service Plans

The recovery/service plan should include the following:

1. The member/ member's family's recovery and resiliency goals.

2. Specific and measurable goals, the timeframes for meeting each goal, and the steps the member/member's family wants to take to achieve their goals.

3. Empowerment activities the peer will use to help the member/family that will support the member's family and member in meeting the recovery goals.

4. A description of how the member/member's family will engage in family support services, utilize empowering self-advocacy tools and other community support services.

5. The frequency and length of service are periodically re-evaluated depending on the intensity of the peer support services needed.

6. Recovery/Service plans for all Peer Services should be reviewed/updated with the member/ member's family as frequently as needed to meet the member/ member's family's needs but at a minimum of every 90 days.

Adult Peer Support

Description

Adult Peer Support services are provided by Certified Peer Support Specialists (CPSSs) who utilize their training, lived experience and experiential knowledge to mentor, guide and coach the member as he/she works to achieve self-identified recovery and resiliency goals. These services are designed to promote empowerment, foster self-determination and choice, and inspire hope as the member progresses through the recovery process. CPSSs use their lived recovery experience from a mental health diagnosis and specific specialist training to assist adult members with defining their goals for recovery and developing a recovery plan. They also assist members with developing the skills for a proactive role in their own treatment plan and help members connect with other members and with their self-defined community.

Provider Qualifications

A provider of Adult Peer Support:

- Has a high school degree or equivalent.
- Has had lived experience with mental health illness or mental health illness co-occurring with substance use disorder.
- Has been in recovery for a minimum of 1 year.
- Has an active Peer Support Specialist certification.
- Is practicing within a group agency in the Optum Idaho network under Optum supervisory protocol.

Provider Responsibilities

The provider is responsible for:

Collaboration with the member and any other individuals selected by the member and will create an individualized recovery plan that reflects the member's needs and preferences.

- The process of recovery planning should be an empowering, engaging and member-centered process that allows the member to take ownership of the recovery plan.
- At a minimum, the CPSS will collaborate with the member to formally review the recovery plan every 90 calendar days. However, revisions to the recovery plan will be made whenever there are significant changes in the member's condition, needs, or preferences.

All Peer Support services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment care needs.

Authorization Type

Threshold is 416 units per member, per calendar year. Additional services must be prior authorized via ***Optum Idaho*** or ***Provider Express***.

Payment Methodology

CPT Code	Modifier	Description	Unit
H0038	*N/A*	Peer Support by certified Peer Support Specialist for members age 18 and older.	1 unit = 15 minutes

Additional Information

This service is provided to members age 18 and older.

The CPSS may not act as a legal representative for the member, participate in determining competence, provide legal advice, or deliver services that are within the scope of a behavioral health or medical provider's licensure.

Optum expects that paraprofessionals are appropriately supervised by a qualified clinician in this activity. For further information, please review the Supervisory Protocol in your Optum Network Agreement.

Please refer to Provider Manual Section 3.6 "Criminal History Background Checks" for information on Criminal History Background Check Waivers/Variances issued by IDHW for Peer Support providers.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

For more information on Adult Peer Support certification, please contact:

BPA Health Peer and Family Support Certification

208-947-1300
info@idahopeercert.com
idahopeercert.com

Family Support Services by Certified Family Support Partners

Description

Family Support services provide support to families and caregivers who are caring for youth who have been identified as having a serious emotional disturbance (SED) or co-occurring disorder and assist the entire family in their own recovery.

Family Support services are provided by a Certified Family Support Partner (CFSP) who is a parent or adult caregiver, with lived experience, specialized training, and has acquired an understanding of another parent's situation via the shared emotional and psychological challenges of raising a child with SED. The CFSP establishes a connection and a trust with the member and family not otherwise attainable through other service relationships (e.g. counselor, psychologist, minister) or someone without the shared experience.

The purpose for these services is to help the family feel less isolated, more empowered throughout the recovery process and engaged in the community. Services aim to improve the quality of life and opportunities for recovery in the child's home, school, and community.

Provider Qualifications

Family Support services are provided by a Certified Family Support Partner (CFSP) and:

- Has at least one year of lived experience as a parent or an adult caregiver who is raising a child or has raised a child who lives with a mental health illness or a with a co-occurring substance use disorder and has navigated the various child-service systems of care (lived experience comes from raising a child before his/her 18th birthday and the lessons learned from raising this child).
- Is practicing within a group agency in the Optum Idaho network under Optum supervisory protocol.
- Has an active Family Support Partner certification.

The Criminal History Background Check Variance issued by the IDHW for Medicaid Peer Support and Recovery Coaching providers cannot be used by Youth Support or Family Support providers.

Provider Responsibilities

CFSP provides services that are focused on the member's family, the role of the member in the family, and guided by the member and family.

CFSP considers the member and member's family's rights and services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment care needs.

CFSP assists the entire family unit with developing the skills for advocacy and the belief that recovery is possible.

The youth's CANS results should be used to inform the recovery plan. Although the recovery plan is driven by the youth/family, key elements and goals from the recovery plan should also be included in the CANS and if applicable, the PCSP for consistency of treatment across providers.

The CFSP activities can include:

- Participation in a Child and Family Team (CFT), when applicable, at the request of the youth and the family who give consent.
- Advocating for the needs of the family.
- Supporting the development of self-advocacy and problem-solving skills.
- Mentoring to instill a sense of hope.
- Role modeling behaviors, attitudes and thinking skills needed for resiliency and coping.
- Helping family members identify and utilize their strengths.
- Role modeling the facilitation of collaborative relationships.
- Teaching the member and family about causes of disorders and importance of adhering to treatment that assists in meeting goals.
- Assisting the family in identifying services and community resources.
- Assisting family members in articulating their needs and goals in preparing for meetings as well as service plans.
- Teaching caregivers how to document all activities that pertain to the child's appointments, meetings, needs, goals, and strengths.
- Assisting the family in preparing for the child's transition to adulthood.

Authorization Type

Threshold is 416 units per calendar year. Additional services must be prior authorized via ***Optum Idaho*** or ***Provider Express***.

Payment Methodology

CPT Code	Modifier	Description	Unit
H0046	*N/A*	Family Support by certified Family Support Specialist	1 unit = 15 minutes

Additional Information

- This service is provided to members under the age of 18 years of age and their family members.
- Services are delivered face-to-face.
- The CFSP refers child and family to the appropriate resources if they are unable to benefit from CFSP services.
- Services are not provided in lieu of other services and are intended to complement the member's behavioral health treatment and/or other services being provided.
- CFSPs provide services for families who are raising a child with a mental health illness or co-occurring disorders. CFSPs do not work with adults who have a mental health illness or co-occurring disorders.
- Optum expects that paraprofessionals are appropriately supervised by a qualified clinician in this activity. For further information, please review the Supervisory Protocol in your Optum Network Agreement.
- For more information on Family Support Partner certification please contact:

BPA Health Peer and Family Support Certification

208-947-1300
info@idahopeercert.com
idahopeercert.com

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Recovery Coaching

Description

Peer support providers serving members whose most significant issue is SUD are known as Recovery Coaches (RCs). The Recovery Coach serves as a personal guide and mentor for members in recovery, helping to remove barriers and obstacles, linking members to services, supports, and the recovery community. Following any episodes of drug or alcohol use or lapses in recovery, the Recovery Coach works to achieve quick turnaround in re-engaging the individual in treatment and/or recovery support. The efforts of the Recovery Coach decrease substance use, number and severity of relapse episodes, and criminal justice involvement.

Provider Qualifications

Optum expects that paraprofessionals will be appropriately supervised by a qualified clinician in this activity. For further information, please review the Supervisory Protocol in your Optum Network Agreement.

Idaho Board of Alcohol/Drug Counselor Certification (IBADCC) is the governing body for Recovery Coaching Certification. Recovery Coaches must meet the current certification requirements for performing this service. They must follow IBADCC's requirements for recovery coach supervision in addition to following the Optum's Supervisory Protocol.

The types of Recovery Coach Certifications are as follows:

- **Certified Peer Recovery Coaches (CPRCs)** are self-identified persons in recovery who have a high school diploma or GED, have 500 hours of paid or volunteer recovery support experience (including supervision hours), have completed 46 hours of education/training related to the CPRC domains, and also meet required illicit drug/alcohol abstinence requirements, per the IBADCC CPRC Eligibility Criteria.
- **Certified Recovery Coaches (CRCs)** are individuals who have a high school diploma or GED, have 500 hours of paid of volunteer recovery support experience (including supervision hours), and have completed 46 hours of education/training related to the CPRC domains per the IBADCC CRC Eligibility Criteria
- **Provisional Certified Peer Recovery Coaches (PCPRCs)** are self-identified persons in recovery who have a high school diploma or GED and have completed 46 hours of education/training related to the PCPRC domains, and also meet required illicit drug/alcohol abstinence requirements, per the IBADCC PCPRC Manual and Application forms. This provisional certification requires no upfront experience but allows the certified individual to work toward their 500 hours of paid of volunteer recovery support experience (including supervision hours) for the CPRC certification. PCPRCs have one year from the date their application is selected to complete the required experience and take the required exam. Additional information regarding requirements and timelines are in the IBADCC PCPRC Manual and Application Forms.
- **Provisional Certified Recovery Coaches (PCRCs)** are individuals who have a high school diploma or GED and have completed 46 hours of education/training related to the PCRC domains per the IBADCC PCRC Manual and Application forms. This provisional certification requires no upfront experience but allows the certified individual to work toward their 500 hours of paid of volunteer recovery support experience (including supervision hours) for the PCRC certification. PCRCs have one year from the date their application is selected to complete the required experience and take the required exam. Additional information regarding requirements and timelines are in the IBADCC PCRC Manual and Application Forms.

IBADCC sources cited in this section can be found at: ***IBADCC – Idaho Board of Alcohol Drug Counselor Certification***.

All services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment needs.

Recovery Coaching services include but are not limited to:

- Assisting with setting recovery goals, developing a recovery action plan, a relapse plan, solving problems and addressing barriers related to recovery.
- Encouraging self-determination, hope, insight, and the development of new skills.
- Connecting the member with professional and non-professional recovery resources in the community and helping the member navigate the service system in accessing resources independently.

- Facilitating activation[2] so that members may effectively manage their own mental illness or co-occurring conditions, and empowering members to engage in their own treatment, healthcare and recovery.
- Helping the member decrease isolation and build a community supportive of the member establishing and maintaining recovery.

Authorization Type

Threshold is 416 units per member, per calendar year. This service is provided to members age 18 and older. Additional services must be prior authorized via ***Optum Idaho*** or ***Provider Express***.

Payment Methodology

CPT Code	Modifier	Description	Unit
H0038	**HF**	Recovery Coaching provided by an IBADCC certified Recovery Coach for peers in a peer-based model when the member's primary diagnosis is Substance Use Disorder (SUD)	1 unit = 15 minutes

[2]*Facilitating Activation refers to client activation which is "an individual's knowledge, skill and confidence for managing their health and health care" (Hibbard et al 2005).*

Additional Information

Please refer to Provider Manual Section 3.6 "Criminal History Background Checks" for information on Criminal History Background Check Waivers/Variances issued by IDHW for Recovery Coaching providers.

For more information, ***IBADCC*** can be reached at:

1404 N. Main St. Ste #102
Meridian, ID 83642
208-468-8802
ibadcc.org

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Youth Support

Description

Youth Support Services exist under the umbrella of Peer Services. Youth Support Services assist and support members ages 12 to 17 in understanding their role in accessing services, becoming informed consumers of services and self-advocacy. (Family Support may be a service to consider for members under the age of 12.) Youth Support may include, but is not limited to, mentoring, advocating, and educating through youth support activities individually or in groups. Youth Support Services are provided in a context that is youth-centered, family-focused, youth-guided, strengths- based, team-based, community-based, outcome-based, culturally sensitive and responsive to each youth's psychosocial, developmental and treatment care needs.

Youth support is intended for youth who have the capacity and ability to understand their diagnosis, needs, strengths, behaviors and symptoms to be an active participant in making decisions for their individualized care.

Provider Qualifications

A provider of Youth Support:

- Has a high school diploma or equivalent.
- Has had lived experience with SED or SED co-occurring with Substance Use Disorder as a youth (standalone SUD lived experience is not eligible).
- Has been in recovery for a minimum of 1 year.
- Has an active Peer Support Specialist certification.
- Has completed the required Optum Idaho Youth Support Endorsement training.
- Is practicing within a group agency in the Optum Idaho network under Optum supervisory protocol.

The Criminal History Background Check Variance issued by the IDHW for Medicaid Peer Support and Recovery Coaching providers cannot be used by Youth Support or Family Support providers.

It is recommended, however not mandatory, that the provider of Youth Support be between the ages of 21 and 30. This recommendation is based on the importance of Youth Support providers having the ability to connect with youth on a peer-to-peer level. To maintain best practices for Youth Support services, it is important for youth to find their Youth Support provider relatable. Providers who are interested in earning the Youth Support endorsement are encouraged to consider their connection to youth culture and their ability to relate to youth on a peer-to-peer level.

Provider Responsibilities

- Youth Support providers model recovery and share their stories of lived experience to connect and engage youth in the recovery process.
- Youth Support is directed by the youth participating in services and aligns with the specific hopes, goals, strengths and needs of the youth.
- If applicable, the member's PCSP developed by the youth's CFT should help inform the recovery plan.
- Youth Support providers are trauma-informed and use a strengths-based framework that emphasizes physical, psychological and emotional safety.
- At a minimum, the Youth Support provider will collaborate with the youth and their family to formally review the recovery plan every 90 days. However, revisions to the recovery plan will be made whenever there are significant changes in the youth's condition, needs, or preferences. The youth's CANS results should be used to inform the recovery plan. Although the recovery plan is driven by the youth, key elements and goals from the recovery plan should also be included in the CANS and PCSP for consistency of treatment across providers.
- Collaborates with youth's clinicians, medical physicians, family/social supports, and/or agencies and other programs with which the member is involved including a CFT if applicable. Collaboration should be ongoing throughout treatment. Empowers the youth to gain the ability to make independent choices and take a proactive role in their individualized treatment

- Supports and educates the youth on navigating behavioral health systems.
- Helps the youth to develop a network of support.
- Empowers the youth to develop skills to improve their overall functioning and quality of life.
- When applicable, Youth Support providers may participate in a Child and Family Team (CFT) at the request of the youth and family who give consent.
- All Youth Support Services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment care needs.
- Please see Optum Idaho Level of Care Guidelines for Children and Adolescent Services: Youth Support for additional information and provider responsibilities.

Authorization Type

Threshold is 416 units per member, per calendar year which includes both individual and group. This service is provided to members under the age of 18 years. Additional services must be prior authorized via ***Optum Idaho*** or ***Provider Express***.

Payment Methodology

CPT Code	Modifier	Description	Unit
H0038	*N/A*	Youth Support by certified Peer Support Specialist with Youth Support Training for members ages 12 to 17	1 unit = 15 minutes
H0038	**HQ**	Youth Support (Group) by certified Peer Support Specialist with Youth Support Training for members ages 12 to 17	1 unit = 15 minutes

Additional Information

Youth Support is provided with the youth present.

Youth Support Services may be provided individually or in groups.

When two or more providers facilitate a youth support group, only one provider can submit a claim for a member. Two or more providers facilitating the same group may not bill for the same members within the group.

Guidelines for Youth Support groups:

- The agency and/or clinical supervisor as defined by the Optum Idaho supervisory protocol should assure that the Youth Support provider has the skills and experience to facilitate a group. The clinical supervisor should also determine whether initial or ongoing training on group facilitation is needed and decide how they will assist and supervise the Youth Support provider's development in providing group services. If rendering Youth Support in a group, Optum strongly recommends group facilitation training. Some options include:
  - Depression and Bipolar Support Alliance (DBSA) Resources for Support Group Facilitators: ***www.dbsalliance.org***
  - Mental Health America's Support Group Facilitation Guide: ***www.mhanational.org***
  - National Alliance on Mental Illness Peer-to-Peer Classes: ***www.namiidaho.org***
- Youth should be involved in creating group agreements/ground rules/guidelines/expectations for groups.
- Youth Support groups will consist of 4 to 12 participants. The minimum ratio is 1 facilitator to 6 participants. Groups exceeding 6 participants would require 2 facilitators or must be conducted as separate groups. Both facilitators must be endorsed Youth Support providers.
- Youth Support groups can be co-facilitated to allow for individual support/ hot topics, reframing, multiple perspectives.

- Youth Support groups should not be co-facilitated by a clinician, as this could lead to the group having therapeutic/clinical focus rather than a peer recovery focus.
- Group members may find it beneficial to have guest speakers to share their experience or expertise
- Speakers could include: people with lived experience, survivors, behavioral health professionals, clinicians, lawyers, human rights advocates, medical professionals etc.
- Youth Support groups should follow an evidence-based curriculum and any activities or topics used within the group should align with the curriculum that the Youth Support provider is trained in, such as the three suggested curriculum options above.
- Youth Support groups should incorporate trauma-informed principles.
- Youth Support group facilitators should strive to create a person-centered, culturally sensitive, and inclusive environment in which to conduct groups.
- Youth Support groups are not Skills Training and Development groups

Youth Support groups can be helpful for youth to:

- Learn about themselves through interacting with others who have similar life experiences and hearing personal recovery stories.
- Gain a sense of exercising control over the quality and direction of their lives.
- Develop a social support network and encourage social interaction to develop confidence and assertiveness.
- Increase hopefulness by listening to the stories of others who are farther along in their recovery journey.
- Receive feedback from other peers, instead of just professionals during facilitated open-forum sessions.
- Reduce isolation, self-harm and substance abuse.

For more information on Adult Peer Support certification and Youth Support endorsement:

BPA Health Peer and Family Support Certification

208-947-1300
info@idahopeercert.com
idahopeercert.com

Optum Idaho Youth Support Endorsement

If you have questions specific to the Youth Support Endorsement process, please contact Optum Idaho's Provider Relations Advocate team at *optum_idaho_network@optum.com*.

4.12 Case Management, SOAR Case Management and Targeted Care Coordination

Case Management

Description

Behavioral Health Case Management is a collaborative process that assesses, plans, links, coordinates, and monitors options and services that address a member's needs. Case Management is provided to members with a behavioral health diagnosis (both mental health and substance use disorders) who are unable to navigate or coordinate the service system independently. Additionally, Case Management can be provided to members transitioning out of an inpatient or residential treatment. Case Management can be provided up to 180 days prior to the member's discharge from the inpatient or residential facility.

Provider Qualifications

Case managers within the IBHP network must hold a minimum of a bachelor's level degree in a health or human services field and be practicing under Optum Idaho supervisory protocol. Providers are encouraged to become Certified Case Managers (CCM) through the Commission for Case Manager Certification.

Provider Responsibilities

- Helps the member to learn about, gain, and maintain access to services and providers.
- Develops a Case Management service plan in conjunction with the member and the member's treatment team.
- Ensures the Case Management service plan includes identification of member's strengths, specific/measurable goals for identified needs, and activities that will support the member in meeting their individual Case Management goals.
- Updates the Case Management service plan at least every 90 days including an ongoing assessment of the member's capacity to independently access services:
  - Updates to the Case Management service plan should include documentation of what the member has been able to accomplish with Case Management.
- The case manager will be reimbursed for care coordination activities under the following conditions (42 CFR 440.169):
  - Collecting and compiling information to support assessment activities.
  - Referral and coordination to arrange for services and related activities.
  - Following up on coordinating care to ensure services are provided and member's needs are adequately addressed.
- Case Management services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment care needs.

Authorization Type

Case Management – Behavioral Health – Threshold is 240 units (60 hours) per member, per calendar year. Additional services must be prior authorized by submitting a Case Management service request form in advance of the provision of services via ***Optum Idaho*** or ***Provider Express***.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Payment Methodology

CPT Code	Modifier	Description	Unit
T1017	*N/A*	Case Management	1 unit = 15 minutes
T1017	**UA**	Case Management-Care Coordination Activities	1 unit = 15 minutes

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol
GT	Service rendered via Telehealth

Additional Information

Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.

Case Management services may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.

- Case managers should rely on the policies and procedures established by their agency, as well as any code of professional conduct that guides their certification or licensure to ensure appropriate boundaries are maintained with the member if providing other direct services.
- Case Management is not covered when it involves the direct delivery of medical, educational, social, or other non-Case Management services (e.g., disease education, medical monitoring, or instruction in health self-management, teaching, coaching or training are not covered).
- A case manager may not be reimbursed for any transportation of the member to and from appointments. Transportation of members is covered by Medicaid and can be arranged by the case manager for the member.
- Case Management is not covered when it is duplicative of another covered Medicaid service being provided.
- Case Management services cannot be duplicative of any services or activities that the member is already getting from any hospital or residential discharge coordinators. Case Managers should work collaboratively with the hospital or residential discharge coordinators to ensure that treatment goals are not duplicative.
- Youth engaged in Targeted Care Coordination should not be receiving Behavioral Health Case Management (which includes Case Management for both Mental Health and Substance Use Disorders), as this is duplication of services.
- Youth working with a case manager through the Divisions of Behavioral Health and FACS (i.e. Idaho WInS [Wraparound Intensive Services] plans, 20-511A, and DD) or a Targeted Care Coordinator, cannot receive behavioral health Case Management through the provider network, as this is duplication of services.

SOAR Case Management

Description

SSI/SSDI, Outreach, Access, and Recovery (SOAR) Case Management provides SSI/SSDI application assistance to individuals, both adult and children, who are experiencing homelessness or are at risk of homelessness and who have severe and persistent mental illness, co-occurring substance use disorders, and/or other medical issues.

Provider Qualifications

SOAR case managers within the IBHP network must hold a minimum of a bachelor's level degree in a health or human services field and be practicing under Optum Idaho supervisory protocol. SOAR case managers must be certified as a SOAR certified case manager through ***SAMHSA***. All questions regarding SOAR Case Manager qualifications must be directed to the current SOAR State Lead who can be contacted at *SOARtraining@dhw.idaho.gov*.

Provider Responsibilities

See Provider Responsibilities in ***Section 4.12 – Case Management***. While providing SOAR Case Management services, providers will ensure they are following the fidelity model outlined in SAMHSA's SOAR certification materials.

Authorization Type

See Authorization Type in ***Section 4.12 – Case Management.***

Payment Methodology

CPT Code	Modifier	Description	Unit
T1017	*N/A*	Case Management	1 unit = 15 minutes
T1017	**UA**	Case Management-Care Coordination Activities	1 unit = 15 minutes

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol
GT	Service rendered via Telehealth

Additional Information

See Provider Responsibilities in ***Section 4.12 – Case Management***. All SOAR Case Management certifications and training are provided through ***SAMHSA***.

The SOAR State Lead will be the primary point of contact and technical resource regarding SOAR Case Management *SOARtraining@dhw.idaho.gov*.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Targeted Care Coordination (TCC)

Description

Targeted Care Coordination (TCC) is the process that assists youth and their family to locate, coordinate, facilitate, provide linkage, advocate for, and monitor the mental and physical health, social, educational, and other services as identified through a child and family teaming process that includes assessment and reassessment of needs and strengths. Targeted Care Coordination occurs through face to face or telephonic contact and is not intended to be duplicative of any other service. Targeted Care Coordination services vary in intensity, frequency, and duration in order to support the member's ability to access, coordinate, and utilize services and social resources that support the member to reach the goals on their coordinated care plan. Targeted Care Coordination can be delivered as a community-based service or in the outpatient clinic setting. Additionally, Targeted Care Coordination can be provided to members transitioning out of an inpatient or residential treatment. Targeted Care Coordination can be provided up to 180 days prior to the member's discharge from the inpatient or residential facility. All treatment, care, and support services must be provided in a context that is child-centered, family-focused, strengths-based, culturally competent and responsive to each child's psychosocial, developmental and treatment needs.

Targeted Care Coordination must be consistent with the Principles of Care and the Practice Model of the Idaho Youth Empowerment Services (YES) system of care.

Provider Qualifications

A provider who holds at least a bachelor's degree in a human services field and has completed the required Optum Idaho Targeted Care Coordination training and is practicing under Optum supervisory protocol.

OR

A provider who holds at least a bachelor's degree and has become a Certified Case Manager (CCM) through the Commission for Case Manager Certification (***ccmcertification.org***) and has completed the required Optum Idaho Targeted Care
Coordination training.

For information on the required Targeted Care Coordination trainings, please go to ***optumidaho.com***> For Network Providers > Provider Meetings & Trainings.

Provider Responsibilities

Targeted Care Coordination is provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment needs.

A Targeted Care Coordinator:

- Provides support and validation through engagement to gain trust to develop and maintain a constructive and collaborative relationship among the youth, family, and involved network providers, community stakeholders, child-serving systems and other formal and informal supports.
- Coordinates and facilitates the Child and Family Team (CFT) Interdisciplinary Team Meetings face-to-face with the family and member present.
- Works with the CFT to develop an outcomes-focused, strengths-based person-centered service plan that includes both formal and informal services and supports.
- Coordinates and facilitates the CFT face-to-face with the member and family present to assess and/or reassess the strengths and needs to determine if changes are needed to update or modify the person-centered service plan (PCSP). This can be done through Telehealth. See the Telehealth Services section of this manual for additional information.
- Serves as a care navigator for the family and is responsible for promoting integrated services, with links between child-serving providers, systems and programs.

- Ensures that services are accessed, coordinated, and delivered in a strengths-based, individualized and relevant manner and that services and supports are guided by family voice and choice.
- Manages documentation of a CFT meeting including a description of the CFT interdisciplinary collaboration that occurred (date, duration), names of the attending participants, and the recommendations agreed upon in the meeting.
- Documents updates of the person-centered service plan and distributes to CFT team participants.
- For members in the YES Program, the PCSP must include all services the member and their family may use during the member's treatment, including any 1915(i) services they will use (currently, the only 1915(i) service is respite).
- Members in the YES Program must complete a Person-Centered Service Plan (PCSP) within ninety (90) days of enrollment in the YES Program and update the PCSP at least annually within three hundred and sixty-four (364) days of the previous plan.
- Works with the member's clinician to update the CANS at least every 90 days or more frequently as needed. If the Targeted Care Coordinator is certified in CANS and has access to the ICANS platform, they may complete the CANS initial/annual and updates.
- Monitors to ensure that outcomes of services and activities are progressing appropriately by evaluating the goals and interventions documented on the PCSP.
- Is responsible for linking, monitoring, and follow up activities, to ensure that the youth and family's needs are met.
- Is responsible for engaging the CFT to develop a crisis/safety and transition plan, which is documented as a part of the PCSP.
- Facilitates the development of a conflict resolution process to resolve disagreements within the Child and Family Team, which is a part of the PCSP.
- Makes contact with the member and the member's family or guardian at least every 30 days. If the Targeted Care Coordinator cannot reach the member or member's family or guardian, they should document attempts made and a plan to re-establish contact.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
T1017	**U3**	Targeted Care Coordination	1 unit = 15 minutes
T1017	**U3, UA**	Targeted Care Coordination – Care Coordination Activities	1 unit = 15 minutes
T1017	**U2**	Targeted Care Coordination – CCM	1 unit = 15 minutes
T1017	**U2, UA**	Targeted Care Coordination – CCM – Care Coordination Activities	1 unit = 15 minutes

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
HO	Master's level provider under supervisory protocol
HN	Bachelor's level provider under supervisory protocol
GT	Service rendered via Telehealth

Additional Information

Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.

Targeted Care Coordination services may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.

Care Coordination Activities: The Targeted Care Coordinator will be reimbursed for care coordination activities under the following conditions (42 CFR 440.169):

- Collecting and compiling information to support assessment activities.
- Referral and coordination to arrange for services and related activities.
- Following up on coordinating care to ensure services are provided and member's needs are adequately addressed.

Supervisors delivering direct services to a member may also supervise that member's TCC if there are no other options available to the member. As a reminder, it is best practice to separate direct supervision of another professional who is also providing services to the same member as the supervising clinician.

- Members who are engaged in Targeted Care Coordination should not be receiving Behavioral Health Case Management as this is duplication of services.
- Targeted Care Coordination services cannot be duplicative of any services or activities that the member is already getting from any hospital or residential discharge coordinators. Targeted Care Coordinators should work collaboratively with the hospital or residential discharge coordinators to ensure that treatment goals are not duplicative.
- TCCs are not to provide other direct services to the member.
- Members engaged in Targeted Care Coordination must have a Child and Family Team (CFT) and a person-centered service plan (PCSP). If a member is a participant in the YES Program, their PCSP must be reviewed by Optum to ensure that the plan meets CFR requirements. Please consult the TCC toolkit for information on how to submit a PCSP to Optum for CFR review through the Optum Support and Service Manager (OSSM) tool.
- Families who are working with a case manager with IDHW's Children's Developmental Disabilities Program or CMH for Wraparound or 20-511A do not need a TCC to create their PCSP to remain eligible for YES. If a family has already developed a PCSP or Plan of Service and is actively working with an IDHW Case Manager, they will not need an additional plan developed and are not required to work with a TCC, as it may be considered a duplication of services.

  However, families working with a Case Manager through IDHW's Child Protection Services (CPS) may also receive TCC, as it is not considered a duplication of services. Families have the same access to services, regardless of whether their PCSP or Plan of Service was developed by an Optum TCC or an IDHW case manager. If you are unsure if a family is working with an IDHW Case Manager, you can contact Medicaid for more information at **1-866-681-7062**.
- Liberty Healthcare conducts the independent eligibility assessments for both the YES Program and DD 1915(i) support services. There are some similarities between the two processes; however, separate assessments are required for each program and families will apply for each separately. This is because DD and YES are separate populations requiring different assessments and the Liberty contracts for each population have different

requirements. Members who do not go through the independent assessment process do not need a Targeted Care Coordinator, though they are welcome to have one if they want Targeted Care Coordination.

- Members who moved from traditional Medicaid to the YES Program for Respite services may move back to traditional Medicaid if Respite is no longer needed or wanted. In this situation, the member does not need to obtain TCC or a PCSP. These members will receive notification from Self Reliance when it's time for renewal. They should follow their instructions to complete a redetermination at that time.
- The CFT meetings are conducted by the Targeted Care Coordinator and member/member's family face-to-face and an independently licensed clinician (or master's-level clinician working under supervisory protocol) must participate face-to-face or telephonically.
- Care Coordination Activities: The Targeted Care Coordinator will be reimbursed the following for care coordination activities:
  - Collecting and compiling information to support assessment activities.
  - Coordinating the Child and Family Team (CFT) meetings to ensure scheduling works for all attendees.
  - Compiling information to ensure all information is ready for the Child and Family Team.
  - Collecting and distributing documentation for CFT meetings.
  - Compiling the finished PCSP, submitting for CFR review, and distributing to the CFT.
  - Arranging referral and coordination for services and related activities included in the PCSP.
  - Following up on coordinating care to ensure services are provided and member's needs are adequately addressed.
  - Targeted Care Coordination via Telehealth: See the Telehealth Services section of this manual.

4.13 Programs

Children's Day Treatment

Description

Day Treatment is a structured program available to children and adolescents exhibiting severe needs that can be addressed and managed in a level of care that is less intensive than inpatient psychiatric hospitalization, partial hospitalization or residential treatment, but requires a higher level of care than intensive or routine outpatient services. These services typically include a therapeutic milieu that may include skills building, medication management, and group, individual and family therapy, provided by an interdisciplinary team. Day Treatment providers will ensure consistent coordination and communication with other agencies working with the child/adolescents, including coordination with the schools. Day treatment programs are offered four-five days per week and may include after hours and weekends. There is a minimum of three hours per day and maximum of five hours per day. All day treatment services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

The day treatment plan must be individualized to the member and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the member's progress; the responsible professional and a member specific crisis safety plan.

Day Treatment Components:

- Assessment and Treatment Planning
- At least 2 of the following:
  - Individual Therapy
  - Family Therapy
  - Group Therapy
  - Psychoeducation
- Skill-Building Activities

CLICK HERE TO RETURN TO TABLE OF CONTENTS

- 24 Hour Crisis Services
- Care Coordination/Transition Management/Discharge Planning

Provider Qualifications and Responsibilities

Doctoral Level and Licensed Prescribing Practitioners

- Psychiatric assessment and monitoring
- Medication management

Master's Level

An independently licensed clinician (or a master's level clinician under supervisory protocol):

- Completes or obtains CDA and CANS functional assessment tool.
- Develops and updates the treatment plan for Day Treatment, including crisis, transition and discharge plans within 72 hours of initiating day treatment. The day treatment plan should align with the member's person-centered service plan if applicable.
- Provides individual, group, family psychotherapy, and/or substance use counseling.
- Coordinates with educational and other treating providers.
- Conducts an intermittent review of the day treatment plan as needed to incorporate progress, different goals, or changes in service focus. The day treatment plan should be updated frequently enough to reflect changes in the member's condition, needs and preferences, or at the request of the member or member's family and the period of time between reviews shall not exceed 30 calendar days.
- Provides continuous and ongoing assessment to ensure the clinical needs of the youth and parent(s)/caregiver are met.
- Oversees the process to identify, respond to, and report crisis situations 24 hours per day, 7 days per week.

Paraprofessional Level

A paraprofessional and/or bachelor's level or higher provider practicing within their scope of practice/training/education and meeting supervisory protocol requirements.

- It is the responsibility of the Day Treatment program to determine which tasks this provider may perform as a function of his or her training, experience, and education.

Other Professionals

It is the responsibility of the Day Treatment program to determine other professionals that may provide a necessary component of the program (e.g. a dietitian or schoolteacher). These professionals will provide appropriate services within their level of training, experience, and education. Services delivered by professionals that are outside of the IBHP cannot be reimbursed by Optum.

Authorization Type

Day Treatment services require prior authorization.

- Clinical documentation should support the number of units requested and length of stay for the program.
- Online request form: optumidaho.com> For Network Providers > Forms.
- Day treatment is authorized per one-hour unit.

Payment Methodology

CPT Code	Modifier	Description	Unit
H2012	*N/A*	Day Treatment	1 unit = 1 hour

Additional Information

- Day Treatment is intended to be a time-limited, intensive service.
- Day Treatment programs are offered 4-5 days per week and may include after hours and weekends. Minimum of 3 hours per day and maximum of 5 hours per day.
- The treatment plan for Day Treatment should be updated at least every 30 days and reflect the member's needs and strengths.
- Day Treatment also includes coordination with school services to reintegrate the member back into the school environment.
- Day Treatment must engage the family in assessment, treatment planning, updating of the treatment plan, therapy, coordination of care, and transition/discharge planning.
- When a member is participating in day treatment it is not appropriate for other behavioral health providers to provide
  services to the member, except for psychiatric services, medication management, Targeted Care Coordination and CFT.
- While a member is participating in day treatment, the member can receive any of the following optional services that can be billed outside of the bundled rate:
  - Case Management/TCC
  - Respite
  - Peer Support
  - Youth Support
  - Family Support
  - Recovery Coaching
  - CFT
  - Psych/Neuropsychological Testing
  - Psychiatric Evaluation
  - Medication Management
- Members cannot receive other outpatient services while engaged in the program except for the ones listed above. Please refer to the ***Continuum of Care Grid***.

Intensive Outpatient Program (IOP)

Description

Intensive Outpatient Programs (IOP) are structured programs available to adults and adolescents who are recovering from mental health (MH) including eating disorders and/or substance use disorders (SUDs), experiencing moderate behavioral health symptoms that can be addressed and managed in a level of care that is less intensive than partial hospitalization but that require a higher level of care. The required program components of IOP are listed below and separated out by services that can be billed under the per diem bundled rate and those that can be billed outside of the per diem bundled rate. All services to members will be individualized in the amounts, frequencies and intensities based on the member's treatment needs and preferences within the program guidelines. The program may function as a step-down program from psychiatric hospitalization, partial hospitalization, or residential treatment. It may also be used to prevent or minimize the need for a more intensive level of treatment. IOP is appropriate for members who live in the community without the restrictions of a 24-hour supervised treatment setting during non-program hours. IOP is provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

IOP and PHP have different requirements, please see chart at end of the PHP section for more information.

IOP Program Type

The type of IOP is dependent upon the member's primary diagnosis. The clinical emphasis in IOP may be directed at MH considerations, and/or SUDs. In the presence of both MH and SUDs concerns, the acute aspects of SUDs treatment should be primary as the initial course for treatment. Programs for adolescents are offered separately from programs for adults.

IOP Programming Requirements

IOP occurs at a minimum of three (3) days per week, maintaining at least nine (9) to nineteen (19) hours of service for adults and at least six (6) to nineteen (19) hours of service for adolescents. Common Treatment duration is six to eight weeks for IOP. Services are expected to be maintained at this level throughout the member's participation in the program. As a member progresses through the program, the hours of service per week can decrease as the member approaches discharge. If a member no longer needs the minimum of nine (9) hours for adults and six (6) hours for adolescents but does not meet medical necessity criteria to transition to outpatient therapy, a transitional step down may be considered for one to two weeks prior to the planned discharge. If a member is engaged in a transitional step down that would result in the member being present in IOP programming for less the minimum nine (9) hours for adults and six (6) hours for adolescents, the outpatient rate for services would apply in lieu of the IOP per diem (bundle) rate.

Services are provided by an interdisciplinary team. IOP consists of a scheduled series of sessions consistent with the treatment plan of the member served. The treatment plan should include evidence-informed practices, such as group therapy, cognitive behavioral therapy (CBT), and motivational interviewing to enhance motivation and support member's recovery, resiliency, and well-being. Plan must include duration and frequency of treatment and must be reassessed and updated at least 30 days and/or as needed if there is a change in member's treatment status. Initial and ongoing risk assessments are required to be administered and documented throughout the course of treatment.

Initial Clinical Diagnostic Assessment conducted by master's level therapist or higher completed within one program day of admission. Initial treatment plan is developed within three program days of admission. Treatment plans are reviewed and updated at least once every 30 program days.

Required IOP components included in the per diem rate:

- Assessment and Treatment Planning
- 24-hour Crisis Services
- Clinical Diagnostic Assessment (also referred to as a Psychiatric Evaluation or Exam)
- Skill-Building activities
- Substance Use Screening and Monitoring
- Drug Testing provided in the amounts, frequencies and intensities as appropriate to the members treatment needs.
- Care Coordination/Transition Management/Discharge Planning
- Physical exam within the first week of treatment to address the member's whole health and ensure this level of care is appropriate.
- Health assessment and monitoring (Eating Disorder)
- Dietary and nutrition services (Eating Disorder)

Additionally, the following services are provided in the amounts, frequencies and intensities as appropriate to the member's treatment needs.

- Individual Therapy
- Group Therapy

- Family Therapy
- Psychoeducation

Required program components that can be billed outside of bundled rate:

- Medication Management

Optional services that can be billed outside of bundled rate:

- Case Management/TCC
- Respite
- Peer Support
- Youth Support
- Family Support
- Recovery Coaching
- CFT
- Psych/Neuropsychological Testing

Members cannot receive other outpatient services while engaged in the program except for the ones listed above and Opioid Treatment Services. This means a member could participate in a MH IOP while also participating in an OTP if medically necessary and meets the requirements for both programs. Please refer to the ***Continuum of Care Grid***.

Provider Qualifications

IOP services may be provided by the following contracted professionals within the scope of their practice:

- Licensed physician, Advanced Practice Registered Nurse, Physician Assistant, Licensed Social Worker, Licensed Counselor, Licensed Marriage and Family Therapist, Licensed Psychologist and Psychologist Extenders.
- Paraprofessionals and/or bachelor's level practicing within their scope of practice/training/education and meeting supervisory protocol requirements.
- It is the responsibility of the Intensive Outpatient Program to determine which tasks the provider may perform as a function of his or her training, experience, and education.

IOP Substance Use Programs: SUD Providers will be licensed clinicians and paraprofessionals as defined per licensure by the Division of Occupational and Professional Licenses, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), Northwest Indian Alcohol/Drug Certification Board (NWIADCB), the Idaho Department of Health and Welfare Division of Behavioral Health (DBH per IDAPA); and practicing under the Optum Idaho supervisory protocol.

Paraprofessionals (defined as individuals who are not independently licensed) providing outpatient substance use disorder treatment services within the IBHP are required to have the appropriate license and/or certification for the services provided.

Substance use disorder providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.

It is important to ensure that services provided are within the scope of practice based on education/training and certification/designation of the substance use provider. State-approved certification/designation entities are IBADCC, NWIADCB, DBH per IDAPA.

During admission, a psychiatrist is available to consult with the program during and after normal program hours.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Provider Responsibilities

Treatment Plan

An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and objectives designed to achieve those goals must also be completed and signed by a licensed network provider within three program days of first day of treatment of IOP. This member-centered plan should be developed in collaboration with the member. All participating staff working within the member's treatment plan should have integrated treatment goals that are coordinated across modalities. The treatment plan is to be reviewed and updated in collaboration with the member every 30 days. Discharge criteria and planning for aftercare options must begin upon admission and are included in the treatment plan. The member's transition out of IOP services should be clinically smooth and safe. Providers must assist the member in his/her transition to other services as needed.

If the member is discharged from IOP services to another provider and/or facility document that communication and/or collaboration occurred for a clinically safe transition along with obtaining the proper releases of information.

The discharge plan, at a minimum, should include the following:

- The reason for discharge is clearly identified.
- The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.
- The discharge/aftercare plan describes specific follow up activities.
- Treatment records are completed within 30 days following discharge.
- The member has a safety plan that, at minimum, address current and expected stressors, risk level, and resources.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
S9480 905	*N/A*	IOP-MH: Intensive Outpatient Services; per diem for providers specifically credentialed and contracted for IOP Services; Facility bill 905 revenue code	Per diem
H0015 906	*N/A*	IOP-SUD: Alcohol and/or drug services; intensive outpatient including assessment, counseling, crisis intervention, and activity therapies or education; per diem for providers specifically credentialed and contracted for IOP services; Facility bill 906 revenue code	Per diem
S9480 905	**U4**	IOP-Intensive Outpatient Eating Disorder Program; per diem for providers specifically credentialed and contracted for Eating Disorder IOP Services; Facility bill 905 revenue code	Per diem

Applicable modifiers based on credentialed level of professional providing the services as below:

Modifier	Professional Level of Provider
GT	Service rendered via Telehealth

Per Diem Rate

Except for psychiatric services and medication management, all services, as referenced above, are included in the per diem rate and should be addressed for the member by the IOP provider.

Additional Information

- Providers of SUD IOP must administer the ASAM assessment that includes the six-dimension ASAM criteria with the outcomes and recommendations documented within the medical record. A GAIN-I assessment may be used.
- The Level of Care Utilization System (LOCUS), the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and the Early Childhood Service Intensity Instrument (ECSII) are nationally recognized tools that the Optum Idaho Utilization Management (UM) Team will be using when evaluating clinical criteria decisions and determining medical necessity for Mental Health Intensive Outpatient Program (IOP).
- Providers are not expected to use these tools but are welcome to review the training and guidance being provided to the Optum UM team if they would like to understand the process and tools for utilization management. For additional information, please visit ***Provider Express*** > Clinical Resources > Guidelines and Policies > Adoption of LOCUS CALOCUS-CASII ECSII.
- IOP services may be provided during evenings and on weekends and/or interventions delivered by a variety of professionals working within a member-centered and coordinated treatment plan. Because IOP programs have such a different approach and intensity, they are not typically designed to be used for extended duration; instead, they rely on an integrated approach using high frequency contact to increase functioning, monitor and maintain stability and support recovery.
- This service may be provided using Telehealth. See the ***Telehealth Services*** section of this manual for additional information.

Partial Hospitalization Program (PHP)

Description

Partial Hospitalization Programs (PHP) are structured, intensive, and time limited services provided by a hospital, free-standing facility, or provider group utilizing evidenced based medical and clinical practices which are provided under the direction of a Medical Director. Partial Hospitalization Programs may serve Members due to mental health, substance abuse, or eating disorders, and may serve co-occurring needs when appropriately meeting the programmatic requirements for each service type provided. PHP treatment should resemble a highly structured, short-term inpatient program, and is a more intense level of care than routine outpatient or an intensive outpatient program (please see chart following this section). PHP treatment must proactively address the Member's needs through individualized treatment planning, coordination of care, comprehensive discharge planning, and structured, evidence based, clinical and medical interventions. Admission to a Partial Hospitalization shall not be for the purpose of social engagement, recreation, custodial care, respite care, or to maintain psychiatric wellness in the absence of acuity that would require a higher level of care. Partial Hospitalization is not for the purpose of housing or to alleviate homelessness. Legal mandates to attend Partial Hospitalization do not supersede the requirement that medical necessity be met in accordance with the Optum Idaho Supplemental Clinical Criteria.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

PHP Programming Requirements

PHP services are to be delivered a minimum of 20 hours per week, no less than four days per week (may include evenings and weekends), for adults, adolescents, and children. A full day of PHP is considered to be 6 or more hours of structured treatment, comprised of the services approved to be a part of the PHP bundle (see below). The goal of PHP treatment shall be to avert admission or readmission to a higher level of care by addressing significant functional impairments experienced by the Member such as acute decompensation of psychiatric symptoms and/or significant regression in daily functioning and will be provided with the goal of stabilization so that the Member may safely return to a less intensive level of care. PHP services are defined by medical necessity and are not a "default" level of care from a higher level of service. All services are provided in a manner that is strengths-based, culturally competent, and responsive to each Member's individual psychosocial, developmental, and treatment needs.

Medical Director

PHP services must be provided under the supervision of a MD/DO. It is preferrable that the services are supervised by a psychiatrist or MD/DO with additional certifications/fellowships related to the specialty of the PHP. The medical director is required to:

- At least annually, provide written attestation to the review of all PHP policies and procedures
- Attend at least two interdisciplinary team meetings for each physical PHP location supervised per month. A licensed medical professional must be present at all interdisciplinary team meetings for each physical PHP location
- Provide coverage of equal licensure to ensure medical supervision of the PHP, should the medical director be on a leave of absence
- Supervise any medical designee in accordance with the appropriate Idaho licensing boarding and Optum Idaho's supervisory protocol

Medical Designee

The day-to-day operations of a PHP (i.e. medication management, medical evaluations of members, and sign-off on the member's PHP treatment plan) may be delegated by the medical director to a prescribing professional (PA, NP, Prescribing Psychologist, MD/DO). The medical director shall establish appropriate policy, procedure, organizational charts, etc. to ensure effective and ongoing medical supervision of the PHP.

- The MD/DO may not delegate medical director responsibilities to a non-prescribing professional.
- Independently licensed medical designees must be supervised by a person of equal licensure, at peer level or higher.
- Non-independently licensed medical designees must be directly supervised by the medical director of the program.

Registered Nurse

At minimum, a registered nurse will be available 24 hours a day.

Staffing

The PHP will be sufficiently staffed, per the staffing description below, to provide intensive, structured, 20 hour per week treatment that is not for the purpose of recreation, socializing, respite, housing, etc. Staffing of PHP component services must be consistent with the guidance presented in the Provider Manual Appendix.

Admission Requirements

Admission to a PHP requires the following components be completed within 24 hours of entry to the program:

- An initial Clinical Diagnostic Assessment (CDA) conducted by a master's level clinician or higher which shall also include the functional assessment (CANS for under 18, adults per LOCGs), risk assessment, and ASAM 6-dimensional assessment (for Substance Abuse). A GAIN I Core is also acceptable in place of an ASAM assessment.
- Admission order to admit to partial hospital services (PHP) by the MD/DO or medical designee. The medical assessment and plan should include evidence to support need for PHP and without PHP services, the member would require inpatient behavioral hospitalization or ASAM Level 3.7 or higher.

- Physical Exam by MD/DO or medical designee if stepping up or entering into a Substance Abuse Partial Hospitalization or when an interruption to services has occurred after stepping down from a higher level of care (i.e. there was a greater than 24 hour period unsupervised where relapse may have occurred).
- Withdrawal screening to include basic vitals and applicable withdraw evaluation such as CIWA, COWS, or CINA.
- Physical Exam by MD/DO or medical designed for any Member admitted to an Eating Disorder Partial Hospitalization.
- Health Assessment and Monitoring by MD/DO or medical designee if stepping up or entering an Eating Disorder Partial Hospitalization
- Dietary and Nutrition Services if stepping up or entering an Eating Disorder Partial Hospitalization

Within the first 72 hours of admission:

- Physical Exam by MD/DO or medical designee for Mental Health and Eating Disorder Partial Hospitalization or for Substance Abuse PHP Member's that have stepped down from a higher level of care with no interrupt to services
- Initial Clinical Diagnostic Assessment by MD/DO or medical designee for all Partial Hospitalization programs. This may occur via telehealth if the member is onsite at the physical PHP location. If clinically indicated, there shall be another provider on the member's treatment team physically present with the member.
- An individualized crisis plan

Within 5 days of admission:

- An initial, individualized, interdisciplinary treatment plan utilizing evidenced based practices for the management of the Members mental health, substance abuse, eating disorder, or co-occurring needs.

Ongoing Requirements

At least every 7 days:

- Psychiatric Review by MD/DO or medical designee. This may occur via telehealth if the member is onsite at the physical PHP location. If clinically indicated, there shall be another provider on the member's treatment team physically present with the member.

At least every 14 days:

- Treatment plan review and update
- As medically and/or clinically indicated:
- Evaluation and re-evaluation of the Member's presentation
- Risk assessment
- Evaluation and re-evaluation of the member's withdrawal with appropriate re-administration of CIWA, COWS, CINA, etc.

Treatment Plan Requirements

An individualized, interdisciplinary treatment plan will be completed within five days of admission to a PHP. The plan will be developed with the oversight of, and signed off by, the Medical Director or designee. A treatment plan may not consist of generic, programmatic goals, or be developed with the goal of completing a predetermined length of program (i.e. 30, 60, 90 days).

The treatment plan shall, at minimum, be:

- Individualized treatment goals that are Member-centered and developed with the Member and full interdisciplinary team including MD/DO or medical designee, nursing, clinical, nutrition, and paraprofessional services.
- Integrated across the interdisciplinary team.
- Specific, time limited, measurable, and include anticipated discharge date. Treatment goals shall be achievable during the PHP stay and shall focus on management of acute symptoms that require structured, medical oversight, and could not be reasonably provided at a lower level of care. Long term goals will be identified for referral to appropriate professional follow up and included in discharge planning.

- Inclusive of criteria for successful discharge.
- Updated to reflect adjustment of goals to reflect the Member's ongoing needs at a minimum of every 14 days.

Discharge

Discharge planning should begin at the time of admission and be incorporated into the treatment plan. Discharge planning shall be robust and to include:

- Identification of basic needs and assistance with obtaining services that provide shelter, food, etc. in accordance with member's identified needs.
- Ensuring that follow up appointments are scheduled within seven days of discharge for IOP/OP and medication management.
- Referral to a primary care physician.
- Releases of information to ensure coordination of care.
- Coordination of care with the member's sources of support and care. Coordination of care shall include coordinating with the member's school, legal team, probation/parole, primary care physician, outpatient treatment team, residential care, inpatient hospital, detox, etc.
- When the member is discharged from PHP, for planned or unplanned reasons, to services from another provider and/or facility the PHP will document that communication and/or collaboration occurred to ensure a clinically safe transition.
- If a member requires admission to a higher level of care, such as a hospital admission, withdrawal management/detox admission, or otherwise is away from the Partial Hospitalization for greater than overnight to another facility or provider, it is appropriate to discharge the member. When the member returns to the program, they shall be re-evaluated for appropriateness and be considered a new admission.
- If a member is unable or unwilling to attend the required 20 hours per week of PHP treatment, the PHP will discharge the member and facilitate engagement in a more appropriate level of care that is the least restrictive environment to meet the member's treatment needs.

The discharge summary, at a minimum, should include the following:

- The reason for discharge is clearly identified.
- Documentation of follow up appointments including provider, time and date of appointment, and contact information.
- A summary of the reason(s) for treatment and the extent to which treatment goals were met.
- The discharge/aftercare plan which will include specific referrals and follow up activities.
- A member-specific safety plan that, at minimum, addresses current and expected stressors, risk level, and resources.
- All treatment records must be completed within 30 days of discharge from the PHP.

Required Services

Partial Hospitalization is an intensive, structured, program that will at minimum include the following services that are individualized to the Member through the interdisciplinary treatment plan:

Bundled (included in the per diem rate)

- Assessment and Treatment Planning
- 24 Hour Crisis Services
- Nursing Services
- Medication Management
- Skills-Building Activities
- Physical Exam

- Clinical Diagnostic Assessment (also known as a Psychiatric Exam)
- Health Assessment/Monitoring
- Individual, Group, and Family Therapy
- Case Management
- Coordination of Care
- Discharge Planning
- Psychoeducation
- Substance Use Screening and Monitoring (only required for substance use programs)
- Drug Testing (only required for substance use programs)
- Dietary/Nutrition Services (only required for eating disorder programs)

Optional, Unbundled Services

A member may receive these services while participating in a PHP. Member's may not receive any other outpatient services while in a PHP. The PHP is expected to provide complete care to the member.

- Opioid Treatment Program (OTP)
- Targeted Case Coordination
- SOAR Case Management
- Respite
- Peer, Youth, Family, or Recovery Support
- CFT
- Psychological/Neuropsychological Testing

Provider Qualifications

Partial Hospitalization programs may be provided by the following contracted professionals within the scope of their practice, under the supervision of an Idaho licensed, Optum Idaho Network approved, MD/DO:

- Licensed physician, Advanced Practice Registered Nurse, Licensed Prescribing Psychologist, Physician Assistant, Licensed Social Worker, Licensed Counselor, Licensed Marriage and Family Therapist, Licensed Psychologist, Registered Psychologist Extender, Registered Nurse, Paraprofessionals and/or Bachelor's level practicing within their scope of practice/training/education and meeting supervisory protocol requirements.
- SUD providers will be licensed clinicians and paraprofessionals as defined per licensure by the Idaho Division of Occupational and Professional Licenses, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), Northwest Indian Alcohol/Drug Certification Board (NWIADCB) and practicing under the Optum Idaho supervisory protocol. Paraprofessionals (defined as individuals who are not independently licensed) providing outpatient substance use disorder treatment services within the IBHP are required to have the appropriate license and/or certification for the services provided.
- Substance use disorder providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.
- It is important to ensure that services provided are within the scope of practice based on education/training and certification/designation of the substance use disorder provider. State-approved certification/designation entities are IBADCC, NWIADCB, DBH per IDAPA.

Authorization Type

Prior Authorization is required.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Payment Methodology

CPT Code	Modifier	Description	Unit
912 (facility only)	*N/A*	Partial Hospitalization, all-inclusive payment three to five hours (half day); Revenue code facility billed.	Per diem
H0035 913	*N/A*	Partial Hospitalization, all-inclusive payment of six or more hours (full day); Facility bill 913 revenue code.	Per diem
H0035 913	**U4**	Partial Hospitalization Program-Eating Disorder, all-inclusive payment of six or more hours (full day); Facility bill 913 revenue code.	Per diem

Per Diem Rate

The per diem rate includes all services as described above and the services shall be addressed for the member by the PHP provider. Exceptions to the per diem rate are also noted above. Please note the 0912, half day PHP, does not supersede the requirement that a member attend 20 hours per week.

Partial Hospitalization Program (PHP) vs. Intensive Outpatient Program (IOP)

Requirements	MH PHP	SUD PHP	ED PHP	IOP
Under supervision of a licensed physician, MD/DO, the following can provide service: Licensed Physician, Advanced Practice Registered Nurse, Licensed Prescribing Psychologist, Physician Assistant, Licensed Social Worker, Licensed Counselor, Licensed Marriage and Family Therapist, Licensed Psychologist, Psychologist Extender (Registered with the Idaho Division of Occupational and Professional Licenses), Registered Nurse, Paraprofessionals and/or bachelors level practicing within their scope of practice/training/education and meeting supervisory protocol requirements.	X	X	X	-
Licensed Physician, Advanced Practice Registered Nurse, Physician Assistant, Licensed Social Worker, Licensed Counselor, Licensed Marriage and Family Therapist, Licensed Psychologist, Psychologist Extender (Registered with the Idaho Division of Occupational and Professional Licenses), Registered Nurse, Paraprofessionals and/or bachelors level practicing within their scope of practice/training/education and meeting supervisory protocol requirements.	-	-	-	X
Providers will be licensed clinicians and paraprofessionals as defined per licensure by the Idaho Division of Occupational and Professional Licenses, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), Northwest Indian Alcohol/ Drug Certification Board (NWIADCB); and practicing under the Optum Idaho supervisory protocol. Paraprofessionals (defined as individuals who are not independently licensed) providing outpatient substance use disorder treatment services within the IBHP are required to have the appropriate license and/or certification for the services provided.	-	X	-	X
Providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.	-	X	-	X
Providers must follow the ASAM Criteria® and administer a six-dimension ASAM assessment with the outcomes and recommendations documented in the medical record. A GAIN-ICORE by a GAIN certified provider is also accepted in place of an ASAM six-dimensional assessment.	-	X	-	X
PHP and IOP Eating Disorders: Health Assessment and Monitoring	-	-	X	X
PHP and IOP Eating Disorders: Dietary and Nutrition Services	-	-	X	X
Assessment and Treatment Planning	X	X	X	X

(Continued on following page.)

Requirements	MH PHP	SUD PHP	ED PHP	IOP
Individual Therapy » Family Therapy » Group Therapy » Psychoeducation are provided in the amounts, frequencies and intensities as appropriate to the members treatment needs.	X	X	X	X
24-hour Crisis Services	X	X	X	X
PHP Psychiatric Evaluation (initial and at least once weekly visits throughout the program) – Required	X	X	X	-
IOP Psychiatric Evaluation (at least once a month) – Required	-	-	-	X
Skill-Building Activities	X	X	X	X
Substance Use Screening and Monitoring	X	X	X	X
Drug Testing provided in the amounts, frequencies and intensities as appropriate to the members treatment needs.	X	X	X	X
Care Coordination/Transition Management/Discharge Planning	X	X	X	X
Physical Exam: If stepping up or entering a PHP program, a new exam within three days (or one program day if SUD or ED). If stepping down within seven days of discharge, previous exam done by behavioral health provider (inpatient or residential level of care) is accepted.	X	X	X	-
Physical Exam within the first week of treatment to address the member's whole health and ensure this level of care is appropriate	-	-	-	X
Medication Management – Required and can be billed outside bundled rate	-	-	-	X
The program's medical director is available to consult with the program during and after normal program hours	X	X	X	X
IOP Length of Stay: Min. of three days per week and up to 19 hours per week, with a min. of nine hours for adults or six hours for adolescents	-	-	-	X
PHP Length of Stay: Min. of four days per week and minimum of 20 hours per week (adults and adolescents)	X	X	X	-
Prior authorization needed	X	X	X	-
Registered nurse or higher is available 24 hours as part of program	X	X	X	-
**Co-occurring treatment needs to include each component of its respective PHP*				

Opioid Treatment Programs (OTP)

Description

Opioid Treatment Programs (OTPs) are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) to treat opioid use disorder (OUD). There are several treatment options prescribed by these specialty programs based on the member's medical and psychiatric history, Substance Use Disorder (SUD) treatment history and member preference. Methadone and buprenorphine/naloxone are two medication options available through the comprehensive bundle covered by the IBHP. OTPs also include counseling, drug testing, substance use education and various office visits for supervised medication administration as required by 42 CFR 8.12. All services must be provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment care needs.

Methadone and buprenorphine/naloxone, as covered by the IBHP, can be effective in the treatment of OUD, but also have significant risks. Due to their addictive nature and potential for abuse and diversion, they are highly regulated as outlined in 42 CFR 8.12. Only certified OTP providers are permitted to prescribe methadone for OUD. Office-based medication assisted treatments (MAT) such as ER-naltrexone are not a benefit covered under the bundled codes. ER-naltrexone may be used to treat OUD in an OTP; however, this medication would be billed directly to Medicaid through a member's pharmacy benefit. Please refer to the Medicaid Pharmacy Program at **1-866-827-9967** for more information.

Provider Responsibilities

OTPs in compliance with the federal opioid treatment standards (***42 CFR 8.12***), certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) Division of Pharmacologic Therapies (DPT), and credentialed with the IBHP can provide this benefit to participants with a diagnosis of OUD.

Please note that temporary emergency guidance/extensions issued by SAMHSA may supersede the rules outlined in this section where applicable.

Required OTP services are outlined in detail in the federal opioid treatment standards (***42 CFR 8.12(f)***) and include:

- Providing or referring for medical, counseling, vocational, educational and other assessment and treatment services.
  - A complete physical exam by a licensed physician, physician assistant or nurse practitioner, including laboratory studies (such as basic metabolic panel, liver function tests, HIV, hepatitis C and hepatitis B testing), within 14 days of admission to the OTP.
  - Initial and periodic assessments, to include treatment plans.
  - Regular SUD counseling.
  - Provide mandatory counseling on preventing exposure to, and the transmission of Human Immunodeficiency Virus (HIV) disease for all members at each admission.
  - Regular urine drug testing, including at least eight random tests per year per member in maintenance treatment,

CLICK HERE TO RETURN TO TABLE OF CONTENTS

with at least monthly testing for members in long-term detoxification treatment.

- A recordkeeping system that adequately documents and monitors care and is in compliance with all Federal and State reporting and confidentiality requirements relevant to medications used in treatment of OUD.
- OTPs must ensure that the approved opioid agonist treatment medications are administered or dispensed by a licensed practitioner under the appropriate State and Federal laws to administer and dispense opioid drugs or by an appointed
  designee of that licensed practitioner such as a pharmacist, registered nurse, or licensed practical nurse or any other healthcare professional authorized by Federal and State law to administer or dispense opioid drugs.
- With regard to methadone:
  - » "Methadone shall be administered or dispensed only in oral form and shall be formulated in such a way as to reduce its potential for parenteral abuse." (42 CFR 8.12(h)(3)(i))
  - » "For each new patient enrolled in a program, the initial dose shall not exceed 30 mg and the total dose for the first day shall not exceed 40 mg, unless the program physician documents in the patient's record that 40 mg did not suppress opioid abstinence symptoms" (42 CFR 8.12(h)(3)(ii)).
  - » "To limit the potential for diversion to the illicit market, opioid agonist treatment medications dispensed to patients for unsupervised use are limited" to a maximum of one dose each week during the first 90 days of treatment, two doses during the second 90 days of treatment, three doses for the third 90 days of treatment, and a maximum of six doses during the final months of the first year of treatment. "After 1 year of continuous treatment, a patient may be given a maximum 2-week supply of take-home medication," and "after 2 years of continuous treatment, a patient may be given a maximum one-month supply of take-home medication" (42 CFR 8.12(h)-(i)).
  - » Decisions regarding eligibility for unsupervised doses as outlined above shall be determined by the OTP's medical director, based on urine drug tests, regularity of clinic attendance, absence of serious behavioral problems, "absence of known recent criminal activity," "stability of the patient's home environment and social relationships," "length of time in comprehensive maintenance," the ability to store take-home doses safely, and an evaluation of the benefits versus the risks of take- home doses, especially with regard to diversion (42 CFR 8.12(i)).
- Medication-assisted Treatment (MAT) at OTPs will be paid for via weekly bundled payments using HCPCS codes that include the services required by 42 CFR 8.12, specifically: the medication and its dispensing or administration, physician visits, substance use counseling, and urine drug tests. These weekly bundled payments will be the same, whether a member is early in their treatment or many months or years into their treatment. A member early on in treatment would be expected to receive more services than someone who is stable and has multiple take-home doses. Urine drug tests should be administered when medically necessary, typically at least once per month and more frequently initially.
- OTPs are encouraged to provide additional support services on site such as recovery coaching. When medically necessary and clinically appropriate, services outside of SUD treatment, such as medication management and recovery coaching, may be billed separately from the weekly bundle, as long as the provider is also credentialed as a qualified provider with the IBHP.

All weekly bundles will be reimbursed through the IBHP. All weekly bundles include medications, with the exception of ER-naltrexone and buprenorphine/naloxone prescriptions, which will be reimbursed fee-for-service through the Medicaid pharmacy benefit.

Provider Qualifications

OTPs in compliance with the federal opioid treatment standards (42 CFR 8.12), certified by SAMHSA, and contracted with the Idaho Behavioral Health Plan (IBHP) can provide this benefit. To obtain further information on provider qualifications, please visit the ***SAMHSA*** website.

Authorization Type

No prior authorization is required for this service.

Payment Methodology

Services rendered at OTPs should be billed using the HCPCS codes below, for weekly bundled payments that vary based on the medication administered.

The billing codes below were established by CMS in the Final Rule and Interim Final Rule, Federal Register, November 15, 2019; (CMS-1715-F and IFC). These codes should be used to bill the weekly (Sunday through Saturday) MAT bundle corresponding to the medication being dispensed or prescribed at the OTP.

CPT Code	Description	Unit
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed	Per week
G2068	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed	Per week
G2074	Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed	Per week

Descriptions of MAT Bundles

HCPCS Code G2067

- G2067 will be reimbursed per the IBHP fee schedule, for members receiving daily administration of methadone onsite at the OTP and for members receiving any number of take-home doses of methadone.
- Participants must have received services or had medication administered or dispensed by the OTP on at least three (3) days of the billed week. Even if a member receives the maximum number of take-home doses, the weekly bundle may be billed every week as long as the member remains in care and is expected to return to the OTP within thirty (30) days.

HCPCS Code G2068

- G2068 will be reimbursed per the IBHP fee schedule, for administration of buprenorphine/naloxone on at least three (3) days onsite at the OTP.
- Once a member takes more than 50% of doses offsite (via prescription), G2074 should be billed instead, and the prescription should be billed to the Medicaid pharmacy program.

HCPCS Code G2074

- G2074 will be reimbursed per the IBHP fee schedule and includes all non-drug treatments provided at the OTP, including physician visits, substance use counseling, and drug testing. This code should be used for members receiving more than 50% of their buprenorphine doses in the form of a take-home prescription or members receiving ER-naltrexone.
- The buprenorphine prescription itself will be billed separately via the pharmacy benefit. The OTP is expected to prescribe all take-home doses as buprenorphine/naloxone combination product; if buprenorphine monoproduct is desired and the member is not known to be pregnant, a prior authorization must be submitted by the prescriber to Medicaid's pharmacy unit.
- The ER-naltrexone prescription itself will be billed separately via the pharmacy benefit.
- Even if a member does not need to follow up more often than monthly, the weekly bundle may be billed every week as long as the participant remains in care and is expected to return to the OTP within thirty (30) days.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

- » OTPs will be paid for via bundled payments using HCPCS codes that include the services required by 42 CFR 8.12, specifically including: the medication and its administration, physician visits, substance use counseling, and urine drug screens.

Additional Information

- The six ASAM dimensions must be included in the member's Comprehensive Diagnostic Assessment (CDA). GAIN certified providers have the option to use the Global Appraisal of Individual Need (GAIN) to meet this requirement. Other assessment tools may also meet this requirement.
- Medically necessary behavioral health services that are not part of the bundle (e.g. psychiatric medication management) can be provided by the OTP or another provider if they are contracted with the IBHP.
- OTPs must comply with their appropriate State statute(s) and rules regarding participation in the State Prescription Drug Monitoring Program.

Therapeutic After School and Summer Program (TASSP)

Description

Therapeutic After School and Summer Programs (TASSP) are structured programs that consist of a range of individualized therapeutic, recreational, and socialization activities for youth. These individual and group therapeutic experiences assist youth in developing social, communication, behavior, and basic living skills, as well as psychosocial and problem-solving skills.

TASSP are a collaboration between provider agencies, community-based organizations, professionals, and/or other entities. The goal of the program is to enable each youth to improve their functioning in the home, school, and community by providing structured treatment services during afterschool, summer, or out of school time.

TASSP can be structured in various ways:

- A provider agency can incorporate activities into their existing clinical service array:
  - » The provider agency determines other professionals that may provide components of their TASSP (e.g. a music professional, Science, Technology, Engineering, Mathematics (STEM) provider or educational tutor). These professionals will provide appropriate activities/services within their level of training, experience, and education. Activities/services delivered by professionals that are outside of the IBHP cannot be reimbursed by Optum.
- A provider could partner with existing non-therapeutic after school and summer programs and provide clinical services within that program.

Services under the IBHP billable for a TASSP:

- Individual, family and or group psychotherapy (mental health and substance use disorder)
- Skills Training and Development
- Skills Building/CBRS
- Family Psychoeducation

Provider Qualifications

Providers will be licensed clinicians as defined per licensure by the Division of Occupational and Professional Licenses and IDAPA and/or practicing under the Optum Idaho supervisory protocol.

Paraprofessional Level

A paraprofessional and/or bachelor level or higher provider practicing within their scope of practice, training or education and meeting supervisory protocol requirements.

- It is the responsibility of the provider agency to determine which tasks this provider may perform as a function of his or her training, experience and education.

- Optum expects that paraprofessionals are appropriately supervised by a qualified clinician. For further information, please review the supervisory protocol in the Optum Network Agreement.

Provider Responsibilities

Providers are responsible for identifying and coordinating with community partners offering experiential and expression-focused activities.

TASSP providers are responsible for ensuring services/activities provided in this program align with the youth's individualized treatment plan and/or PCSP, if applicable.

All providers will deliver services in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment care needs.

Authorization Type

Some services require prior authorization (please see individual service descriptions).

Payment Methodology

Therapeutic After School and Summer Programs: The UC modifier is used to indicate that the service was rendered as a component of a Therapeutic After School and Summer Program.

The UC Modifier can be added to the following codes: 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90853, H0001, H0004, H0005, H2014, H2017 and H2027.

Services delivered by professionals that are outside of the IBHP cannot be reimbursed by Optum.

Additional Information

For more information on Therapeutic Afterschool and Summer Programs, please contact: *optum.idaho.tassp@optum.com*.

Outpatient Continuum (Day TX, IOP, PHP)

Day Treatment	Intensive Outpatient (IOP)	Partial Hospitalization (PHP)
Children/Adolescents	Children/Adolescents/Adults	Children/Adolescents/Adults
Day Treatment is a structured program available to children and adolescents exhibiting severe needs that can be addressed and managed in a level of care that is less intensive than inpatient psychiatric hospitalization, partial hospitalization or residential treatment, but requires a higher level of care than intensive or routine outpatient services. These services typically include a therapeutic milieu that may include skills building, medication management, and group, individual and family therapy. Day Treatment providers will ensure consistent coordination and communication with other agencies working with the child/adolescents, including coordination with the schools.	Intensive Outpatient Programs (IOP) are structured programs available to adults, children and adolescents who are recovering from mental health (MH), including eating disorders (ED), and/or substance use disorders (SUDs), experiencing moderate behavioral health symptoms that can be a ddressed and managed in a level of care that is less intensive than partial hospitalization but that require a higher level of care than outpatient services. The program may function as a step-down program from psychiatric hospitalization, partial hospitalization, or residential treatment. It may also be used to prevent or minimize the need for a more intensive level of treatment. IOP is appropriate for Members who live in the community without the restrictions of a 24-hour supervised treatment setting during non-program hours.	Partial Hospitalization can be used to treat mental health (MH), including eating disorders (ED), or substance use disorders (SUD), or both; i.e., co-occurring conditions. Partial Hospitalization is a facility-based, structured bundle of services for participants whose symptoms result in severe personal distress and/or significant psychosocial and environmental issues. Partial Hospitalization programs are appropriate for members who are experiencing symptoms that can be addressed and managed in a level of care that is less intensive than psychiatric hospitalization but who require a higher level of care than routine outpatient or other intensive services. Partial Hospitalization provides not only behavioral health treatment, but also the opportunity to practice new skills. Services for adolescents are offered separately from services for adults, and each program and its staff must meet the certification and credentialing criteria of the Idaho Department of Health and Welfare. Services must be delivered under the supervision of a licensed physician.
Agency or Facility Based	**Agency or Facility Based**	**Agency or Facility Based**
Prior Authorization	**No Prior Authorization**	**Prior Authorization**
Common Treatment Duration: 6-8 weeks	**Common Treatment Duration**: 6-8 weeks	**Common Treatment Duration**: 4-6 weeks
Mental Health/Co-Occurring	**Mental Health/SUDS/ Co-Occurring**	**Mental Health/SUDS/ Co-Occurring**
Individual and Group: Min. of 3 hours per day, max of 5 hours per day, 4-5 days per week.	**Individual and Group**: Min. 3 days per week, <19 hours per week. **Children and Adolescents**: Min. 6 hours/week. **Adults**: Min. 9 hours/week.	**Individual and Group**: Min. 20 hours per week.

Day Treatment	Intensive Outpatient (IOP)	Partial Hospitalization (PHP)
Children/Adolescents	Children/Adolescents/Adults	Children/Adolescents/Adults
Required* Program Components Included in Bundled Rate: • Assessment and treatment planning • At least 2 of the following: » Individual therapy » Family therapy » Group therapy » Psychoeducation • Provided by interdisciplinary team • 24-hour crisis services • Care coordination, transition management, discharge planning • Skill-building activities	**Required* Program Components Included in Bundled Rate**: • Assessment and treatment planning • Additionally, the following services are provided in the amounts, frequencies and intensities as appropriate to the members treatment needs: » Individual therapy » Family therapy » Group therapy » Psychoeducation • Provided by interdisciplinary team • 24-hour crisis services • Psychiatric Evaluation • Medication Management • Skill-building activities • Substance Use screening and monitoring • Drug testing • Care coordination/transition management/discharge planning • A physical exam within the first week • A psychiatrist is available to consult with the program during and after normal program hours • *ED (Health assessment and monitoring) • *ED (Dietary and nutrition services)	**Required* Program Components Included in Bundled Rate**: • Assessment and treatment planning • Additionally, the following services are provided in the amounts, frequencies and intensities as appropriate to the members treatment needs: » Individual therapy » Family therapy » Group therapy » Psychoeducation • Services must be delivered under the supervision of a licensed physician • Provided by interdisciplinary team • 24-hour crisis services • Psychiatric evaluation • Medication management • Skill-building activities • Substance use screening and monitoring • Drug testing • Care coordination, transition management, discharge planning • A physical exam within the first week • *ED (Health assessment and monitoring) • *ED (Dietary and nutrition services)

(Outpatient Continuum table continued on following page.)

Day Treatment	Intensive Outpatient (IOP)	Partial Hospitalization (PHP)
Children/Adolescents	Children/Adolescents/Adults	Children/Adolescents/Adults
Optional Services that can be Billed Outside of the Bundled Rate: • Case management/TCC • Respite • Peer support • Youth support • Family support • Recovery coaching • CFT • Psych/neuropsychological testing • Psychiatric evaluation • Medication management Members cannot receive other outpatient services while engaged in the program except for the ones listed above.	**Required Services that can be Billed Outside of the Bundled Rate**: • Medication management • Psychiatric evaluation **Optional Services that can be Billed Outside of the Bundled Rate**: • Case management/TCC • Respite • Peer support • Youth support • Family support • Recovery coaching • CFT • Psych/neuropsychological testing Members cannot receive other outpatient services while engaged in the program except for the ones listed above and Opioid Treatment Services. This means a member could participate in a MH IOP while also participating in an OTP if medically necessary and meets the requirements for both programs.	**Required Program Components that can be Billed Outside of the Bundled Rate**: • Medication management • Psychiatric evaluation **Optional Services that can be Billed Outside of the Bundled Rate**: • Case management/TCC • Respite • Peer support • Youth support • Family support • Recovery coaching • CFT • Psych/neuropsychological testing Members cannot receive other outpatient services while engaged in the program except for the ones listed above and Opioid Treatment Services. This means a member could participate in a MH PHP while also participating in an OTP if medically necessary and meets the requirements for both programs.

**The required components of the bundled programs are listed below and separated out by services that can be billed under the per diem bundled rate and those that can be billed outside of the per diem bundled rate. All services to members will be individualized in the amounts, frequencies and intensities based on the members treatment needs and preferences within the program guidelines.*

4.14 Adjunctive Services

Alcohol and Drug Testing

Description

Presumptive/qualitative drug testing is used when necessary to determine the presence or absence of drugs or a Drug Class. Presumptive/qualitative drug testing is an important part of treatment for substance use disorder (SUD). Presumptive/qualitative drug testing can be used to assess for adherence, persistent substance use, and diversion.

Presumptive/qualitative drug testing is not considered definitive testing that would typically be performed in a laboratory. Presumptive/qualitative drug testing is performed using a method that establishes preliminary evidence regarding absence or presence of drugs or metabolites in a sample, results being expressed in a positive or a negative.

Presumptive/qualitative drug testing is used as a therapeutic tool within behavioral health treatment, used to assist in treatment planning, and to therapeutically monitor and support recovery. Presumptive/qualitative drug testing is not covered as part of routine physicals or for legal, criminal justice, employment or administrative purposes.

Provider Qualifications

To be reimbursable, presumptive/qualitative drug tests must be determined to be medically necessary by a licensed or certified healthcare professional enrolled with the IBHP. Claims for tests ordered by non-enrolled providers (e.g. non-enrolled recovery support staff, law enforcement personnel, probation and parole officers, etc.) will be denied and/or are subject to recoupment action.

- **Provider Proficiency (ASAM, 2017)**:
  - Providers responsible for ordering tests should be familiar with the limitations of presumptive and definitive testing. Please note that the IBHP does not cover definitive testing.
  - Providers responsible for ordering tests should be familiar with the potential for cross-reactivity in drug testing.
  - Providers responsible for ordering tests should consider the possible impact of tampering on test results. Providers should note that tampering is more likely in settings where consequences for substance use are severe, such as discharge from treatment.

All presumptive/qualitative drug testing services must be provided by or under the direction of a qualified behavioral health provider.

Provider Responsibilities

Presumptive/qualitative drug testing may be performed with a member as long as the clinical use for drug testing is documented in the member's record as to why it would be recommended therapeutically. Drug testing should be used to monitor recent substance use in all addiction treatment settings.

Per ASAM guidance, it would not suffice for a provider to cite that drug testing is court ordered as part of their recommendation as it is not considered a compliance tool, rather a therapeutic tool within behavioral health treatment, used to assist in treatment planning, and to therapeutically monitor and support recovery.

It is the treating provider's responsibility to ensure evidence-based practice criteria are followed.

It is the treating provider's responsibility to include the type, amount, frequency, duration, indicated diagnosis, and anticipated goals in the member's individualized treatment plan.

Recommended Practices and Procedures (ASAM 2017)

Prior to the use of drug testing, the treating provider has determined the clinical value of the following:

- **Drug Testing and Self-Report of Substance Use (ASAM, 2017):**

- Drug testing is used in combination with an individual's self-reported information about substance use.
- Drug testing is used as a supplement to self-report as individuals may be unaware of the composition of the substances(s) they have used.
- Drug testing is appropriate for individuals facing negative consequences if substance use is detected and are less likely to provide accurate self-reported substance use information.
- Discrepancy between self-report and drug tests results can be a point of engagement for the provider.

- **Drug Testing as a Therapeutic Tool (ASAM, 2017):**
  - Drug testing is used as a therapeutic tool as part of evidence-based addiction treatment and recovery.
  - Providers should utilize drug testing to explore denial, motivation, and actual substance use behaviors with individuals.
  - If drug-testing results contradict self-reports of use, therapeutic discussions should take place.
  - Providers should present drug testing to individuals as a way of providing motivation and reinforcement for abstinence.
  - Providers should educate individuals as to the therapeutic purpose of drug testing. To the extent possible, persuade individuals that drug testing is therapeutic rather than punitive.
  - If an individual refuses a drug test, the refusal itself should be an area of focus in the individual's treatment plan.
- **Assessment (ASAM, 2017)**
  - Treatment providers should include drug testing at intake to assist in an individual's initial assessment and SUD treatment planning.
  - Drug test results should not be used as the sole determinant in assessment for SUD. They should always be combined with individual history, psychosocial assessment, and a physical examination.
  - Drug testing may be used to help determine optimal placement in a level of care.
  - Drug testing can serve as an objective means of verifying an individual's substance use history.
  - Drug testing can demonstrate a discrepancy between an individual's self-report of substance use and the substances detected in testing.
  - For an individual presenting with altered mental status, a negative drug test result may support differentiation between intoxication and/or presence of an underlying psychiatric and/or medical condition that should be addressed in treatment planning.
  - Drug testing can be helpful if a provider is required to document an individual's current substance use.
- **Monitoring (ASAM, 2017):**
  - Drug testing should be used to monitor recent substance use in all addiction treatment settings.
  - Drug testing should be only one of several methods of detecting substance use or monitoring treatment; test results should be interpreted in the context of collateral and self-report and other indicators.
- **Responding to Test Results (ASAM, 2017)**
  - Providers should attach a meaningful therapeutic response to test results, both positive and negative, and deliver it to individuals as quickly as possible.
  - Providers should not take a confrontational approach to discussing positive test results with individuals.
  - Providers should be aware that immediate abstinence may not be a realistic goal for individuals early in treatment.
  - When making individual care decisions, providers should consider all relevant factors surrounding a case rather than make a decision based solely on the results of a drug test.
  - Considering all relevant factors is particularly important when using drug test results to help make irreversible individual care decisions such as discharging from treatment or involving law enforcement.

Authorization Type

Threshold is 24 units (combination 80305, 80306, 80307) per member per calendar year; additional services must be prior authorized via ***Optum Idaho*** or ***Provider Express***.

Payment Methodology

CPT Code	Modifier	Description	Unit
80305	*N/A*	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service (combination 80305, 80306, 80307)	1 unit = 1 test
80306	*N/A*	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service (combination 80305, 80306, 80307)	1 unit = 1 test
80307	*N/A*	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service (combination 80305, 80306, 80307)	1 unit = 1 test

Additional Information

- Additional presumptive/qualitative testing units can be requested through the Optum Idaho Service Request Form (SRF) process. The form can be found at ***optumidaho.com***.
- Level of Care Guidelines for admission and continued stay criteria for this service can be found at ***optumidaho.com***
- Medical/Definitive/Quantitative testing is not a benefit available through the Idaho Behavioral Health Plan. Questions about the prior authorization process for these services may be submitted to the Medical Care Unit at *MedicalCareUnit@dhw.idaho.gov*.
- Presumptive/qualitative drug tests that are administered as part of a program billed as a bundle in the IBHP such as Intensive Outpatient, Partial Hospitalization, or Opioid Treatment Programs are not counted as part of the 24-unit threshold authorization. Drug tests administered in these programs are included in the bundled rate.

Health Behavior Assessment and Intervention (HBAI)

Description

Full-service ambulatory clinics that provide medical services can receive reimbursement for the Health Behavior Assessment and Intervention (HBAI) codes. These allow integrated medical clinics to provide brief behavioral interventions to Idaho Medicaid members.

These interventions do not require a Comprehensive Diagnostic Assessment (CDA) or a full treatment plan. Additionally, these services will not require the completion of the CANS assessment for members under the age of 18. However, the interventions are to be documented in the member's medical record and must be billed with a primary medical diagnosis. The services must be provided by a qualified licensed behavioral health clinician.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Interested clinics should contact their Provider Relations Advocate to learn more about the criteria and how to amend their contract to receive a separate fee schedule that includes these codes.

Provider Qualifications

Providers will be licensed clinicians as defined per licensure by the Idaho Division of Occupational and Professional Licenses and IDAPA.

Provider Responsibilities

Services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs.

Refer to American Psychological Association 2020 Health Behavior Assessment and Intervention Billing and Coding Guide for additional guidance on service delivery.

Authorization Type

Threshold is 60 units for all codes combined per member, per calendar year. Each billed instance of the codes below will equally count as one unit each towards the members 60-unit threshold. Each visit shall not exceed one hour in duration, irrespective of the specific code(s) billed for the visit. Additional services must be prior authorized by submitting a Health Behavior Assessment and Intervention service request form in advance of the provision of services via ***Optum Idaho*** or ***Provider Express***.

Payment Methodology

CPT Code	Modifier	Description	Unit
96156	*N/A*	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), face-to-face with the patient; initial assessment or reassessment.	1 unit = 1 assessment, 15 minutes
96158	*N/A*	Health and behavior intervention, individual, face-to-face. Initial 30 minutes.	1 unit = first 30 minutes
96159	*N/A*	Health and behavior intervention, individual, each additional 15 minutes (add-on).	1 unit = each additional 15 minutes
96164	*N/A*	Health and behavior intervention, group. Initial 30 minutes.	1 unit = first 30 minutes
96165	*N/A*	Health and behavior intervention, group, each additional 15 minutes (add-on).	1 unit = each additional 15 minutes
96167	*N/A*	Health and behavior intervention, family w/patient. Initial 30 minutes.	1 unit = first 30 minutes
96168	*N/A*	Health and behavior intervention, family w/patient, each additional 15 minutes (add-on).	1 unit = each additional 15 minutes

Language Interpretation Services (Sign Language or Oral Interpretation)

Description

Federal law and Idaho Medicaid regulations require Medicaid providers to make reasonable modifications in their practices or clinics to ensure members who have limited ability to read, speak, write or understand English have full access to Medicaid services. This limitation is referred to as Limited English Proficiency (LEP).

LEP individuals are entitled to language assistance to help facilitate the delivery of Medicaid services. Medicaid providers may utilize methods such as interpretation, translation, or Braille to meet the requirement for effective communication. However, these services must be free of charge to Medicaid members.

When an Optum Network provider is unable to communicate with a member due to deafness, hearing impairment, vision impairment or LEP, Optum Idaho will provide reimbursement for the provision of the interpretation, translation, Braille or sign language services.

If the member is under the age of 18 years, and either the child or the parent/guardian is deaf, hearing or vision impaired, or a person with LEP, then interpretation and/or translation services must be provided to facilitate the care of the member receiving the Optum Idaho reimbursed service.

Reimbursement for interpretation, translation, or sign language services is not available for:

- Administrative services such as:
  - Scheduling appointments
  - Making reminder calls
  - Canceling appointments
  - Travel time for the interpreter
  - No show appointments
- Assisting members to understand information not related to the Optum Idaho reimbursed service
- Interpretation services provided by an immediate family member (e.g. parent, spouse, sibling, child)
- Interpretation or translation services provided by any individual not meeting the definition of a qualified interpreter/translator. (Note: The provider delivering the Optum Idaho reimbursed service must ensure that the individual is qualified to communicate directly with the member).
- Interpretive or translation services when the provider of the Optum Idaho reimbursed service is able to communicate effectively, orally or in writing, with the member.
- Teaching sign language
- Services not reimbursed by Optum Idaho (e.g. claim is denied)

General Information

Medicaid providers must not require a member to provide his or her own interpreter or translation services and must not rely on adult or child accompanying an individual who is deaf, hard of hearing, or a person with LEP to interpret or to facilitate communication. Exceptions to this include the following:

- Emergency situation involving an imminent threat to the safety and welfare of an individual or to the public.
- Members specifically request that an accompanying adult family member or friend interpret for them.

Both “exceptions” must be determined to be appropriate by the medical provider (e.g. appropriate for the procedure/service being rendered).

Translation services may be provided via Telehealth when the method of communication does not jeopardize the care of the client and when services are delivered in accordance with the Telehealth Services section of this manual.

It is typically the provider’s responsibility to arrange for the services of interpreters, when indicated, for members under your care. Interpreter services are covered under the IBHP and the appropriate service codes for billing are included on the Optum Idaho Medicaid fee schedule.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Provider Qualifications

The language services may be provided in person or via telehealth. It is the responsibility of the provider or its agency to hire or contract with a qualified interpreter or translator to facilitate communication with a member when they are providing an Optum Idaho reimbursed service. If interpretive services are provided using telehealth, the interpretive services must be delivered in accordance with the Telehealth Services section of this manual.

Provider Responsibilities

Providers must generate documentation at the time of service enough to support the claim for reimbursement of interpretive, translation, or sign language services. Sufficient documentation must include the following elements:

- Name of the member.
- Member's Medicaid Identification number
- If the member is a child, the name and relationship of the family member who is being interpreted for must be documented.
- Name, title, and signature of the provider of the IBHP service.
- Description of the Optum Idaho reimbursed service and the translation service being provided (e.g. documentation translation, interpreting for nurse/physician).
- Name, signature, and title (if applicable) of the individual providing interpretive or translation services.
- Date, time, and duration of the interpretive or translation services.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
T1013	*N/A*	Language Interpretation Services (sign language or oral interpretation).	1 unit = 15 minutes

It may be necessary for a member to be seen for medically necessary services multiple times per day requiring interpretive services for each of those services on the same day. When interpretive services are provided multiple times on the same date, the claim form must have the appropriate modifiers to assist the claims processor in knowing it was appropriate to have interpretive services provided multiple times that date. Modifiers are used to identify when interpretive services are billed multiple times for the same date of service. The modifier used would be determined by the billing person to correspond with the reason for the duplicate service being billed on the same day. Here is an example on how to bill for multiple interpretive services on the same date of service:

Billing multiple incidents of interpretive services on the same date of service:	
Only 1 interpretive service	No modifier needed
2nd incident on date of service	Add modifier 76
3rd incident on date of service	Add modifier 25

The provider's billing department will need to determine the correct modifier to be used as there are multiple modifiers available to justify the medical need.

Telehealth

Description

Optum Idaho covers the delivery of the following behavioral health services (mental health and substance use disorder) by a provider qualified to deliver the respective service via telehealth or "virtual care" as defined in the Idaho Virtual Care Access Act (formerly the Idaho Telehealth Access Act):

- Assessment and diagnosis (such as the CDA, CANS, etc. see the respective service sections in this manual)
- Behavior Modification and Consultation (codes 97155 & 97156 only)
- Intensive Home and Community Based Services (if the attested model recommends telehealth delivery)
- Peer Services – Individual/group (Peer Support, Youth Support, Family Support, Recovery Coaching)
- Targeted Care Coordination/Case Management
- Skills Training and Development (STAD)
- Skills Building/CBRS and Skills Building Treatment Planning
- Child and Family Teams (CFT)
- Individual, group, or family psychotherapy
- Family Psychoeducation
- Language Interpretation
- Medication management
- Intensive Outpatient
- Telephonic Crisis Response (audio-only)

The clinician (and/or clinical supervisor) will determine if telehealth is the appropriate modality for the patient at the time of service.

Provider Qualifications and Responsibilities

Requirements for providers using telehealth to provide services:

- Is a masters level provider who is a licensed clinician, or a provider qualified to deliver the service in question working under supervisory protocol.
- Abides by Optum's Telehealth Checklist Protocol and the American Telemedicine Association's Practice Guidelines for Video-Based Online Mental Health Services, both of which are located on Provider Express.
- Comply with the Idaho Virtual Care Access Act (formerly the Idaho Telehealth Access Act)
- Uses the current Optum Idaho fee schedule for determining which telehealth services are covered by Optum.
- Are licensed in the state in which the member resides at the time of service or are working under the supervision of a provider licensed in the state in which the member resides at the time of service.
- Providers may be physically located outside of Idaho when seeing Idaho members, as long as they are licensed in Idaho.
- Providers located outside of Idaho must comply with the Idaho Virtual Care Access Act and any Telehealth Access Act within the state they are located.

Authorization Type

No prior authorization is required.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Payment Methodology

CPT Code	Modifier	Description	Unit
Q3014	**GT**	Telehealth Originating Site Facility Fee	1 unit = 1 visit

Additional Information

Optum Idaho ***does not*** cover the following services:

- Telephone only services as a part of telehealth (however, certain services do allow telephonic participation, which are separate from and not included in this telehealth policy). Services that may be provided telephonically include: Crisis response; Case Management and Targeted Care Coordination. See the respective service section in this manual for additional information.
- Telephone-based services including telephone counseling, email, texting, chat rooms, voicemail, or facsimile.
- Remote medical monitoring devices.
- Virtual reality devices.
- Technologies that do not comply with HIPAA and other applicable privacy and security requirements (e.g., Skype).
- Store-and-forward transmissions of case information.

Mileage

Description

When clinically indicated, family or individual therapy may be provided in the member's home by a licensed clinician when the member is present.

In addition to the member's home, mileage reimbursement is available for other locations such as school, another office, etc., as long as it is the first location where the provider is meeting with the member. Mileage reimbursement is available for the provider to return to their office after meeting with the member in the home or alternative location. Specifically, the provider cannot claim the mileage reimbursement code at a different location that day for the same member. Mileage reimbursement is not available for member transportation. When documenting the member's location only put the cross streets, not the address, to not violate HIPAA.

For those members being provided family or individual therapy in the home, the provider may use the code (T2002) to offset the provider's travel costs with the family and individual billing codes. The provider is required to document the elements of care and the estimated length of stay for home-based therapy in the member's clinical chart.

Provider Qualifications and Responsibilities

Provider seeing one member in one trip

If a provider is traveling to see one member, they would document in the medical record the starting location and the end location.

Provider seeing multiple members in one trip

If a provider travels from their office to see member A and then on to other locations to see additional members and then back to the office, they can bill the mileage for this trip. Here is an example:

- ***Member A***: Start at office in McCall and travel to see member A in Donnelly. Bill under member A for 13 miles and document in the medical record the starting location and the end location.

- ***Member B***: Start at member A's location in Donnelly to the location meeting with member B in Cascade. Bill under member B for 15 miles and document in the medical record the starting location and the end location.
- ***Member C***: Start at member B's cross streets in Cascade to the location of the meeting with member C outside of Cascade (3 miles). Return to the provider's office (Cascade to McCall = =29 miles). Bill under member C (member B to member C = 3 miles and member C to provider's office = 29 miles for a total of 32 miles) and document in the medical record the starting location, the location of member C, and the end location.

Authorization Type

No prior authorization is required.

Payment Methodology

CPT Code	Modifier	Description	Unit
T2002	*N/A*	Mileage Reimbursement	1 unit = 1 mile

Providers should review the Optum Idaho Professional Reimbursement Schedule for more details related to allowable procedure codes (90791, 90792, 90846, 90847, 90832, 90833, 90834, 90836, 90837, 90838, H1011, H0031, H0036, H2033, S5150 and T1017).

Additional Information

How to enter on claim form

On the claim form, the provider will enter in how many miles they travel, and they will be paid $0.58 per mile. For example, if the provider travels 25 miles to see the member at school, they will enter 25 under the # of units on the claim form and they will be reimbursed $14.50 (25 x $0.58). Reimbursement is for the roundtrip.

4.15 Youth Empowerment Services (YES)

The State of Idaho manages a children's mental health system of care for children and youth with serious emotional disturbance (SED) titled Youth Empowerment Services (YES). YES has been authorized by the Idaho Department of Health and Welfare (IDHW) as part of the settlement agreement resulting from the Jeff D. class action lawsuit.

The YES system of care refers to the entirety of the mental health supports and resources for children and youth in Idaho. The YES system of care requires provider adherence to the YES Practice Model and the YES Principles of Care for all child and youth members they serve. All children and youth mental health services are part of the YES system of care.

As part of the YES system of care, Optum's Idaho Behavioral Health Plan (IBHP) Network provides updated behavioral health services and supports to children and youth.

The YES system of care improves the quality of care, accessibility of services, and outcomes for children served by offering a comprehensive array of services and supports to address the needs of children and youth diagnosed with SED. Through a coordinated and collaborative effort, multiple child-serving agencies such as family medical and behavioral health providers, Department of Education, Department of Juvenile Corrections, and Department of Health and Welfare work with the family to build a coordinated care plan around the unique needs and strengths of each child.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

YES Program

The Youth Empowerment Services (YES) Program refers to a specific population within the YES system of care. These individuals are under the age of 18 and eligible for Medicaid under the ***1915(i) State Plan Amendment***. A member who is part of the YES Program will have the word "YES" in the Plan Name field when checking member eligibility.

To be eligible for Medicaid under the ***1915(i) State Plan Amendment***, individuals must undergo an independent assessment with the independent assessor. The independent assessor determines if the child or youth has SED. When the independent assessor determines that the individual has SED, those who did not previously qualify for Medicaid then apply for Medicaid with higher income limits. If Medicaid eligibility is approved, these new members may receive Medicaid-funded services. A member who was already Medicaid eligible before the independent assessment is also considered to be a part of the YES Program and can access services that are available only in the ***1915(i) State Plan Amendment***, which is currently Respite.

When a member gains Medicaid eligibility retroactively, Optum works with the member and provider as needed to determine coverage for services covered in the Idaho Behavioral Health Plan rendered during the time period covered by a member's retroactive eligibility. Medicaid eligibility determinations are managed by the Idaho Department of Health and Welfare (IDHW). To learn more about Medicaid eligibility, members may contact IDHW at **1-877-456-1233** or ***healthandwelfare.idaho.gov/contact-us***.

YES Website

The Idaho Department of Health and Welfare's Division of Behavioral Health developed a website for the purpose of providing general information about the YES system of care and project: ***yes.idaho.gov***. The administrative rules for the YES Program can be found in ***IDAPA 16.03.10.635-638***.

Additional information may also be found by visiting ***optumidaho.com*** > For Network Providers> Youth Empowerment Services (YES).

Glossary of YES Terms

These definitions are general definitions applied for purposes of this manual. State law, certain practitioner agreements and individual benefit contracts define some of these terms differently. In such cases, the definitions contained in the applicable law or contract will supersede these definitions. In the definitions below, and throughout this manual, "we", "us" and "our" refer to Optum Idaho.

The 1915(i) State Plan Amendment

If the member does not have Medicaid based on traditional income requirements, they need to apply for Medicaid based on meeting the requirements under the ***1915(i) State Plan Amendment*** to begin receiving services through the IBHP.

The ***1915(i) State Plan Amendment*** allows child and youth with SED, as determined by the independent assessor, to access Medicaid benefits in the IBHP with family income up to 300% of the federal poverty level (FPL). This includes those individuals accessing Respite through traditional Medicaid or that have been identified in the 186-300% FPL income. The 1915(i) State Plan Amendment contains additional benefits that can only be accessed under the YES Program. Respite can be accessed through the 1915(i) State Plan Amendment.

Members in the YES Program must utilize a 1915(i) service (currently, the only 1915(i) service is respite) at least one (1) time per eligibility year with a Medicaid-enrolled provider. Respite must also be listed in the member's PCSP.

Note: Children and youth who are not Medicaid members and are over 300% FPL income can access resources available through their local children's mental health offices. These services may be available to the child or youth even if they have private insurance. The family would need to apply online for services to be approved for the YES Program. The Medicaid Self Reliance Team will complete a manual review process and send a formal notice to the family informing them their child or youth qualifies for the YES Program.

Independent Assessment

Independent assessment is the process by which the Medicaid-contracted independent assessor conducts the Comprehensive Diagnostic Assessment (CDA) and Child and Adolescent Needs and Strengths (CANS) assessment. The independent assessment will determine if a child meets the definition of an individual with an SED. In order to receive Respite or become Medicaid eligible under the ***1915(i) State Plan Amendment*** (up to 300% FPL), an independent assessment is mandatory.

To schedule an independent assessment, call the independent assessor (Liberty Healthcare) at **1-877-305-3469** or email *YESLiberty@idhw.idaho.gov*.

Person-Centered Service Plan (PCSP)

The person-centered service plan (PCSP) incorporates the results of the Comprehensive Diagnostic Assessment (CDA) and CANS functional assessment and is a result of Child and Family Team (CFT) Interdisciplinary Team Meetings. This process is directed by the individual, is ongoing, and focuses on the strengths, interests, and needs of the whole person. The person is supported to use their own power to choose what they will do and who will help them to achieve a life meaningful to them. PCSPs include the member's overall treatment goals and objectives, strengths, needs, a risk management plan, and a transition plan. For members who are Medicaid eligible via the ***1915(i) State Plan Amendment***, the PCSP must be developed according to ***42 CFR 441.725*** and submitted to Optum for approval. An Optum-approved person-centered service plan is not an approval of any service, but rather confirmation that Code of Federal Regulation (CFR) requirements have been met.

YES Practice Model

The YES Practice Model describes the six key components to provide care in the YES system of care.

The six components are:

- **Engagement** – Actively involving children and youth and their families in the creation and implementation of their coordinated care plan.
- **Assessment** – Gathering and evaluating information to create a coordinated care plan.
- **Care planning and implementation** – Identifying and providing appropriate services and supports in a coordinated care plan.
- **Teaming** – Collaborating with children, their families, providers and community partners to create a coordinated care plan.
- **Monitoring and adapting** – Evaluating and updating the services and support in the coordinated care plan.
- **Transition** – Altering levels of care and support in the coordinated care plan.

YES Principles of Care

Eleven principles that are applied to all areas of mental health treatment planning, implementation, and evaluation as outlined in the Jeff D. settlement. The Principles of Care are 11 values that are applied in all areas of the YES system of care.

The 11 principles are:

- **Family-centered** – Emphasizes each family's strengths and resources.
- **Family and youth voice and choice** – Prioritizes the preferences of children and youth and their families in all stages of care.
- **Strengths-based** – Identifies and builds on strengths to improve functioning.
- **Individualized care** – Customizes care specifically for each child, youth and family.
- **Team-based** – Brings families together with professionals and others to create a coordinated care plan.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

- **Community-based service array** – Provides local services to help families reach the goals identified in their coordinated care plan.
- **Collaboration** – Brings families, informal supports, providers, and agencies together to meet identified goals.
- **Unconditional** – Commits to achieving the goals of the coordinated care plan.
- **Culturally competent** – Considers the family's unique needs and preferences.
- **Early identification and intervention** – Assesses mental health and provides access to services and supports.
- **Outcome-based** – Contains measurable goals to assess change.

4.16 Care Planning

Child and Family Team

The CFT Interdisciplinary Team Meeting is scheduled by the TCC and is a face-to-face meeting with the member and the member's family present. The CFT meeting must also include an independently licensed clinician (or a master's level clinician under the supervisory protocol) who participates face-to-face or telephonically. Other than the TCC, network providers must participate face-to-face or telephonically, when appropriate. Additionally, a CFT will include individuals selected by the child, youth and family who are to be involved in coordinating their care.

The Child and Family Team (CFT) is a group of caring and invested individuals who are invited by the child and family to work together to support their child through a teaming approach.

Members of the CFT include the child and family and the mental health provider, but may also include extended family, friends, individuals from child-serving agencies, and community members. The CFT uses the different perspectives of the individual members to create a more informed and collaborative coordinated care plan for the child and family. The child and family are active participants of the CFT, and their goals, concerns, and perspectives inform all decisions.

The CFT will use the information gathered by the CANS to identify goals and then recommend appropriate services and supports to help children and families reach those goals. Members of the CFT may change over time as the needs and goals on the coordinated care plan change.

See the Child and Family Team (CFT) Interdisciplinary Team Meeting service section on how to bill for the service.

Person-Centered Service Plan (PCSP)

All children and youth members in the YES Program are required to have a PCSP developed in a Child and Family Team, which is facilitated in the Idaho Behavioral Health Plan by a TCC. However, services may begin while the PCSP is being developed. If the child's needs are being met through counseling or counseling and medication management, then those services would be included in the PCSP as identified through the Child and Family Team.

A person-centered service plan (PCSP) is directed by the individual, is ongoing, and focuses on the strengths, interests, and needs of the whole person. The person is supported to use their own power to choose what they will do and who will help them to achieve a life meaningful to them. The PCSP is a collaborative effort by all members of the Child and Family Team (CFT). An Optum Targeted Care Coordinator (TCC) enrolled in the Optum network facilitates the formal CFT meetings and creates and finalizes the plan with input from the team. If the member has gone through the independent assessment, Optum must review the finalized PCSP to ensure adherence to the Code of Federal Regulations. PCSPs must be updated at least annually or more frequently if the member/family requests it or whenever clinically indicated, such as by changes in the CANS.

A person-centered service plan is one form of a coordinated care plan and is a requirement for children and youth who receive a serious emotional disturbance (SED) determination through the Liberty Healthcare assessment process and want to access mental health services through Medicaid. Members who are eligible under the 1915(i) State Plan Amendment must complete a PCSP within ninety (90) days of enrollment in the YES Program and update the PCSP at least annually within three hundred and sixty-four (364) days of the previous plan. The PCSP must include all

services the member and their family may use during the member's treatment, including any 1915(i) services they will use (currently, the only 1915(i) service is respite).

Families who are working with a case manager with IDHW's Children's Developmental Disabilities Program or CMH for Wraparound or 20-511A do not need a TCC to create their PCSP to remain eligible for YES. If a family has already developed a PCSP or Plan of Service and is actively working with an IDHW Case Manager, they will not need an additional plan developed and are not required to work with a TCC, as it may be considered a duplication of services. However, families working with a Case Manager through IDHW's Child Protection Services (CPS) may also receive TCC, as it is not considered a duplication of services. Families have the same access to services, regardless of whether their PCSP or Plan of Service was developed by an Optum TCC or an IDHW case manager. If you are unsure if a family is working with an IDHW Case Manager, you can contact Medicaid for more information at **1-866-681-7062**.

Optum Idaho Network Providers may bill for attending a CFT meeting using G9007, regardless of whether it's facilitated by the Optum TCC or IDHW case manager, as it is important for the providers to engage in all of the care for the child or youth.

Person-centered service plans must meet federal requirements and YES practice standards. In order to do so, the Principles of Care and Practice Model are used to meet the criteria listed below:

- The child, youth and family lead the process as much as possible.
- The planning process is timely and occurs in a location convenient for the child, youth and family.
- The plan includes cultural considerations for the child, youth and family.
- Guidelines are included to resolve conflicts and disagreements.
- The child, youth and family are given choices for services and supports and for who will provide them.
- The plan includes strengths, preferences, needs and goals that the child, youth and family identify.
- The plan identifies services, both established and projected, to support the child in meeting their goals. If a provider has not been identified for a specific service, the provider's name is not required on the PCSP form. At least one provider must be identified within the PCSP form.
- The plan identifies risks and includes a plan to minimize them.
- The child and youth's signature and the signatures of the family, providers and other Child and Family Team members are on the plan.
- If a provider is unable to attend the CFT meeting, a signature is still required on the PCSP form. The provider signature confirms agreement to work on the goals identified in the PCSP plan in the specific service(s) recommended within the PCSP plan and intends to render the service to the member.

Service Specific Treatment Planning

The treatment plan stems from the member's presenting condition and is used to document realistic and measurable treatment goals as well as the evidence-based treatments that will be used to achieve the goals of treatment. Effective treatment planning should also take into account significant variables such as the member's functional deficits, strengths and weaknesses, as well as age and level of development, the history of treatment, whether the proposed services are covered in the IBHP and are available in the community, and whether community resources such as support groups, consumer-run services, and preventive health programs can augment treatment. Providers should include the member in the treatment planning.

The provider should also take into account the member's preferences as those might be directly expressed or documented in an advance directive or crisis plan. Finally, effective treatment planning also includes the formulation of discharge criteria specifically designed around the member's therapy goals. For some members, treatment is part of a broader recovery & resiliency effort, so the recovery & resiliency goals which may be documented in a recovery plan should also be considered. Please refer to the Idaho Medicaid Supplemental Clinical Criteria (***Optum Idaho Level of Care Guidelines***) for more details related to treatment planning requirements.

A change in the member's condition should prompt a reassessment of the treatment plan and selection of appropriate services. When his or her condition has improved, the reassessment should determine whether a less restrictive level

CLICK HERE TO RETURN TO TABLE OF CONTENTS

of care or different services may be adequate to treat the condition, or whether he or she no longer requires treatment based upon the original discharge criteria. When a member's condition has not improved, or it has worsened, the reassessment should determine whether the diagnosis is accurate, the treatment plan should be modified, and/or the condition is better treated with different services, or if a higher level of care is required.

Effective discharge planning enables the member's safe and timely transition from one level of care to another and documents the services he or she will receive after discharge. Discharge planning begins at the onset of treatment when the member and provider include the discharge criteria and estimated time treatment might take into the overall plan. The initial discharge plan may evolve in response to changes in the member's condition and his or her preferences. The final discharge plan should document the anticipated discharge date, the proposed post-discharge services, the plan to coordinate discharge with the provider at the next level of care when indicated, and the plan to reduce the risk of relapse such as by confirming that the member understands and agrees with the discharge plan. The risk of relapse can also be mitigated by arranging a timely first post-discharge appointment.

As the member transitions from one level of care to another, Optum expects that the first appointment at the next level of care will be scheduled commensurate with the member's needs. The first post-discharge appointment following inpatient care should occur no later than seven (7) days from the date of discharge. This timeframe is in accordance with the HEDIS® standard for follow-up treatment after discharge from inpatient care. Compliance with this standard is assessed on an annual basis. At Optum, Care Advocates and Field Care Coordinators monitor discharge planning, and are available to assist with identifying and facilitating access to available treatment services and community resources.

Optum expects that the provider will collaborate with the member during treatment, recovery and discharge planning whenever possible.

To coordinate and manage care between behavioral health and medical professionals, Optum requires that you seek to obtain the member's consent to exchange appropriate treatment information with medical care professionals (e.g., primary physicians, medical specialists) and/or other behavioral health clinicians (e.g., psychiatrists, therapists). Optum requires that coordination and communication take place at: the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate. Coordination of services improves the quality of care to members in several ways:

- It allows behavioral health and medical providers to collaborate
- It allows a primary care physician to know that his or her patient followed through on a behavioral health referral
- It minimizes potential adverse medication interactions for members who are being treated with psychotropic and non-psychotropic medication
- It allows for better management of treatment and follow-up for members with coexisting behavioral and medical disorders
- It promotes a safe and effective transition from one level of care to another
- It can reduce the risk of relapse

To facilitate effective communication among all treatment professionals involved in a member's care, Optum Idaho requires network providers to coordinate services with the member's primary care physician (PCP) at a minimum, by applying the following standards for care coordination:

- During the diagnostic assessment session, request the member's written consent to exchange information with all appropriate treatment professionals.
- After the initial assessment, provide other treating professionals with the following information within two weeks:
  - Summary of member's evaluation
  - Diagnosis
  - Treatment plan summary (including any medications prescribed)
  - Primary clinician treating the member
- Update other behavioral health and/or medical clinicians when there is a change in the member's condition or medication(s).
- Update other health care professionals when serious medical conditions warrant closer coordination.

- At the completion of treatment, send a copy of the discharge summary to the other treating professionals.
- Attempt to obtain all relevant clinical information that other treating professionals may have pertaining to the member's mental health or substance use disorder problems.

Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum, as well as accrediting organizations, expect you to make a "good faith" effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the member as part of an overall approach to coordinating care. A good faith effort is considered to be done when a company or an agency has exhausted all possible means.

Optum establishes guidelines and requirements for providers. Where required by law, more stringent standards may be applied. However, if applicable law permits the application of less stringent standards, the Optum standards specified herein shall still be applied pursuant to the terms of your Agreement. In accordance with industry standards and Best Practices, Optum may review and modify authorization procedures.

Optum administers managed behavioral health care Benefit Plans for members nationwide. These plans vary in types of benefits and amounts of coverage. All members shall be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other patients of the provider. Covered services will be available and accessible to all members.

In some states, Optum provides the behavioral health network and may manage the benefits for membership covered under Medicaid plans. State regulations vary significantly regarding eligibility, benefits and processes related to serving the Medicaid membership. To learn more about Medicaid requirements in your state, see the "State-Specific Provider Information" in the "Our Network" section of ***Provider Express*** or contact Provider Relations.

4.17 Integrated Substance Use Disorder Treatment

Integrated Substance Use Disorder Treatment is a philosophy of care rather than a specific benefit. Individuals who suffer from Substance Use Disorders and mental health disorders are described as experiencing a Co-Occurring Disorder. Optum will support the development of the capacity of all network providers to offer integrated care for members with co-occurring disorders.

Integrated treatment for co-occurring disorders is a program provided in an individual or group setting including an array of services within a system of care that integrates mental health and substance use interventions. The interventions are tailored to the complex needs of the member with comorbid disorders.

Interventions are combined into one coherent package that address mental illnesses and substance use disorders simultaneously with evidence-based practices as described in an individualized service plan. The services appear seamless, with a consistent approach, philosophy, and set of recommendations.

All treatment, care, and support services are provided in a context that is person-centered, family-focused, strengths-based, and culturally competent and responsive to each member's psychosocial, developmental, and treatment care needs.

Optum Idaho substance use disorder (SUD) provider agencies must have the capacity to treat members with co-occurring mental health and substance use disorders. Optum Idaho mental health provider agencies that do not treat SUD are required to asses/identify SUD diagnoses and refer a member to a SUD provider as needed.

Effective July 1, 2019, Optum implemented a change in policy to allow master's level clinicians in a SUD agency to bill psychotherapy codes where the primary diagnosis is a substance use disorder. This allows for master's level clinicians to address co-occurring issues in psychotherapy sessions. Optum offers several Co-Occurring Disorder courses found on ***Relias***. Providers can access these courses to begin to increase the competency in referral, screening, assessment, and treatment of Co-Occurring Disorders.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

4.18 Care Advocacy and High-Need Members

Care Advocates

The Optum Idaho Care Advocacy Center (CAC) focuses on activities that impact IBHP members' stabilization and recovery and promote active participation in their care. This approach consists of targeted interventions intended to facilitate member services, identify members who may be at risk, and assist you in the coordination and delivery of care to members. This approach supports a collaborative relationship between you and the Care Advocate, including Field Care Coordinators.

The Optum Idaho Care Advocacy Center is open for standard business operations Monday through Friday from 8 a.m. to 6 p.m. MT in the Boise office location. Providers can call to discuss urgent and emergent situations, clinical benefit determinations or other questions about the prior authorization process.

Optum offers a Member Access and Crisis Line (**1-855-202-0973**) for members which are available twenty-four hours a day, seven days a week, including holidays and weekends, to discuss urgent and emergent situations and provide telephonic support and connection to resources.

Care Advocacy activity may include:

- Emphasizing the integration of medical and behavioral care by promoting communication among all treating providers involved in members' care.
- Ensuring that members being discharged from facility-based care have appropriate discharge plans, that they understand them and that they are able to access and afford the recommended services.
- Using the information on the Wellness Assessments to identify members who may be at-risk.
- Proactively reaching out to providers to discuss members' care when an individual has been identified as being at-risk.
- Offering clinical consultations with Optum Idaho medical staff.
- Reaching out to members in some circumstances to educate, evaluate risk and offer assistance.
- Supporting members to actively participate in treatment and follow-up care.
- Referencing web-based and written information for members and treating clinicians regarding behavioral health conditions, designed to support informed decision-making.

Field Care Coordinator (FCC) Program Description

The mission for our FCC program is to:

- Focus on member centered principles of recovery and resiliency
  - » FCCs will support members in their community by collaborating with providers on services, identified needs, and potential solutions.
- Provide clinical expertise on all aspects of a high-risk member's treatment
  - » FCCs will attend multi-disciplinary team (MDT) meetings, to assist teams with clinical support, treatment planning, and help coordinate appropriate services to meet the member's needs.
- Offer support on best practice standards of care
  - » FCCs will attend meetings with providers, members, and member's families to address treatment opportunities and identity appropriate services.
- Propose innovative solutions for behavioral health treatment
  - » FCCs will serve as a resource for services in and out of the Idaho Behavioral Health Plan.
- Foster and support meaningful coordination of care
  - » FCCs will work with Targeted Care Coordinators to address a member's needs and services or the development of services within communities.

Field Care Coordinator Processes and Referral

When a member is identified as having high need or being at high risk, a Field Care Coordinator (FCC) is assigned to contact the provider and/or the member or their parent or legal guardian and provide information about Optum Idaho's care management program, assess the member and/or their parent or legal guardian's interest in FCC activity. Typically, an FCCs activity is directed at consultation with the provider and assisting with the provider's clinical intervention plan when it's requested. Unless the member or parent/guardian refuses assistance, the FCC assists in evaluating the member's needs and goals, provides consultation on best practice interventions, promotes improved care coordination, and provides information about Optum Idaho managed services.

Members who may benefit from FCC are identified through any of the following:

- Referrals from other Optum Idaho staff
- Referrals from stakeholders including but not limited to wellness coordinators at state and community psychiatric hospitals, law enforcement, person-centered service plan facilitators, school systems, and human service agencies
- Self-referral or referral by a member's parent or legal guardian referrals from outpatient providers

FCC's receive referrals identifying members whose circumstances require more intensive clinical attention. Such circumstances may include barriers to access best practice and medically necessary services, barriers to coordination of care, risk of needing a higher level of care, and/or other factors determined to interfere with member's recovery and resiliency.

Optum Idaho recognizes that different strategies and levels of effort are appropriate for different populations. FCCs provide additional attention to the unique needs of children such as: engagement with family and schools, earlier intervention in the course of illness, and possibly more complex care coordination.

In addition, referrals may come from Optum staff, members or their authorized representatives, behavioral health providers, primary care physicians, stakeholders, or community agencies and organizations. A Field Care Coordinator, typically from the member's geographical region, is assigned to reach out to members and /or their providers, assess their needs and goals, and consult on treatment planning and evidence-based practices.

Field Care Coordination Program Staff

Optum Field Care Coordination staff includes an independently licensed Manager, independently licensed Field Care Coordinators, and Wellness Coordinators whose functions are generally distinct from utilization management and from Case Management activities provided by agencies and schools.

For a listing of regional Field Care Coordination staff please visit the "***Contact Us***" page on the Optum Idaho website.

Field Care Coordination at the System Level

Optum Idaho's FCC program seeks to improve the experience of members and/or their parents or legal guardians with the behavioral health system of care, human service agencies and other resources through any of the following activities:

- Meeting with agencies, the school and court systems, and other key stakeholders to help align services, establish referral and communication protocols, and to facilitate joint service planning and training.
- Participating in health fairs and other community events and activities aimed at promoting the use of evidence-based practices and to further educate others about the concepts of recovery and resiliency.
- Participation in quality improvement activities.

EPSDT (Early Periodic Screening, Diagnosis and Treatment)

If a child is under 21 years of age and has a need for outpatient behavioral health services not covered by the State Plan, the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit can be requested for prior authorization and approval.

EPSDT prior authorization requests may be ordered by the child's physician specialist or primary care provider for outpatient BH services deemed medically necessary that are not available in the Idaho Behavioral Health Plan. The EPSDT Authorization Form that can be found on ***optumidaho.com*** is used for this purpose. The physician specialist or primary care provider makes the referral for the specific outpatient behavioral health service needed by the child and the parent/guardian or authorized representative must consent by completing and signing the form. The physician specialist or primary care provider must also complete and sign their sections of the form. Also, sufficient clinical documentation that substantiates the medical necessity of the request must be documented on the form along with any attachments necessary to substantiate how the requested outpatient behavioral health services will:

- Maintain, correct, or improve the child's condition, and
- Demonstrate that the service requested is safe, and effective, and
- Show the service requested meets acceptable standards of medical practice.

The EPSDT Request for Treatment Services must be prior authorized by Optum Idaho prior to treatment and payment for the treatment/service. When EPSDT outpatient behavioral health treatment service is requested, Optum will require information to substantiate the request which includes:

- Describe the member's specific assessed needs that require the service being requested AND how the service will maintain, correct or improve the child's condition.
- Document the name and a descriptive summary of the service(s) being requested and the necessary qualifications of the provider for these services.
- Describe the goals & objectives that will be addressed by the service being requested, along with the expected outcome of the service.
- Requested dates of service, frequency and duration of this service (note: services will not be backdated from approval date).
- Describe the specific goals/objectives which CANNOT be met without this service.
- Provide a list of the Behavioral Health Services the member is currently receiving, along with the names and credentials of these providers.
- Provide a list of other specialized Medicaid Services that this member receives such as DD Waiver Services, Personal Care Services, etc.
- If the member has received inpatient or residential level care for their Behavioral Health Needs in the last 6 months, please provide this information, and submit the information from the discharge report including discharge recommendations.
- Submit the most recent psychiatric assessment date & recommendations that have been completed within the last 6 months.
- Submit the most recent Comprehensive Diagnostic Assessment/Update for this member.
- For children and adolescents: The state-approved functional assessment tool results from the last 90 days: Child and Adolescent Needs and Strengths (CANS) Functional Assessment Tool

Out of Network Requests

If there is no Optum provider in the area to serve a member, Optum will work with out-of-network (OON) providers to develop an agreement to serve that member and will attempt to engage that provider to join the network to ensure other members in that area receive the services they require. However, all out-of-network services do require provider-specific prior authorization.

For additional information, please contact the Optum Idaho clinical team.

4.19 Optum Member Services and Crisis Line

A mental health crisis is a crisis situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress due to psychiatric symptoms associated with mental illness or substance use disorder(s). These persons may be considering self-harm or harm to others, be disoriented or out of touch with reality or have a compromised ability to function or are otherwise agitated and unable to self-calm. An immediate response to their circumstances is needed.

The Optum Member Services and Crisis Line, answers calls for members enrolled in the IBHP 24 hour a day, 7 days a week, 365 days a year. The Optum Member Services and Crisis Line number **1-855-202-0973** is published and promoted via the ***Optum Idaho*** website, the Member Handbook and through providers. This service provides crisis triage and crisis counseling and emphasizes keeping a member supported and in the community. This is accomplished through live crisis counseling on the phone, coordination with applicable law enforcement, emergency room staff, crisis centers, mobile crisis providers, and community resources as available and clinically indicated. Trained clinical staff work with members directly on the phone to help keep them safe, assist them to manage symptoms and make plans with the member to reach out for support from their provider, NAMI, Peer Support, and other community-based resources. Hospitalization is only used when it is determined the member is an imminent danger to self or others.

Optum Member Services and Crisis staff generate a comprehensive log on a daily basis describing crisis calls received. This report includes pertinent member identification information, the nature of the crisis, and the member's disposition. The log enables the Optum Care Advocate or Field Care Coordinator to contact callers the following day to ascertain their status and determine if further action is needed. This ensures that the caller has received clinical support if they have not already contacted their provider. When clinically indicated, the Optum Care Advocate will make contact with the member's provider.

Providers should speak with their members directly as soon as possible to ensure the member's crisis has been resolved. Providers' responsiveness to members whether by phone or in person when there is a crisis should include reviewing and updating the member's existing crisis plan. The provider should also assess the member's ability to implement strategies to prevent a crisis in the future. Providers should arrange follow up professional services and contact the member to ensure no further assistance is needed.

Optum also proactively identifies members who are at high risk of a crisis or hospitalization. Care Advocates and Field Care Coordinators reach out to providers of these members to coordinate care and develop treatment plans and discuss interventions to minimize the risk of those members in crisis and seeking crisis services. Optum continually assesses network providers' compliance with contracted performance requirements via provider auditing of medical records and utilization management data reviews. This includes evaluation of crisis services listed in their contract.

4.20 Affirmative Incentive Statement

Optum expects all treatment provided to Optum members are outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. Optum 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.

4.21 Eligibility Inquiry

The services a member receives are subject to the terms and conditions of the IBHP. It is important that you inquire about what services are covered and the member's enrollment status and obtain required prior authorizations (unless there is a clinical extenuating circumstance that is a barrier to doing so) before providing services. This will help to ensure that you see members eligible to access this Agreement and the services you provide. Deceased members are not eligible for services and providers will not receive reimbursement for services provided after the member's date of death.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

We encourage you to use ***Provider Express*** "Secure Transactions" to conduct eligibility inquiries. This service is only available to Optum-contracted providers who are registered with Provider Express. Select the "First-time User" link in the upper right-hand corner of the home page and follow the prompts. You may also inquire about eligibility by calling the Optum Idaho Provider Services phone number **1-855-202-0983**. Be prepared to provide the following information: the member's name, address, and identification number. In addition, in the event that an authorization is required but is not already in place, providers may initiate a request for pre-authorization of routine outpatient services online.

In addition to contacting Optum to inquire about eligibility, we encourage you to discuss with the member the importance of keeping you informed of changes in coverage or eligibility status. Optum will not always have the eligibility information at exactly the same time as the organization that controls the eligibility decisions. The Agreement states that if an individual was not eligible for coverage for services rendered, those services shall not be eligible for payment by Optum. Medicaid members do not carry any financial burden if services are provided and not covered.

Pharmacy Benefits

Pharmacy benefits are not managed by the IBHP. For information about formularies, pharmacy benefits and cost management programs, please contact the Idaho Medicaid office at **1-888-528-5861**.

Section **5**

Utilization Management Guidelines

Optum Idaho's Utilization Management Program is intended to improve provider practice in real time through consultations about care that are informed by our evidence-based ***Optum Idaho Level of Care Guidelines***, Level of Care Utilization System (LOCUS), Behavioral Clinical Policies, the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), Early Childhood Service Intensity Instrument (ECSII), the American Psychological Association (APA) Psychological and Neuropsychological Testing Billing and Coding Guide and American Society of Addition Medicine (ASAM) Criteria® for all levels of care. The evidence base for the Optum Idaho Level of Care Guidelines includes generally accepted national standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs). Optum's guidelines also inform discussions about appropriate alternative services or levels of care and inform coverage determinations.

Optum bases medical necessity coverage determinations on the individual's signs and symptoms, whether the services or level of care can meet the individual's immediate needs; whether appropriate alternative services or levels of care are available in the service system to meet those needs, and whether the proposed services or level of care are in accordance with the individual's person-centered plan including advanced directives. These guidelines are used to ensure that services authorized are sufficient in amount, duration, and/or scope, and can reasonably be expected to achieve the purposes for which the services are provided. ***The Optum Idaho Level of Care Guidelines*** are finalized in collaboration with the IDHW.

The Level of Care Utilization System (LOCUS), the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and the Early Childhood Service Intensity Instrument (ECSII) are nationally recognized tools that the Optum Idaho Utilization Management (UM) Team will be using when evaluating clinical criteria decisions and determining medical necessity for ONLY mental health Intensive Outpatient Program (IOP) and the mental health Partial Hospitalization Program (PHP). These tools are strictly

CLICK HERE TO RETURN TO TABLE OF CONTENTS

being utilized as UM tools for IOP and PHP as these two services have national standards rather than state-specific standards. These tools will not be used to determine a diagnosis or functional impairment for any member; they are only being utilized for UM purposes.

Providers are not expected to use these tools but are welcome to review the training and guidance being provided to the Optum UM team if they would like to understand the process and tools for utilization management. For additional information, please visit ***Provider Express*** > Clinical Resources > Guidelines and Policies > Adoption of LOCUS CALOCUS-CASII ECSII.

The evidence base for the ***Optum Idaho Level of Care Guidelines*** includes generally accepted national standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs). The IBHP criteria and guidelines are applied to all utilization management decisions. Requirements established by the IDHW, including that criteria and guidelines be clearly written, objective and evidence-based whenever possible, are the basic standards on which the criteria and guidelines are evaluated.

Optum Idaho Level of Care Guidelines are posted on the Optum website, updated at least annually and are available to any interested party such as providers and members in writing at their request. The ***Member Handbook*** provides a simplified version of all guidelines used by Optum and the provider network. These guidelines are reviewed annually through the QAPI Committee structure.

The Optum Idaho Level of Care Guidelines are based on the following principles:

- **Care Should Promote the Member's Recovery/Resiliency**: Members have the right to be treated with respect and recognition of their dignity, strengths, preferences, right to privacy, and unique path to recovery. Members also have the right to information that informs decision making, promotes participation in treatment, enhances self-management, and supports broader recovery/resiliency goals.
- **Care Should be Effective**: There must be a reasonable expectation that evidence-based treatment delivered in the appropriate level of care improves the member's presenting problems within a reasonable period. Effectiveness is measured by the improvement in treatment and the risk of the member's condition likely deteriorating if treatment were to be discontinued. Improvement must also be understood within a recovery/resiliency framework where services support movement toward a full life in the community. Specific measures of effectiveness and progress should be documented in the member's chart and upon any submission of a pre-service request.
- **Care Should be Accessible**: Ideal clinical outcomes result when access to the most appropriate and available level of care is facilitated upon admission to care and when transitioning between levels of care. A member's transition between levels of care should be timely and occur in a safe manner, and pertinent clinical information should be communicated to the provider at the next level of care.
- **Care Should be Appropriate**: Optimal clinical outcomes result when evidence-based treatment is provided in an appropriate level of care that is available, structured and intensive enough to adequately treat the member's presenting problem and support the member's recovery/resiliency. Evidence-based treatments are interventions that have been shown to be safe and effective, not been deemed experimental or investigative, and are appropriate for the treatment of the member's current condition.

Treatment planning should consider significant variables such as the member's current clinical need, age and level of development, functional needs, and identified strengths. It should also include whether the proposed services are covered in the member's benefit plan and if the proposed forms of treatment are appropriate. The frequency and duration of treatment should be evidence-based and available in or near the member's community. Community resources such as self-help and Peer Support groups, consumer-run services, and preventive health programs, can also augment treatment.

A change in a member's condition should prompt an updated treatment plan and selection of the appropriate level of care. When a member's condition has improved, the reassessment should determine if a lower level of care may safely and adequately treat the member's current condition, or if the member no longer requires treatment. When a member's condition has not improved, or it has worsened, the reassessment should determine the accuracy of the diagnosis. The reassessment may also address whether the treatment plan should be modified, or the member's condition should be treated in another level of care. However, failure of treatment in a lower level of care is not a prerequisite for authorizing coverage for a higher level of care. Authorizing coverage of a level of care is dependent on the request for services meeting the criteria of medical necessity.

Idaho-Specific Criteria and Guidelines

It is critical that the clinical criteria and guidelines developed and implemented for the IBHP be appropriate—both for the services included in the benefit plan and for the people who use those services. The guidelines will be reviewed at least annually.

Direct and Timely Access to Services

The utilization management process for the IBHP is designed to encourage members' direct access to outpatient mental health and substance use treatment. The utilization management process also ensures that individuals have timely access to services. In particular:

- The behavioral health provider is required to encourage the member to visit a Primary Care Provider regularly and to authorize the sharing of behavioral health information with the Primary Care Provider.
- Optum requires no prior authorization for some initial behavioral health services, such as treatment evaluations, which is the first step in seeking treatment.
- Optum enables the provider to offer an array of routine outpatient services, such as psychotherapy. This enables the provider and the member to use the treatment modalities most appropriate for the member as the member progresses in treatment.

Long-term Services and Access to Several Services Concurrently

While the benefit package for the IBHP contains some requirements for authorization of new services and the continuation of services, Optum recognizes the need for some members to receive services for an extended period of time. Some members may require access to several services concurrently. Nothing in the Optum benefit package limits the member's access to covered services as long as the services are medically necessary. These needs are recognized for both children and adults.

Timeliness of Decisions

The timeframe for Optum to respond to outpatient service requests is 14 calendar days from the day the request is received by Optum to the day the determination letter is mailed. Optum takes steps to address the timeliness of utilization management decisions made on the basis of medical necessity. Optum requires that a provider be notified immediately by telephone if an expedited/urgent service request is not approved. All other determinations result in either authorization which are sent to the provider or written adverse determinations which are sent to both the provider and the member within 14 days.

Providers may cancel a request for a variety of administrative reasons, such as the member is no longer available to participate in the service, the service is no longer necessary, or there is an identified error on the service request form. In those circumstances, Optum notifies the member via mail of the decision to cancel that was made by the provider.

Limitation, Modification or Denial of Payment

Optum limits/modifies payment to only those services authorized and approved for reimbursement (for example, basic outpatient services that require no authorization) under the guidelines which Optum has developed and the IDHW has approved. Optum understands that any denial of payment for services funded through the Medicaid capitation payment is subject to appeal to the IDHW pursuant to standards in both state administrative rules and the State Plan or waiver.

Involvement of Practicing Providers and Nationally Recognized Standards

Optum core clinical criteria and guidelines were developed by nationally recognized experts and organizations and have been adopted to provide objective and evidence-based admission and continuing stay criteria. The criteria and guidelines are based on the following components and are reviewed annually to reflect new scientific evidence as well as:

- The broad clinical experience of Optum staff

CLICK HERE TO RETURN TO TABLE OF CONTENTS

- Multi-disciplinary input from the Optum nationwide provider network
- Input from members
- Published references from the industry's most esteemed professional sources, including the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, and from the current version of the Diagnostic and Statistical Manual of Mental Disorders

In developing and updating clinical services and guidelines, Optum also solicits input from members and their families, community advisory committees, specialty practitioners, community-based treatment centers, regional providers and other key stakeholders.

Practitioner Suggestions for Utilization Management Guideline Revisions

Optum provides a forum to receive practitioner suggestions for Utilization Management Guideline revisions at least annually, and documents all changes made subsequent to practitioner input.

The Provider Advisory Committee of the Quality Integrity program is one of the groups responsible to review and submit recommendations for revisions to the utilization management criteria and guidelines each contract year. Practitioners and agencies have other venues to recommend revisions as well, including but not limited to:

- Regional staff meet regularly with Regional Behavioral Health Advisory Boards and include a time for questions and recommendations from providers and others in attendance
- All staff members accept complaints, which are logged into the Optum complaint tracking system
- Optum provides ongoing training for providers, and includes a time during each training session for questions and recommendations from providers
- Optum meets regularly with the IDHW Contract Manager and records suggestions made to the IDHW about the criteria and guidelines or other parts of Optum operations

Optum also has a Peer Review Committee which reports to the Quality Assurance/Performance Improvement (QAPI) Committee. The Peer Review Committee reviews quality of care concerns with specific providers and adverse incidents.

The Chief Medical Officer chairs the Peer Review Committee which is charged with:

- Reviewing quality of care concerns and/or complaints about a specific provider
- Requesting and reviewing provider treatment records in response to quality of care concerns
- Determining appropriate action plan(s) that involve(s) Network Services staff and the provider in question
- Requesting audits of provider offices when indicated
- Following up with provider and agency-specific improvement action plans and incorporating quality of care concerns into the credentialing decision-making process
- Reviewing Critical Incidents/Adverse Events necessitating committee input

Annual Review

Utilization management criteria, which have been customized for Idaho, are reviewed annually through the Quality Assurance/Performance Improvement (QAPI) Committee structure. Optum includes provider involvement in this development, review and modification through their participation in the Provider Advisory Committee.

Guideline Approval and Modification

All guidelines and any modifications made to the guidelines are submitted to the IDHW for approval and are shared with providers at least thirty (30) calendar days prior to implementation of the guidelines. After Optum corporate level clinical committee reviews and approves recommended clinical criteria and guidelines, we submit them to the IDHW for approval. Optum follows the same basic process when requesting approval for any revision of the criteria or guidelines so we can provide at least 30 days' notice before implementing changes.

The IDHW as the Final Authority

Optum recognizes that the IDHW is the final authority for all disputed decisions reviewed through the Medicaid appeals process.

Utilization Management Program Overview

Utilization management is one of the most basic ways in which Optum ensures the quality, appropriateness, and effectiveness of treatment services provided to members of the Idaho Behavioral Health Plan (IBHP). It also is an integral part of Optum network management, quality improvement, and system change efforts. Perhaps most importantly, utilization management is one of the most frequent opportunities for Optum to build strong working relationships with Optum network providers.

Utilization management is the process in which Optum clinicians may interact regularly with providers from mental health and substance use agencies about the needs of the members we jointly serve. It enables Optum Care Advocates and the Chief Medical Officer to reinforce the Optum focus on medical necessity, clinical criteria, evidence-based best practices, and recovery and resiliency.

Based on a member's need, benefit coverage, available community resources, and the protocols outlined in the ***Optum Idaho Level of Care Guidelines***, LOCUS, CALOCUS-CASII, ESCII, Behavioral Clinical Policies, the American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide, ASAM, or other guidelines required by contract or regulation; Care Advocates determine coverage for the most appropriate level of care based upon medical necessity.

It is the goal of Optum to provide for the open exchange of information between professionals and an efficient authorization process as providers deliver medically necessary care to Optum members.

In collaboration with the IDHW, members, and providers, Optum continues to develop, implement, and maintain a utilization management program for the IBHP to monitor the appropriate utilization of covered services and to:

- Simplify the administrative processes for providers, enabling them to devote more staff time to treating members
- Encourage members to access services at the time they first recognize symptoms in themselves or in a family member
- Ensure that all services provided are medically necessary, focused on measurable outcomes, and are supporting the member's recovery and/or the family's resiliency

The prior authorization process is explained in the ***Member Handbook*** and other relevant member materials. The Optum toll-free Member Access and Crisis Line, Customer Service Line and website (***optumidaho.com***) are also available for those who need additional clarification.

The Optum utilization management plan for the IBHP is in full compliance with the requirements in 42 CFR §456.22 for the ongoing evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services. Should the IDHW or CMS direct that we add additional utilization controls, Optum will work with the IDHW to expand Optum utilization management program.

5.1 Utilization Management Begins at Intake

Optum believes that a "no wrong door" approach is the best way to ensure that members or their families can access services at the time they first recognize symptoms. Therefore, Optum Idaho has intake policies that facilitate immediate access to treatment:

- A member can simply contact a network provider's office and request an appointment.
- A family member can contact a network provider's office and request an appointment for a member.
- The Optum Idaho Member Access and Crisis Line is available 24 hours a day, 365 days a year, and provides a member or family member with immediate contact with someone who can help identify a network provider most appropriate to the member's needs and preferences. If requested, Optum Idaho will contact the provider

on the member's behalf and finalize arrangements to help the member get to the provider's office or emergency/crisis services.

Member Intake

At the time of the first appointment, the clinician must complete a Comprehensive Diagnostic Assessment (CDA). Authorization is not required to complete the CDA and any standardized assessments.

In addition to the diagnostic assessment, to guide treatment for children and youth diagnosed with serious emotional disturbance (SED) and adults recovering from a Severe and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI), the provider is required to utilize a functional assessment tool when appropriate to identify the member's strengths and needs. The provider will utilize the (CDA) and a functional assessment tool to guide individualized treatment planning and to make recommendations for an array of services based on the severity and complexity of the member's symptoms and needs. The functional assessment tool can be administered by a provider who is certified/licensed to administer the specific assessment tool.

Idaho Department of Health and Welfare has selected The Child and Adolescent Needs and Strengths (CANS) assessment as the functional assessment tool to be used for children and adolescents under the age of 18 receiving Medicaid benefits. There is no specific functional assessment tool which is mandated for adults, but one is required to be used.

If a provider identifies the need to administer a specialized assessment to further understand the member's substance use concerns, the provider may administer the GAIN or another specialized SUD assessment tool. CDAs that are completed for members with a SUD need identified will need to include the six ASAM dimensions. As of July 1, 2019, CDAs that are completed for members with an identified substance use need will need to include the six ASAM dimensions. Providers may still administer a Global Appraisal of Individual Needs (GAIN) or another appropriate assessment tool to meet this requirement.

- For additional information on the CANS go to: ***praedfoundation.org***.
- For additional information on GAIN-I Core go to: ***Global Appraisal of Individual Needs***

Before or after the member's first appointment with the provider, the member must be asked to complete the Optum Wellness Assessment without assistance or coaching by the staff. Wellness Assessments are available in adult and youth versions, and in English and Spanish.

The Adult Wellness Assessment is designed for adult consumers age 18 or older. However, clinicians are free to use their discretion and use the Adult Wellness Assessment with older or emancipated adolescents when clinically appropriate.

The Youth Wellness Assessment is designed as a parent/guardian completed report measure so may be used with children as young as 5 years. However, if the youth is being asked to complete the form themselves, we recommend using the form with youth aged 12 or older.

If the member refuses or is unable to complete the Optum Wellness Assessment at the time of the initial session, the network provider is still allowed to submit an Idaho Service Request Form (SRF) to request the member's needed service(s) if it requires prior authorization. However, the provider is encouraged to work with the member to try to complete the Optum Wellness Assessment, as it's strongly preferred as a component of comprehensive care management.

The provider with the member/member's family will utilize the comprehensive diagnostic assessment in conjunction with the appropriate functional assessment tool to develop individualized treatment plans within 10 days of initiating services.

Treatment plans shall contain the following:

- A statement of the overall goal of treatment as identified by the member/member's family.
- Concrete, measurable treatment objectives to be achieved by the member, including time frames for completion.
- The specific evidence-based interventions or modalities that will be used to achieve the member's goals and objectives of treatment.

- A substantiated diagnosis
- Documentation of or referral to a primary care physician, if the member has not had a history and physical examination within the last twelve (12) months, and to assist the member with receiving an annual examination thereafter.
- The person responsible for providing the treatment/ intervention, and the amount, frequency and expected duration of service.
- Treatment plans should address needed linkages with all other services, supports and community resources as indicated necessary by the member/member's family.

Pre-Service Review

A prior authorization review to determine approval of services, in whole or in part, in advance of the member obtaining services. The pre-service review process will be conducted in response to a request for care or services in advance of a member receiving the care or services. Pre-service review may be requested on a non-urgent or urgent (expedited) basis.

Service Request Form (SRF)

Benefits that require pre-service review and authorization require that the provider submit a service request form to Optum prior to provision of the service. Optum has a provider portal available for submitting SRFs at ***Provider Express*** or on the Optum Idaho website at: ***optumidaho.com***. A pre-service review may be requested on a non-urgent basis or on an expedited basis within 72 hours when required due to the member's condition.

When continued services are medically necessary, providers are expected to request additional services in advance of the expiration of the current authorization, with requested dates that do not overlap the existing authorized services. For example, if you have an existing authorization in place for January 1st through March 31st, and you are requesting continued services, the next authorization's requested effective date should be April 1st.

Authorization for additional services must be requested following the same process that was required to request authorization to initiate those services.

Once a request for prior authorization is submitted, providers may withdraw a request for a variety of administrative reasons, such as the member is no longer available to participate in the service, the service is no longer necessary, or there is an identified error on the submissions.

Providers may withdraw a request for prior authorization in one of two ways:

- Electronically through the Service Request Form Portal either on ***Provider Express***, or you may access the portal also on ***optumidaho.com***. You may withdraw a request up until the time the case status is "Under Review by Optum"

OR

- Any time prior to the scheduling of a peer review by calling us at **1-855-202-0983** and pressing "1" to speak to a Care Advocate about canceling a request.

Optum will process requests for pre-service authorizations using standard or expedited review processes:

Standard Review

Coverage determinations for non-urgent cases will be made within 14 days, which you're requested service start dates should reflect. Providers will be notified in writing of non-urgent determinations.

Expedited Review

Coverage determinations for urgent/expedited cases will be made within 72 hours of the receipt of a telephonic or written request. Expedited service authorizations are intended for cases where the provider, attending health care

CLICK HERE TO RETURN TO TABLE OF CONTENTS

professional, attest that following the standard timeframe could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function. Providers may request an expedited review by submitting their Service Request via ***Provider Express*** and then calling ***Optum Idaho*** at **1-855-202-0983** and pressing "**1**" to speak to a Care Advocate about an expedited review. Hours of operation are Monday through Friday, 8 a.m. – 6 p.m. MT.

Retrospective Review

A retrospective review may be requested when extenuating clinical circumstances prevent the provider's ability to obtain a required pre-service review and prior authorization, and no claim has yet been filed. When a claim has been filed and provider seeks reimbursement, please see the provider dispute process later in this manual. Retrospective reviews are always considered to be non-urgent issues. (See "Retrospective Review Process" below.)

Peer Review

Because Care Advocates may authorize services but may never deny, a clinical review conducted by Peer Reviewer at the doctoral level. The Peer Reviewer conducts the review to determine whether or not a non-coverage determination is warranted.

Peer to Peer Conversation

After receiving an adverse benefit determination, but before an appeal application is completed, providers may opt to request a Peer-to-Peer conversation to receive details about the determination made. Instructions for scheduling a Peer-to-Peer conversation can be found on the provider's copy of the Adverse Benefit Determination letter. These conversations may be helpful when deciding, along with the member, whether an appeal may be indicated. The intent of the Peer-to-Peer conversation is not to reverse the determination, but to clarify the clinical considerations addressed in the review.

Administrative Review

In the event that a request involves a service that may not be a covered benefit, the case is referred to the Clinical Program Manager or designee for an administrative review. The Clinical Program Manager or designee makes all administrative denials based on the benefit coverage outlined in the Member's Certificate of Coverage or Summary Plan Description.

5.2 Required Assessment

Comprehensive Diagnostic Assessment (CDA)

The initial evaluation for treatment or comprehensive diagnostic assessment (CDA) is completed by a clinician. No specific instrument is required for the diagnostic assessment; however, the assessment should include:

- Presenting problem
- Behavioral health treatment history, including family history
- Medical history, including family history
- Complete DSM-V diagnosis
- Mental Status Exam
- Risk assessment
- When a substance use concern is identified during the assessment process, the provider must include the six ASAM dimensions in the CDA. Please note a GAIN can be used to fulfill this requirement. The ASAM assessment and placement determination must be completed by an individual trained in the ASAM Criteria® multidimensional assessment process and level of care placement decision making. The six ASAM dimensions are:
  - » **Dimension 1**: Acute Intoxication and/or Withdrawal Potential
  - » **Dimension 2**: Biomedical Conditions and Complications

  - » **Dimension 3**: Emotional, Behavioral, or Cognitive Conditions and Complications
  - » **Dimension 4**: Readiness to Change
  - » **Dimension 5**: Relapse, Continued Use, or Continued Problem Potential
  - » **Dimension 6**: Recovery/Living Environment.
- Assessment of spiritual and culture variables impacting treatment
- For children and adolescents, a developmental history is documented
- When applicable, medication information including prescriptions or refills, medication education and informed consent
- Recommendations

Child and Adolescent Needs and Strengths (CANS)

The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose functional assessment tool developed for children's services to support decision making, including recommendations for an array of services based on the severity and complexity of the member's symptoms and needs; treatment planning; to facilitate quality improvement initiatives; and to allow for the monitoring of outcomes of services. The CANS should be administered with youth and family engagement, and results must be reviewed with the youth and family. The CANS is designed to follow the course of the member and family from system access to goal attainment and transition. This functional assessment tool is used to communicate the shared vision throughout the system. All treatment plans that address a functional need (i.e. Psychotherapy) must be based on the CANS. The CANS is required prior to a child or adolescent member receiving any outpatient behavioral health services except those services that do not address a functional need. Services that do not require a CANS are as follows: Neuro/Psychological Testing, Medication Management, and Crisis Services.

The initial or annual updated CANS can be completed in conjunction with an initial or updated Comprehensive Diagnostic Assessment (CDA), by the Independent Assessor or the treating clinician, and entered in the ICANS platform. If the CANS is completed by a bachelor's level provider, an Independent Assessor or the treating clinician will need to conduct the CDA. The results of the CANS entered into the ICANS platform guides person-centered service plan development and additional specific treatment plans. Therefore, each member should only have one CANS and one person-centered service plan that follows the member through the system of care. The provider delegated to update the CANS may vary (see CANS provider qualifications). For example, for one member the assigned targeted care coordinator will update the CANS and for another member, it may be the treating clinician. The member's team should collaborate to identify what works best for the member and member's family being served.

CANS updates must be completed at least every 90 days or more frequently as necessary based on the member's needs, the request of the family, or if there is a change in condition. The provider who is completing the CANS should be working with the family. When a CANS update identifies that changes in treatment are necessary, then the member's person-centered service plan and specific treatment plans must be modified.

Providers seeking to become certified to administer the CANS can register on the Praed website: ***praedfoundation.org***.

The CANS is only reimbursable if entered into the ICANS platform, which is owned and operated by the Division of Behavioral Health. For more information on ICANS, visit: ***icans.dhw.idaho.gov***.

For additional information regarding the Provider Qualifications and Responsibilities, please see the CANS Service Section in this manual.

Wellness Assessment (WA)

The one-page 24 item (25 items for youth) Wellness Assessment (WA) is completed by the member or guardian at the initial outpatient appointment and returned to Optum via the fax number indicated on the form. The tool may be obtained in both Spanish and English at ***Wellness Assessments***. A second WA is completed between session three and five. The Wellness Assessment is further described later in this document.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

5.3 Member Appeals, State Fair Hearings and Retrospective Reviews

Member Appeal Process

The Appeal process is available to members, or their authorized representative with their written permission, which may be their legal guardian, other person of their choice, or provider at any level of care, in the event of an Adverse Benefit Determination when a claim for the appealed dates of service have not been filed. If Optum issues an Adverse Benefit Determination, in whole or in part, then such determination will be subject to the applicable appeal process concurrently, if specifically requested, providers may ask to discuss the determination with an appropriately licensed peer reviewer. For all services requiring a prior authorization, a request must be made and approved prior to providing the requested service and submitting a claim. If a member appeal is filed after a claim is submitted, the request will be subject to the provider dispute process.

The procedures for the member appeal process, i.e. how to file a member appeal and where to send it, are listed below. It is important to note that during this process the member or their representative has the right to submit any additional or new information to the medical reviewer for their reconsideration of the original determination made. The provider or authorized representative must have the written member consent to file an appeal. This must be made available to Optum upon request. Member appeals may be handled as urgent or non-urgent.

Urgent timeframes apply in situations where, in your opinion, application of non-urgent procedures could seriously jeopardize the member's life, health or ability to regain maximum functioning. To initiate an urgent appeal, contact Optum immediately at **1-855-202-0983** and press prompt **4**. Provider-initiated urgent appeals by phone must be followed up with a written request. For an urgent appeal, Optum will make the review determination, notify you by telephone, and send written notification of the outcome to you and the member or authorized member representative within 72 hours after receipt of the request. By definition, urgent appeals are not available in situations where services have already been provided.

A non-urgent appeal must be requested within 60 calendar days from the date the Notice of Adverse Benefit Determination is mailed. Optum will make a determination and notify you and the member or the authorized member representative. This notification will be provided as expeditiously as the enrollee's health condition requires in writing and sent within 30 calendar days from receipt of the request.

If you have received an authorization letter or a Notice of Adverse Benefit Determination and you wish to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, please follow the instructions in the letter and call the toll-free number provided in the letter. Authorization is not a guarantee of payment (except as required by law), payment of benefits is still subject to all other terms and conditions of the member's plan and your Agreement.

A clinical peer reviewer who has not previously been involved in the Notice of Adverse Benefit Determination and is not a subordinate of the person who made the initial decision will review the appeal request. The reviewer will review all available information, including treatment records, to make a determination. For a case involving a clinical determination, the reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted license. For non-clinical administrative appeals, the reviewer will be an appropriately qualified Optum professional who was not involved in the initial Notice of Adverse Benefit Determination and who is not a subordinate of any person involved in the initial decision.

If the decision is to uphold a Notice of Adverse Benefit Determination, Optum will notify you and the member, or the member representative, of the outcome and any additional levels of review that are available, as applicable.

Members only have one appeal option with Optum and must exhaust that appeal option before being eligible to file a State Fair Hearing (see State Fair Hearing section below). If Optum fails to adhere to the notice and timing requirements, the member is deemed to have exhausted Optum's appeal process.

Instructions for Filing a Member Appeal

An appeal can be requested orally by the member, provider, lawyer, or other trusted party by calling the Optum Member Line at **1-855- 202-0973**. The provider or authorized representative must have the written member consent to file an appeal available upon request. An Optum Appeal Request form is included in the clinical Adverse Benefit Determination letter sent to the member and provider. An appeal may be requested orally, by using the Optum Appeal Request form or by sending the request in a letter with the following information:

- Member identifying information:
  - Name
  - Medicaid Identification Number (MID)
  - Date of birth
  - Address
- Each applicable date of service
- Your identifying information:
  - Name
  - Tax identification number
  - Contact information
- Any additional information you would like to have considered as part of the Appeal process, including records relating to the current conditions of treatment, co-existent conditions, or any other relevant information
- Your explanation as to why the adverse decision should be overturned

Where to Submit a Member Appeal

- Mail: Optum Idaho, 322 E Front Street, 4th Floor, Boise, ID 83702
- Fax: 1-855-272-7053
- Email: *optumidaho.appeals_grievance@optum.com*
- For questions or assistance, call **1-855-202-0983** and press prompt **4**.

State Fair Hearing Process

The member has the right to request a Fair Hearing with IDHW if they are not satisfied with an Optum Appeal decision. Members must exhaust the one appeal option before being eligible for a State Fair Hearing.

Fair Hearing requests must be in writing and must be filed within 120 days from the date of the appeal resolution from Optum. The member may choose to have someone help them with this such as their legal guardian, or a provider.

The Fair Hearing Request form is included in the member's appeal resolution letter. You may use the Fair Hearing Request form or send the request in a letter. The request for a State Fair Hearing is sent directly to the State; and processed by the State.

The request for a Fair Hearing must explain why the member disagrees with the Optum appeal decision and include any additional information that should be considered. Include a copy of the Optum appeal resolution letter. State if the member wants to continue to receive the service being appealed. To continue receiving services, a member must request a State Fair Hearing within ten (10) days of the postmark date on the Optum appeal resolution notice and check the box on the State Fair Hearing form that indicates that the member wants to continue to receive the service pending decision by the State Fair Hearing Officer.

If benefits are continued by the member, and the hearing officer decides that an Optum adverse benefit determination was correct, such benefits will not be reimbursed in the event the appeal decision is upheld, or Optum may take action to collect the cost of those benefits as allowed by ***42 CFR 431.230(b)***.

To Submit a Fair Hearing Request

Notify IDHW in writing or complete a 'Fair Hearing Request Form'. The form is included with the member's Optum appeal resolution letter. The form is also available at any Health and Welfare local office or via email at: *mybenefits@*

CLICK HERE TO RETURN TO TABLE OF CONTENTS

dhw.idaho.gov. Include a copy of the Optum appeal resolution letter with your State Fair Hearing request. You can bring your appeal to any local Health and Welfare office, fax or mail it to:

- Mail: Administrative Procedures Section Hearing Coordinator
  Idaho Department of Health and Welfare
  P.O. Box 83720
  Boise, ID 83720-0036
- Deliver To: 450 West State Street, 10th Floor, Boise, ID 83720-0036
- Fax: 1-208-639-5741
- Email: *APS@dhw.idaho.gov*

Retrospective Review Process

A retrospective review may be requested when extenuating clinical circumstances (e.g. member eligibility, coordination of benefits) prevent the provider's ability to obtain a required pre-service review and prior authorization, and a claim has not been filed. If a retrospective review is filed after a claim is submitted, the request will be subject to the provider dispute process. Retrospective review requests must be submitted within 365 calendar days following the date(s) of service. For all retrospective reviews, Optum will issue a written determination within 30 calendar days of receipt of the request.

The Retrospective Review request process must be initiated in writing by contacting Optum at the address listed below and must include the following information:

- Member identifying information:
  - » Name
  - » Identification number
  - » Date of birth
  - » Address
- Service type
- Dates and units of service requested retrospectively
- Your identifying information:
  - » Name
  - » Tax identification number
  - » Contact information
- Any additional information you would like to have considered as part of the retrospective review, including records relating to the current conditions of treatment, co-existent conditions, or any other relevant clinical information which may justify the medical necessity of the service requested per the ***Optum Idaho Level of Care Guidelines***
- Your explanation as to why a prior authorization was not requested in advance of the provision of the service

Where to Submit a Retrospective Review

- Mail: Optum Idaho
  Attention: Retrospective Review
  322 E. Front Street, 4th Floor
  Boise, ID 83702
- Fax: 1-888-950-1182
- Email: *optum.idaho.provider.dispute@optum.com*

For questions or assistance, call **1-855-202-0983** and press prompt **4**.

A clinical review process will be initiated upon receipt of all information necessary to process a timely filed retrospective review request and will result in a determination that is noticed to the provider and member. The provider's right to dispute this determination then applies And will be subject to the member appeal process, or, if a claim was submitted, to the provider dispute process.

Section **6**

Quality Improvement

6.1 Participation in the Optum Idaho Quality Assurance and Performance Improvement Program

We are committed to the highest quality of care provided in a manner consistent with the dignity and rights of members and to meeting or exceeding customer expectations. Our Quality Assurance and Performance Improvement (QAPI) Program monitors: accessibility; quality of care; appropriateness, effectiveness and timeliness of treatment; and member satisfaction. The QAPI Program is comprehensive and incorporates the review and evaluation of all aspects of the behavioral health managed care delivery systems. If you have any feedback regarding QAPI projects and processes or are interested in participating in any QAPI committees, please contact Optum Idaho Network Management at **1-855-202-0983**.

Compliance with the QAPI Program is required in accordance with your Agreement, including cooperation with Optum and IDHW in their efforts to adhere to all applicable laws, regulations and accreditation standards.

The key components of the QAPI Program required of you as a participating provider include, but are not limited to:

- Ensuring that care is appropriately coordinated and managed between you and the member's primary medical physician and other treating clinicians and/or agencies.
- Cooperation with On-site Audits and requests for treatment records.
- Cooperation with the member complaint process (e.g., supplying information necessary to assess and respond to a complaint).
- Cooperation with the Achievements in Clinical Excellence (ACE) program (formerly called Campaign for Excellence (CFE)).

(Please refer to the "**Achievements in Clinical Excellence (ACE) Clinicians**" section of this manual for more information.)

- Responding to inquiries by our Quality Improvement staff.
- Participation in Quality Improvement initiatives related to enhancing clinical care or service for members.
- Submission of information related to an Optum review of potential quality of care concerns and critical incidents.
- Helping to ensure members receive care that is consistent with national performance measures including rapid follow-up upon discharge from an inpatient level of care.

Upon request, Optum makes information available about the QAPI Program, including a description of the QAPI Program and a report on our progress in meeting goals. Some of the activities that may involve you are described in more detail below.

6.2 Achievements in Clinical Excellence (ACE) Clinicians

ACE for Solo Clinicians and Group Practices

ACE Clinicians recognizes in-network individual and group practices based on effectiveness and efficiency metrics after the threshold for volume of Member Wellness Assessments has been met. Data for inclusion in ACE Clinicians program with a Platinum designation is run annually and clinicians are notified when they achieve Platinum recognition or when there is a change in recognition status.

Criteria for Inclusion in Achievements in Clinical Excellence

Network clinicians must have a minimum of 10 cases and group providers must have a minimum of 20 cases for the measurement period (two years) in which the initial Wellness Assessment for each of those 10/20 cases measured in the clinical range for global distress. In addition, each of those 10/20 cases must have submitted at least one follow-up Wellness Assessment attributable to each of those cases.

Access and Tracking ACE Scorecards

Network clinicians and group providers who achieve Platinum status are eligible for a number of rewards including performance-based contracting and recognition on Clinician directories. For more information please see our "ACE Clinicians" page on ***Provider Express***.

Clinicians and group providers will be able to view their scores by logging into ***Provider Express***: > Providers Report > Achievements in Clinical Excellence on their dashboard. ACE metrics will be calculated annually and shared with you in the 4th Quarter. Providers have a 60-day period to review their data prior to public recognition on ***liveandworkwell.com***.

Network clinicians and group providers may request a review of their data by submitting an ACE Review Request Form. In order to ensure a timely review, please submit your review request within 30 days of being notified of your ACE score.

6.3 Wellness Assessments

The Optum Wellness Assessment provides information that is critical to the algorithmic analysis of a member's clinical and medical condition, need for treatment, and progress in treatment. Members must be asked to complete the Optum Wellness Assessment each time their provider requests authorization to provide services. The provider must fax in the completed Wellness Assessment where the information becomes part of the clinical information in

the member's record. The WA includes a range of questions to measure symptom severity and overall well-being, and screens for functional impairment, substance use disorder and medical co-morbidity risks. The following process is for IBHP members who are receiving routine behavioral health outpatient services:

- You provide the one-page WA to each new IBHP member, or to the parent/guardian of a child or adolescent patient
- You promptly return each completed WA to Optum as instructed on the form
- A second WA is administered between session three and five. Optum reviews the WA and alerts you if a targeted risk is identified. You will either be notified by letter, or contacted by a Care Advocate to discuss the case and/or assist in coordinating additional services
- A follow-up WA will also be sent by Optum directly to the member approximately four months after the initial evaluation

The information contained in the Wellness Assessment (WA) is confidential and will not be shared without the member's consent. A member may also decline to participate. If this occurs, submit a WA to Optum by completing the clinician and member demographic sections and filling in the "MRef" (Member Refusal) bubble located in the top demographic section of the WA. In the case of members who are minors (except for those who are emancipated or able to consent to their own treatment under the laws of your state), the parent or guardian should be asked to complete the form.

The two versions of the Wellness Assessment, Adult and Youth, are also available in Spanish. WA forms can be obtained from ***Provider Express*** or by calling the Forms Hotline at **1-800-888-2998** ext. **5759**. You may go to ***Provider Express*** for detailed information about ***Wellness Assessments***.

6.4 Clinical Outcomes Model

Clinical- and Claims-based Algorithms

The Optum Wellness Assessment is a key component of the Idaho clinical outcomes model and for that reason; all providers are required to ask all members to complete the Assessment at the initiation of treatment and to monitor treatment progress whenever the provider requests authorization to continue treatment. The Optum Wellness Assessment supports the following:

- **Risk stratification of members** – Using a series of algorithms identifies initial member risk based on the member self-report. This is used in combination with other data to refine the determination of that individual member's/level of risk.
- **Monitoring of progress in treatment** – Optum Care Advocates receive flags whenever the system identifies potential issues with a member's medical condition or progress in treatment. Through the Wellness Assessment Dashboard, providers also have access to the information generated by the Wellness Assessment to self-monitor and manage the member's outcomes and progress in treatment.
- **Monitoring of progress in treatment** – With data from the Wellness Assessment, Optum Quality Improvement (QI) staff are able to measure and report clinical outcomes for the membership of the IBHP.
- **Clinician Effectiveness** – The data from the Wellness Assessment is key to measuring clinician effectiveness. Provider measures provider and provider group severity adjusted effect size every quarter. The effect size is a standard measure in the social sciences for measuring the effectiveness of treatment. The data from the Wellness Assessment shows the amount of change a provider's patients have reported. Regression modeling is then applied to adjust the change reported given the member's initial severity. Finally, the provider's overall effectiveness is measured using the severity-adjusted effect size. By using this methodology Optum is able to compare providers and determine if a specific provider has demonstrated clinical effectiveness. This is the core metric used to tier the outpatient provider network on quality.

The model uses two distinct algorithm programs: Member-Centered Risk Algorithms and Provider-Centered Practice Management Algorithms. The model generates flags if a member is at risk for any one of 15 conditions, supports the creation of provider profiles, and augments claims data in detecting fraud, waste and abuse.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Member-Centered Risk Algorithms

This is a suite of algorithms that run nightly and identify members at risk. These rely on data from the Optum Wellness Assessment, behavioral health claims and, if available, psychotropic pharmacy claims. Claims algorithms can be triggered for both in-network and out-of-network providers. The algorithms and subsequent interventions target different risks:

- **Clinical Risk** – Elevated clinical risk algorithms are largely based on member self- report from the Wellness Assessment. If a member reports severe impairment or distress, Optum notifies the provider so that they are aware of the risk. Most of these algorithms result in letters to the provider. However, if a member triggers three or more of these risk factors, or triggers Optum Facility Predict algorithm indicating the likelihood of imminent facility-based care, a Care Advocate calls the provider to review the clinical risks identified and ensure adequate treatment planning and coordination of care.
- **Utilization Risk** – The utilization algorithms are based on claims and do not rely on the Wellness Assessment. These algorithms are identifying members at risk for over-utilization. These are all directed to Care Advocates who call the provider to discuss the treatment plan to ensure the provision of evidence-based care. Based on the discussion, one of three outcomes are possible:
  - » Care provision is determined to be evidence-based and recovery-based.
  - » Care provision is not evidence-based, but the provider is willing to modify the treatment plan. Follow-up is scheduled to ensure that the modification takes place.
  - » Care provision is not evidence-based and provider unwilling to modify treatment plan. Peer Review may be scheduled.

Provider-Centered Practice Management Algorithms

- The provider-centered practice management algorithms are run quarterly and support the identification of high cost provider practices that are outliers based on utilization, billing patterns, and/or consistent provision of non-evidence-based care.
- Practice patterns are analyzed via a proprietary tool: Practice Pattern Analysis (PPA). Based on the PPA results, the Optum practice specialists coordinate with network, fraud & abuse, and clinical operations to determine the most appropriate provider outreach strategy. When appropriate, telephonic outreach can occur with the provider/group to discuss noted patterns and educate them regarding the provision of evidence-based care and proper billing of actual services provided.

For Substance Use Disorders (SUDs) Services: The state-approved SUDs Assessment results with 6 ASAM dimensions.

Optum will require all necessary documents are received to complete a review of the request, and upon receipt, an Optum clinical staff will review the information and request received. This process frequently entails contact with the providers as well as parent/guardian and can take up to 14 days dependent on Optum's receipt of all the necessary information. A decision will be made on the case and there are two outcomes, an authorization or a denial. Optum will work with the provider and parent/guardian related to their receipt of an authorization and this will be documented by the receipt of a letter detailing the authorization. If the determination is a denial of the service request, the provider and the parent/guardian will receive an Adverse Benefit Determination (ABD) denying the services and providing the member's right to appeal the EPSDT decision.

Return the Optum EPSDT Prior Authorization Form to:

- Fax: 1-855-844-7042
- Email: *optumidaho_epsdt@optum.com*

If you have questions about EPSDT, you may contact us at **1-855-202-0983**.

Optum only reviews requests for outpatient behavioral health services. If you have an EPSDT request for another type of service, you will need to submit your request to Medicaid directly using their EPSDT Request Form. Please visit the ***IDHW website*** and search for EPSDT Form or contact Medicaid directly.

If you would like additional information about the Federal Requirements related to EPSDT, you may find that on the ***Medicaid.gov*** website.

Practice Management

Practice Management, a clinical team, in coordination with other Optum Departments, works with in-network providers on the following key elements:

- Managing outliers, through the identification of potential practice patterns that appear to fall outside typical patterns, including the measurement of improvement over time
- Identifying and resolving potential practice patterns that may constitute Fraud, Waste and/or Abuse (see Fraud, Waste and Abuse section)
- Evaluating compliance with clinical processes and external clinical guidelines, Optum Reimbursement Policies and contractual obligations

Practice Management employs intervention strategies to address practice patterns. Interventions may include, but are not limited to, a direct conversation with the provider, education, referral for peer-to-peer reviews, and site and/or treatment record audits/re-audits.

Potential results of a Practice Management intervention may include ongoing monitoring, Corrective Action Plans, non-coverage (adverse) benefit determinations, referrals to Peer Review, Credentialing Committee or Program and Network Integrity (PNI) as appropriate.

For additional information, please see the sections on "Anti-Fraud, Waste, and Abuse" and the "Treatment Record Documentation Requirements" in this manual.

Clinical Outcomes Model

Optum is committed to partnering with our network to achieve optimal therapeutic outcomes for the individuals we mutually serve. This approach focuses on assisting the network to make consumer-directed, outcomes-based, cost-effective and clinically necessary treatment decisions. With that goal in mind, we have developed a clinical outcomes model, which includes an authorization or notification process, when required. By effectively identifying outliers[2] and guiding interventions, the Outpatient Management program helps control direct and indirect outpatient costs while ensuring optimal clinical outcomes.

The outlier management system uses member responses to a validated tool, the one-page Wellness Assessment (WA), along with claims data. Both WA and claims information are analyzed through a set of algorithms to determine a member's behavioral health status and potential risks. In addition, the algorithms identify cases that may benefit from a review. Such reviews may include consideration of ***Best Practice Guidelines***, Optum Idaho ***Level of Care Guidelines***, and The ASAM Criteria®. The algorithms offer opportunities for earlier intervention on potential treatment complications. Care Advocacy will use a combination of letters and/or calls to inform you about any targeted risk or the requirement to complete a review. This allows us to work together more efficiently focusing on those members with the greatest potential for benefit from such collaboration.

The Wellness Assessment is completed at multiple points rather than at a single point in treatment. This offers more immediate feedback on changes in health status and functioning which may inform further treatment planning, including level of care changes or coordination with medical professionals.

Psychiatrists, Psychologists with prescriptive authority and prescribing nurses are not required to submit Wellness Assessments, unless they want to participate in the ***Achievements in Excellence (ACE)*** – Clinicians outcomes recognition program. Please note that claims-based algorithms do apply to prescribing clinicians and may require Care Advocacy reviews, as noted above.

[2]*"Outlier: a statistical observation that is markedly different in value from the others of the sample." Merriam-Webster.com. Merriam-Webster, n.d. Web. 26 Aug. 2014. <https://www.merriam-webster.com/dictionary/outlier>.*

CLICK HERE TO RETURN TO TABLE OF CONTENTS

6.5 Critical Incidents

Critical incidents are 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/agency providing services, which has, or may have, deleterious effects on the member, including death or serious disability, that occurs during the course of or subsequent to a member receiving behavioral health treatment. Reportable Critical Incident categories include but are not limited to:

- **A completed suicide by a member** who was engaged in treatment services 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 engaged in treatment services at any level of care at the time of attempt, or within the previous 60 calendar days.
- **An unexpected death of a member** that is not related to the natural course of a member's medical condition or illness that occurred while the member was engaged in treatment services at any level of care at the time of death, or within the previous 60 calendar days.
- **A serious injury of a member** that required an overnight admission to a hospital medical unit that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
- **A report of a serious physical assault of a member** that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
- **A report of a sexual assault of a member** that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
- **A report of a serious physical assault by a member** that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
- **A report of sexual assault by a member** that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
- **A homicide that is attributed to a member** who was engaged in treatment services 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** that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
- **An instance of care ordered or provided for a member** by someone impersonating a physician, nurse or other health care professional.
- **High profile incidents identified by the IDHW** as warranting investigation.

If you are aware of a critical incident involving a member that meets any of the above categories, you must notify Optum by calling the Provider Services Line at **1-855-202-0983** and asking to speak with a Customer Service Representative to report the incident.

We have established processes and procedures to investigate and address critical incidents. This includes a Peer Review Committee chaired by Optum Idaho Chief Medical Officer and incorporates appropriate representation from the various behavioral health disciplines. You are required to cooperate with critical incident investigations.

For further details on the Critical Incident reporting process, visit ***optumidaho.com*** > For Network Providers > Guidelines & Policies.

6.6 Satisfaction Surveys

Member Satisfaction Survey

We regularly conduct a Member Satisfaction Survey of a representative sample of members receiving behavioral health services within the Optum Idaho network. The results of the survey are reviewed. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Provider Satisfaction Survey

We regularly conduct a provider satisfaction survey of providers delivering behavioral health services to IBHP members. This survey obtains data on provider satisfaction with Optum services including Care Advocacy, Network Services and Claims Administration. The results of the survey are analyzed for tracking and trending. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Performance Improvement Program

Our Performance Improvement Programs (PIP) are selected and developed based on the demographic, cultural, clinical, and risk characteristics of members. You may be enlisted to participate in the design and implementation of a PIP. We encourage all clinicians and agencies to review the content and process of Optum PIPs. These programs are described at ***optumidaho.com*** as they are developed. If you would like a paper copy of these programs, please contact Network Management.

Practice Guidelines

Optum has adopted clinical guidelines from nationally recognized behavioral health organizations and groups. The adopted ***Best Practice Guidelines*** are available through ***optumidaho.com***. Your feedback is encouraged on all guidelines and any suggestions on new guidelines to be considered for adoption are welcome. If you would like a paper copy of these guidelines, please contact ***Network Management***.

6.7 Complaint Investigation and Resolution

You are required to cooperate with Optum in the complaint investigation and resolution process. If we request written records for the purpose of investigating a member complaint, you must submit these to Optum within 14 business days, or sooner as requested. Complaints filed by members should not interfere with the professional relationship between you and the member.

Quality Improvement (QI) staff, in conjunction with Network Management staff, monitors complaints filed against all clinicians and agencies, and solicits information from them in order to properly address member complaints. In general, resolution of most complaints is communicated to the member when the complaint is received from, or on behalf of, the member. Quality of Care complaints do not include member notification of resolution.

We require the development and implementation of appropriate Corrective Action Plans (CAP) for legitimate problems discovered in the course of investigating complaints. Such action may include, but is not limited to, having Optum:

- Require you to submit and adhere to a CAP
- Monitor you for a specified period, followed by a determination about whether substandard performance or noncompliance with Optum requirements is continuing
- Require you to use peer consultation for specific types of care
- Require you to obtain specific additional training or continuing education

CLICK HERE TO RETURN TO TABLE OF CONTENTS

- Limit your scope of practice in treating members
- Hold referrals of any members to your care by changing your availability status to "unavailable" and/or reassigning members to the care of another participating clinician or agency
- Terminate your participation status with Optum

Cooperation with an unavailable status associated with complaint, Quality of Care or critical incident investigations may include:

- Informing members of unavailable status at the time of an initial request for services, and identifying other network clinicians or agencies to provide services or referring the member to Optum for additional referrals
- Informing current members of status and their option to transfer to another network clinician or agency
- Assisting with stable transfers to another network clinician or agency at the member's request

6.8 Audits of Sites and Records

On-site and record-only audits may occur with any contracted provider. The on-site audit involves a review of policies and procedures, including policies related to hiring and supervision of staff, discussion of services that are offered and a tour of the agency or office site.

Optum Idaho representatives conduct site visits at agencies such as mental health clinics, SUD treatment centers and clinician offices. This includes audits of providers who offer community-based rehabilitation services (CBRS) for adults and/or youth. On-site audits are routinely completed with agencies without national accreditation. In addition, audits are completed to address specific quality of care issues or in response to member complaints about the quality of the office or agency environment.

Agencies that hold national accreditation through organizations such as: The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), DNV Healthcare, Accreditation Commission for Health Care (ACHC), or Healthcare Facilities Accreditation Program (HFAP), receive credit for meeting those standards of care for the identified accredited services or programs without additional review prior to the initial credentialing process.

Agencies that are not accredited will be required to participate in an on-site audit prior to credentialing and a re-credentialing audit prior to their specified re-credentialing timeframe. Any agency, regardless of their accreditation status, may be subject to an on-site audit for any member complaints or suspected quality of care concerns brought to the attention of Optum.

During on-site and record-only audits for all types of providers, chart documentation is reviewed, including (but not limited to) the assessment, diagnosis, treatment plan, progress notes, monitoring risk issues, coordination of care activities and discharge planning. This process also verifies that services were provided to members. You are expected to maintain adequate medical records on all members and document in the record all services that are provided. Prior to the audit, you will be notified of the specific types of charts that will be reviewed. Failure to adequately document services that are rendered and/or dates of services may lead to a request for a Corrective Action Plan (CAP). (Please see the "Treatment Record Documentation Requirements" section of this manual for more information). The audit tools are based on NCQA, the Joint Commission and Optum standards. These forms are used during audits and are available at ***optumidaho.com***.