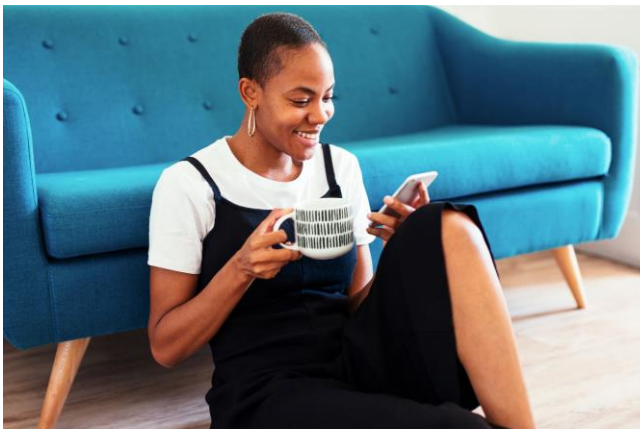
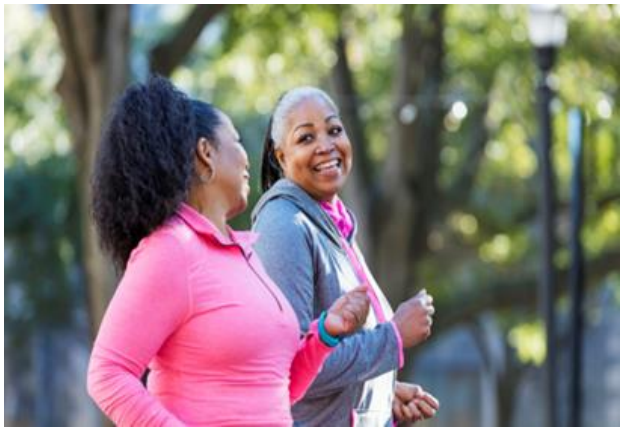
Behavioral Health Solutions
National Network Manual





Effective Dec. 1, 2023

BH5176_12/2023

United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum

Table of Contents

Change Index

(NOTE: The change index does not include minor changes to content or formatting)

SECTION	PAGE(S)	CHANGE TO CONTENT
Glossary of Terms	20-25	Removed several terms since they are duplicative of terms/definitions already referenced in each provider's Participation Agreement: • Affiliate • Algorithm • Clinician • Community Mental Health Center • Fraud, Waste, Abuse and Error • Live and Work Well • Member • Mental Health and/or Substance Use Disorder • One Healthcare ID • Payor • Provider Dispute • Provider Express • Reimbursement Policies
Network Requirements	38	• **Continuation of Services after Termination:** Beginning Jan. 1, 2022, when a provider is terminated from the Optum Behavioral Health network, the member must elect to continue treatment. As outlined in the Consolidated Appropriations Act, continuation of coverage (CoC) is no longer automatically given
Benefit Plans, Authorizations, EAP and Access to Care	43	• **Emergency Admissions:** Updated language to clarify that Optum requires notification within one business day after a member's admission. The timeframe was previously outlined as 24 hours after admission.
Treatment Philosophy	53	• **Medicare Coverage Summaries**: Added CMS Benefit Policy manuals to the list of items that contribute to the information in the summaries. • **Clinical Technology Assessment Committee:** Added language to further define what is considered evidence, and how often the committee meets.
Treatment Record Documentation Requirements	58	• Removed reference to Supervisory Protocol, as it will no longer be a part of onsite audits.
Compensation and Claims Processing	74-75	• Claims Submission: Updated language and added billing codes to better differentiate between mental health/substance abuse disorder services and EAP services.
Provider Reconsideration and Appeals Process	81-83	• This section has been completely updated to reflect the new 2-step reconsideration and appeal process for prior authorization and claim decisions. The process applies only to Commercial and Medicare Advantage claims.
Appendix A	89-92	• Added state-specific and program-specific appendices which outline regulatory or contractual requirements that behavioral health network providers shall comply with, as applicable.

Introduction

Welcome

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 continually 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 Network 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.

Tracy Davidson
President, Network and Benefits Management
Optum Behavioral Health Solutions

About United Behavioral Health and Optum

United Behavioral Health (UBH) was officially formed on Feb. 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 and 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®.

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.

Resource Guide

Websites

Provider Express Secure Portal

The *Provider Express* secure portal gives you access to patient- and practice-specific information that helps you check member eligibility and benefits, check prior authorization requirements and submit requests, get updates on claims, reconsiderations and appeals, and more. It is available to network clinicians and group practices, as well as out-of-network individual clinicians.

Register for Access

The secure portal is accessed from the provider website ***providerexpress.com.*** You must register for a One Healthcare ID and password to access the secure portal. Select the "First-time User" link in the upper right-hand corner of the home page and follow the prompts.

- **Training Information** includes webinar offerings and guided tours of secure transaction features such as claim entry, eligibility and benefits and the message center.
- **Video Channel** features how-to guides and videos that explain how to access and use many of the features available on the secure portal, such as:
  - Requesting prior authorization
  - Submitting claims
  - Claim inquiries and adjustments
  - Updating your practice information

Secure Transactions

With access to the *Provider Express* secure portal, you can:

- Submit initial credentialing application and check status of initial credentialing
- Check member eligibility and view benefit information, including authorization requirements
- Request authorization or complete notification for higher levels of care
- View authorization details
- Update provider and practice information:
  - Add NPI
  - Add taxonomy code(s)
  - Update ethnicity, languages spoken and other areas of expertise
  - Update email address
  - Update provider gender
  - Add Medicaid/Medicare numbers
  - Manage address locations, including practice, remit, 1099 and credentialing
  - Update phone and fax numbers
  - Change availability status for accepting new patients
  - Update office information, including weekend or evening practice hours, wheelchair accessibility, public transportation access, etc.
- Submit professional claims and view status
- Request claim adjustments
- Request claim or clinical appeals
- Access Provider Remittance Advice statements
- Attest to participation in telemental health
- View performance dashboards

- Obtain pre-populated Wellness Assessments
- Attest to accuracy of directory information
- Send secure messages to Optum using the Message Center
- Create and maintain My Patients list
- Add and manage other users' access (Admin-level users only)
- Link to the clinician version of *liveandworkwell.com* to obtain patient education resources in English and Spanish (see "**Live and Work Well**" section below)

Provider Express Public Website

The ***Provider Express*** **website** has information and updates to help us work together – from changes to administrative processes and state-specific information, to product-specific news and other topics. In addition, there are Quick Links to frequently accessed pages:

- **Behavioral Health Toolkits**
- **Claim Tips**
- **Add/Update Clinician Tax ID Form**
- **General forms**
- **Guidelines / Policies & Manuals**
- **Substance Abuse Disorder Treatments**
- **Navigating Optum**
- **Optum Pay**

Live and Work Well

Liveandworkwell.com is our primary member website. It provides resources and patient education in English and Spanish. Information on the site is customized according to the member's benefit packages. On this site, members can:

- Manage behavioral health benefits:
  - Check eligibility/benefits
  - Submit/track claims
  - View claim status
  - Submit out-of-network claims
- Request services
- Identify network clinicians and facilities
- Take self-assessments
- Locate community resources
- Find articles on wellness and daily living
- Take computer-based trainings to learn about:
  - Depression
  - Anxiety
  - Stress
  - Alcohol & Drug Use
- Access Parent/Teen/Child integrated medical/behavioral information on adolescent health

Members can also 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

Providers may use ***Liveandworkwell.com*** to:

- Access behavioral health education information for patients. (You can access the clinician version by using the guest access code "Clinician"
- Refer patients to appropriate benefit specific online resources

Employee Assistance Program (EAP) Services

- Upon completion of EAP services, you may refer for, or begin provision of, most routine outpatient services for clients whose benefits are administered by Optum
- The Statement of Understanding is a form that describes the scope and limitations of EAP services, signed by both you and the member
- EAP Claim submission can be done through the *Provider Express* secure portal

Wellness Assessments

The one-page Wellness Assessment is a reliable, confidential, consumer-driven tool used to help identify targeted risk factors in addition to establishing a baseline for tracking clinical changes and outcomes. The tool is available in both English and Spanish. It 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.

- 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

Review detailed instructions and access the Wellness Assessment on our provider website. Questions? Email us at **WellnessAssessmentDashboard@optum.com.**

Claims and Customer Service

Information for claims and customer service issues can be found in the Contact Us section of the *Provider Express* website.

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

For Further Assistance

For general information and contractual questions, call the Provider Service Line at **1-877-614-0484**.

Frequently Asked Questions

Network Requirements

Who can I contact with specific questions or comments?

For general information contact Provider Relations at **1-877-614-0484.** For contractual questions contact Outpatient Contracting at **1-877-614-0484** or your Facility Contract Manager.

What is a payor?

Our payor definition is the entity or person that has the financial responsibility for funding payment of covered services on behalf of a member, and who is authorized to access mental health/substance abuse disorder services in accordance with the Participation Agreement.

How do Network Lease Partnerships work?

Some patients may have access to the Optum network discounts through Network Lease Partners. All claims for members accessing your services through these arrangements are processed, paid by and the responsibility of the Network Lease Partners and not Optum. Please submit claims directly to these Network Lease Partners for processing. Claims submission information is available on the member's ID card.

Do I have to notify anyone if I change my name, address, telephone number, accepting new patient status or Tax Identification Number?

Yes. You are required to notify us within 10 calendar days, in writing, of any changes to your practice information, unless otherwise required by applicable state or federal law. This is especially important for accurate claims processing and the accuracy of the provider directory for members. We encourage you to make such changes by going to the *Provider Express* secure portal to update your practice demographics.

As a contracted facility, are we required to notify Optum if we discontinue or change a program, service or location?

Yes. You will need to contact your Facility Contract Manager to discuss the discontinuation or change to a program, service or location.

As a contracted facility, would the addition of programs, services or locations require review of our current contract?

Yes. Contact your Facility Contract Manager to initiate a review.

Can I be considered a participating clinician at one practice location and non-participating at another?

No, not if you are individually contracted with us. Your Participation Agreement requires that you see all members eligible for services. It is not specific to a location or Tax Identification Number (TIN). It is important to provide us with all practice locations and the TINs under which you submit claims.

If you are part of multiple group practices and also maintain a private practice, it is possible to be participating at one location and not at another, based on how you and/or your group(s) are contracted with us. Contact Provider Relations for assistance in evaluating your specific situation.

Since our facility or practice group is contracted, does that mean all of our affiliated clinicians are considered participating network clinicians?

No. Generally, only clinicians who are credentialed with Optum are considered network clinicians. The Optum network status of a facility or group does not guarantee that all clinicians who practice there are network clinicians. In situations where an agency is credentialed by Optum, their affiliated clinicians are not credentialed but are considered participating under the agency's Participation Agreement.

When you add clinicians to your group/facility, you should not assign a member to the clinician until you confirm that the clinician has been added to the network. Any claims submission for a rendering clinician who has not been added to the network is subject to denial.

May I bill for mental health/substance abuse disorder services that another practitioner, intern or assistant provides to Optum members in my office?

No. You can bill only for services which you personally provide. Please follow the American Psychological Association (APA) ***Psychological and Neuropsychological Testing Billing and Coding Guide*** regarding the use of psychometrists.

If my practice is filling up or if I am going to take a leave of absence from my practice, may I choose to be unavailable for new Optum referrals?

Yes. You may request to be listed in our database as unavailable at one or more of your practice locations for a period of up to six months. You are required to update your availability in the provider directory or notify Provider Relations within 10 calendar days of your unavailable status for new referrals. Group practices and facilities/agencies that wish to be made unavailable should contact Provider Relations.

Are there procedures to follow if I withdraw from the Optum network?

Yes. The terms and conditions for withdrawal from the network are outlined in your Participation Agreement. For additional details, or to initiate the process, contact Provider Relations or your Facility Contract Manager. Please also see information about Continuation of Services after Termination in the **Network Requirements** section of this manual.

Benefit Plans, Authorizations and Access to Care

How can I review a member's benefits and eligibility?

The fastest way to determine eligibility and benefits is using the *Provider Express* secure portal. This **tutorial** gives step-by-step instructions on using the portal to obtain this information. You may also call the provider services phone number located on the back of the member's ID card.

Services and/or conditions not covered under the member's specific benefit plan are not eligible for payment. We comply with regulatory requirements related to coverage election periods and payment grace periods. These requirements can lead to delays in our knowledge of a member's eligibility status. As a result, we recommend you check with the member at each visit to ensure you have up-to-date health plan information.

Can members initiate authorization of benefits for routine outpatient mental health or outpatient substance abuse disorder services?

Typically, authorization for routine outpatient services is not required. Members may contact Optum or use the member website to obtain in-network referrals for most routine outpatient services.

Do any benefit plans require prior authorization for outpatient treatment?

Most benefit plans do not require prior authorization for routine outpatient services. To check a plan's requirements, you can use the ***Provider Express*** secure portal. You may also call the provider services phone number located on the back of the member's ID card.

What constitutes a "non-routine" outpatient service?

Non-routine outpatient services include, but are not limited to, psychological testing and intensive outpatient care. These services typically still require authorization of benefits prior to providing those services. To obtain those authorizations, please use the ***Provider Express*** secure portal. You may also call the provider services phone number located on the back of the member's ID card.

What if I see someone for an extended period due to an unforeseen crisis?

In situations where there may be an unanticipated need for an extended office visit, you should use the crisis code 90839 to bill for the first 60 minutes of psychotherapy. Prior authorization is not required for crisis sessions.

Is the Wellness Assessment administered more than once?

Yes. The Wellness Assessment is administered at the first session or in the second session if the member presents in crisis during the first session. It should be administered again, preferably at the third visit, but may be given at either the fourth or fifth visit. The exact timing is at the clinician's discretion.

Is there a way to ensure confidentiality with the Wellness Assessment for emancipated minors who are requesting services?

Yes. In these circumstances, you should only complete the demographic sections located at the top of the Wellness Assessment and return it to Optum. Fill in the bubble labeled "MRef" if the member refuses to complete the assessment. A follow-up assessment will then not be sent to the adolescent's home.

Where can I get more information about the Wellness Assessments?

Please refer to the **Benefit Plans, Authorizations, EAP and Access to Care** section of this manual or the Wellness Assessment information on *Provider Express*.

Can I make referrals directly to other Optum network clinicians?

You or the member may identify network clinicians in 1 of 3 ways:

- Use the ***Find a Provider*** tool on *Live and Work Well*
- Review the ***Clinician Directory*** on *Provider Express*
- Call Optum using the number on the member's ID card

Typically, authorization for routine outpatient services is not required. Prior authorization may be required if referring a member for non-routine outpatient services such as psychological testing, intensive outpatient services or other higher levels of care.

Employee Assistance Program (EAP) Procedures

What is an Employee Assistance Program (EAP)?

EAP is a health and wellness service provided by an employer. It is designed to provide assessment and referral, as well as a brief counseling intervention for members and their families.

How can I become identified as an EAP provider?

Optum does not have a separate EAP network. All Optum-contracted therapists may provide and submit claims for EAP services and are encouraged to participate. As a participating network therapist, you earn the same contracted rate for EAP services as for routine outpatient therapy services, and you are reimbursed directly from Optum.

Note: There are limitations around the use of EAP benefits with psychiatrists.

Learn more about providing EAP services and how to update your directory listing to reflect that you accept EAP clients.

Do EAP services require prior authorization?

Yes. EAP benefits require prior authorization. An initial authorization may be obtained by the member or by the provider. Members may make the authorization request by phone, via the *myliveandworkwell* mobile application, or through ***liveandworkwell.com***. Providers making an authorization request on behalf of members should call **1-866-248-4094**. The member will receive an EAP authorization letter and is instructed to bring that to their initial session.

Do I need to obtain prior authorization for members who transition from EAP to Optum benefits for routine psychotherapy services?

Typically, authorization for routine outpatient services is not required upon completion of EAP services.

Does use of EAP benefits change authorization or notification requirements for mental health/substance abuse disorder services?

No. You may check a member's benefits and eligibility through the *Provider Express* secure portal or by calling the number on the member's ID card.

If a member I am seeing through EAP benefits requires medication management services, is prior authorization required?

No. Medication management services do not require prior authorization.

Should members be given the Wellness Assessment at their initial EAP visit?

Yes. All Optum members should be asked to complete a Wellness Assessment during their first visit.

Am I required to give a Wellness Assessment to a member transitioning from EAP benefits?

Yes. All Optum members should be offered the Wellness Assessment. If the member reports having already completed a Wellness Assessment with the EAP clinician, it is not necessary to complete an assessment during your initial session with the member. However, you should administer the Wellness Assessment at either session three, four or five.

Do EAP benefits require a new authorization when a new benefit year begins?

Yes. You will need to obtain a new EAP authorization when a new benefit year begins. Remember to ask the member for a copy of the EAP authorization letter to note the expiration date of the authorization.

Is there a time frame in which I may seek a retrospective review of services that were provided but not previously authorized?

Yes. On occasion, emergent or other unusual circumstances will interfere with the pre- authorization processes. In those cases, requests for a retrospective review of services must be submitted within 180 calendar days of the date(s) of service, unless otherwise mandated by state law.

Treatment Philosophy

On the ***Guidelines/Policies & Manuals*** page of the *Provider Express* website, you can find information regarding various guidelines and clinical criteria used by Optum, including:

- LOCUS/CALOCUS-CASII/ECSII clinical criteria
- ASAM criteria
- Behavioral clinical policies
- Clinical practice guidelines
- State/contract specific criteria
- Supplemental clinical criteria

Am I expected to coordinate care with a member's primary care physician or other health care professionals?

Yes. We require network clinicians to coordinate care with the member's primary physician as well as other treating medical or behavioral health clinicians. A signed release of information should be maintained in the clinical record. If a member declines consent to the release of information, his or her refusal should be documented along with the reason for refusal. In either case, the education you provide regarding risks and benefits of coordinated care should be noted.

How can I learn more about Recovery & Resiliency?

Optum considers Recovery & Resiliency to be important in the provision of behavioral health services. The **Recovery & Resiliency toolkit for Providers** has a number of resources available for use.

Confidentiality of Records

Do HIPAA regulations allow me to exchange protected health information with Optum?

Yes. The HIPAA Privacy Rule permits clinicians and Optum to exchange protected health information for activities involving treatment, payment and operations, with certain protections and limits. An individual's authorization for the release of information is not required by HIPAA in these cases, though disclosures should be consistent with any other applicable federal or state privacy law.[1]

[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.

Quality Improvement

Does Optum audit clinicians and facilities?

Optum representatives conduct site visits at clinician offices, agencies such as Community Mental Health Centers (CMHCs), facilities and group provider locations. Onsite audits are routinely completed with CMHCs and facilities 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 facility environment. For additional information, please see the **Quality Improvement** section of this manual.

Compensation and Claims for Further Assistance

Can members be billed prior to claims submission?

No. Members are never to be charged in advance of the delivery of services with the exception of applicable copayment. Members should be billed for deductibles and co-insurance after claims processing. The Provider Remittance Advice you receive will indicate member responsibility.

Is there one format to be used for diagnosis on claims?

Yes. Submit your claims using the industry-standard ICD-10 code.

How should I submit claims to Optum?

Electronic claims: Optum recommends electronic submission of claims for the most efficient claim processing. Network clinicians and group practices can submit claims electronically through the *Provider Express* secure portal using the claim entry function. In addition, any clinician, group practice or facility provider can submit claims electronically through an EDI clearinghouse using Payor ID #87726.

Clinician claim forms: Paper claims should be submitted using the 1500 claim form, the UB-04 claim form (for outpatient services rendered and contracted within a hospital setting), or their successor forms as based upon your Participation Agreement. All paper claims must be typewritten.

Facility claim forms: Paper claims should be submitted to Optum using the UB-04 claim form or any successor forms, as appropriate.

Do I need a National Provider Identifier (NPI) to submit claims?

Yes. We require the billing clinician to include accurate NPI and contact information on all claims. This information is needed to process claims and communicate with members.

With all of the different products that Optum manages, is there some easy way for me to determine where to send my claim?

Yes. Claims submitted electronically through the *Provider Express* secure portal are automatically routed to the appropriate claim office. You may also elect to submit electronically through an EDI vendor. EDI claims are also automatically routed to the correct claim offices. We pay claims for Members using a number of different claims systems. To assure prompt and accurate payment for claims submitted using the U.S. Postal Service, you should verify the mailing address for your claim by calling the number on the member's ID card. Often, the claims payment address for a medical claim is different than the address for a behavioral health claim.

Do I have to submit my claims within a certain time frame in order for them to be paid?

Yes. All information necessary to process claims must be received by Optum no more than 90 calendar days from the date of service, or as required by state or federal law or specific member benefit plans or based upon the terms of your Provider Agreement.

Am I responsible for coordination of benefits?

Yes. You are responsible for determining if the member has other insurance coverage. If so, you should bill the primary insurance carrier first, then notify Optum of your findings Optum is required to process claims using industry-wide coordination of benefits (COB) standards and in accordance with benefit contracts and applicable state laws.

Can I bill a member when treatment is not authorized, as required, but the member elects to receive services?

Possibly. If you seek prior authorization and Optum does not authorize the requested services, the member may be billed under limited circumstances. For more detailed information, please review the *Billing for Non-Covered Services and No Shows"* section in the **Compensation and Claims Processes** section of this manual.

May I submit a claim to Optum for no-shows?

In general, no. However, if the member has signed a written statement explaining your billing policy for appointments not kept or cancelled, you may bill the member no more than your Optum contracted rate. Note that some plans and government-funded programs prohibit billing for no-shows under any circumstances For more detailed information, please review the *Billing for Non-Covered Services and No Shows"* section in the **Compensation and Claims Processes** section of this manual.

May I submit a claim to Optum for telephone counseling or after-hours calls?

Optum covers telephone counseling in some situations when clinically necessary and appropriate, and in accordance with the member's benefit plan. Telephone counseling must be pre-authorized by Optum.

May I balance bill the member above what Optum pays me?

No. You may not charge members the difference between your billed usual and customary charges and the aggregate amount reimbursed by Optum and member expenses.

Will Optum process claims retrospectively?

In the event a Participation Agreement with Optum has not been executed timely or a commercially reasonable amount of time is not provided to align Optum systems with a Participation Agreement, Optum will not assign a retroactive effective date or pay claims retrospectively unless federal or state mandated. In addition, no interest or penalty otherwise required under applicable law will be due on any claim which was initially processed timely and accurately, but which requires reprocessing as a result of the untimely execution of a Participation Agreement or amendment; or the inability to align Optum systems in a commercially reasonable period of time.

Anti-Fraud, Waste and Abuse (FWA)

Am I required to participate in all anti-fraud, waste and abuse programs?

Yes. All fraud, waste and abuse investigation activities are a required component of your Participation Agreement. This includes, but is not limited to, providing medical records as requested and timely response to inquiries.

Do I have to complete anti-fraud, waste and abuse or compliance training?

All providers and affiliates working on Medicare Advantage, Part D or Medicaid programs must provide compliance program training and fraud, waste and abuse 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 any CMS-approved source.

What should I do if I suspect Fraud, Waste or Abuse?

Any time there is a suspicion of fraud, waste or abuse, please report it immediately. The faster we know about it, the faster we can intervene. We need your assistance to maximize success.

How do I contact the Optum Program and Network Integrity Department?

Communications are confidential and may be anonymous.

Telephone: 1-877-972-8844
Email: optum.pni.tips@optum.com
Fax: 1-248-733-6379

General inquiries:
pni.triage.team@optum.com

Mail: Optum Program and Network Integrity Department
PO Box 30535
Salt Lake City, UT 84130-0535

Where can I find more information about anti-fraud, waste and abuse?

More information is available on the **Fraud, Waste, Abuse, Error and Payment Integrity** page on the *Provider Express* website.

Prior Authorization Appeals

Can I initiate the appeals process if I disagree with the decision Optum made not to authorize services I have requested?

Yes. Urgent appeals should be pursued as quickly as possible following an adverse determination. For non-urgent appeals, Optum has established a 180-day timeframe in which a clinician or member can request an appeal. These timeframes apply unless otherwise mandated by applicable law or customer requirement.

Are there different contacts for issues with claims processing or payment?

Yes. You may need to call different customer service numbers to request assistance for some members.

We have several main customer service phone numbers. See the **Resource Guide** or **Compensation and Claims Processing** sections of this manual. However, it is best to call the phone number listed on the Provider Remittance Advice you receive for the claim.

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.

Adverse Determination

See definition for “**Non-Coverage Determination”** below.

Agency

A non-facility-based outpatient provider meeting specific criteria. Examples include Federally Qualified Health Centers (FQHC), Community Mental Health Centers (CMHC), State-Licensed Outpatient Clinics, Community-based Service Agencies and School-Based Health Centers (SBHC).

Agreement (may be referred to as Provider Agreement or Provider Participation Agreement)

A contract describing the terms and conditions of the contractual relationship between us and a provider under which mental health and/or substance use disorder services are provided to members.

Appeal

A specific request to reverse a non-coverage (adverse) determination or potential restriction of benefit reimbursement.

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 United Behavioral Health contracted rate and the clinician or facility’s usual charge for that service.

Behavioral Clinical Policies

Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make determinations regarding proven or unproven technologies, services and treatments.

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. EAP Care Advocates are referred to as EAP Specialists.

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.

Clean Claim

A UB-04 or a Form 1500 claim form, or their successors, submitted by a facility or clinician for mental health and/or substance use disorder 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 on the *Provider Express* secure portal.

Co-insurance

The portion of covered health care costs for which the member is financially responsible, usually according to a fixed percentage. Co-insurance often is applied after a deductible requirement is met.

Co-payment

A cost sharing arrangement in which a member pays a specified charge for a specified service (e.g., $20 for an office visit). The member usually is responsible for payment at the time the health care is rendered. Typical co-payments are fixed or variable flat amounts for clinician office visits, prescriptions or hospital services. Sometimes the term "co-payment" generically refers to both a flat dollar co-payment and co-insurance.

Community-based Service Agency

Includes peer support group services and drop-in centers (clubhouse model) that have a business license and/or state license as applicable.

Credentialing

This refers to the process by which a provider is accepted into our network and by which that association is maintained on a regular basis.

Deductible

The annual amount of charges for behavioral health care services, as provided in the member's benefit plan, which the member is required to pay prior to receiving any benefit payment under the member's plan.

EAP (Employee Assistance Program)

A health and wellness benefit provided by one's employer. EAP services are designed for brief intervention, assessment and referral. These services are short-term in nature.

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.

Emergency

A serious situation that arises suddenly and requires immediate care and treatment to avoid jeopardy to life or health. For appointment access standards, see **Emergency — Life threatening**, **Emergency — Non-life threatening** and **Urgent** below.

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 6 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.

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.

Facility

An entity that provides inpatient, residential or ambulatory services and has contracted to deliver behavioral health care services to members (also known as a network Facility).

Facility Contract Manager

An Optum professional dedicated to managing contractual relationships with hospitals and freestanding behavioral health programs and services for our network.

Federally Qualified Health Centers (FQHC)

A Federally qualified Health Center (FQHC) 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 of 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. Reimbursement to clinicians is based upon licensure rather than degree.

Group Practice

A group of individually credentialed clinicians who participate in the network under a group contract and share a single Tax Identification Number (TIN). The group practice site(s) is the location of practice for at least the majority of each clinician's clinical time. In addition, medical records for all patients treated at the practice site are available to and shared by all clinicians, as appropriate.

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 (HIPPA) outlines a set of national standards are set for the protection of certain health care information, among other topics. 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, **HHS.gov**.

Identification (ID) Card

Any reference to ID Card includes a physical or a digital identification card.

Independent Review Organization

An independent entity/individual retained by a private health plan or government agency to review non-coverage (adverse) determinations (based on medical necessity) that have been appealed by, or on behalf of, a member (also sometimes known as External Review Organizations).

Least Restrictive Level of Care

The level of care at which the member can be safely and effectively treated while maintaining maximum independence of living.

Legal Entities

- United Behavioral Health (UBH)
- United Behavioral Health of New York, I.P.A., Inc. (UBHIPA)
- U.S. Behavioral Health Plan, California (USBHPC) – see OptumHealth Behavioral Solutions of California Network Manual

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.

Medical Necessity

Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to member benefit plans or state laws (also referred to as clinical necessity).

Optum expects that all treatment provided to members 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.

Medicare Coverage Determinations

Medicare National and Local Coverage Determinations (NCDs and LCDs) are criteria used to make medical necessity determinations for Medicare benefits.

Non-Coverage Determination

A denial, reduction or termination of coverage, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on the eligibility of a member or beneficiary to participate in a plan; and a denial resulting from utilization review, the experimental or investigational nature of the service, or the lack of medical necessity or appropriateness of treatment. The term “adverse determination” may be used to describe non-coverage determinations.

Notification

A benefit plan requirement that providers contact us when a member accesses services. Notification, when required, should occur prior to the delivery of certain non-routine outpatient services and scheduled inpatient admissions, and as soon as reasonably possible for an emergency admission. Notification requirements include clinical information to determine benefit coverage.

Optum Pay

Optum Pay delivers electronic payments and provides 835 files for health care providers and facilities. Optum Pay® helps optimize claims reconciliation and improve cash flow. Providers choose how to receive payments from a network of payers.

Outpatient Contract Manager

An Optum professional dedicated to managing contractual relationships with clinicians and groups providing outpatient services for our network.

Prospective Program

Claim review completed before payment is made that may be denied due to a conflict with a reimbursement policy and/or when more information is needed before a claim can be processed. When more information is needed, a request for medical records will be sent to the provider and/or member, as appropriate.

Provider Relations

Consists of staff who provide services and information to providers. In addition, they may act as liaisons with other departments such as Contracting, Care Advocacy, Account Management and Sales to contract and retain experienced mental health and substance use disorder treatment professionals.

Qualified Behavior Analyst/Specialist

Generally, a board-certified Behavior Analyst but may also include provider types designated by a specific state as eligible to serve as Applied Behavior Analysis supervisors.

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. Federal and state regulations typically require 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.

Retrospective Program

Review of claims after payment has been made and are subsequently identified as having potential for fraud, waste, abuse and/or error activity.

Routine Access

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

School Based Health Center (SBHC)

Provides a comprehensive array of behavioral health services, including outpatient, case management and telehealth services.

State Licensed Outpatient Clinic (Non-CMHC)

An organization that is licensed and/or accredited by a state entity to provide mental health and/or substance use disorder services.

Telemental Health

The provision of behavioral health services by a behavioral health provider via a secure two-way, real-time, interactive audio/video telecommunication system. These services may be referred to as telehealth, telemental health or virtual visits.

Termination Period

The timeline for continued treatment up to 90 calendar days from the effective date of the contract termination, or as outlined in the Participation Agreement, or until one of the following conditions is met, whichever is shortest:

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

The Care Advocate may continue to issue authorizations for treatment during this period at the Optum contracted rate as provided by the Participation Agreement.

Urgent Access

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

Utilization Management

The process of evaluating and determining the coverage for and the appropriateness of behavioral health services, as well as providing assistance to a clinician or patient in cooperation with other parties, to help ensure appropriate use of resources. Utilization management includes prior authorization, concurrent review, retrospective review, discharge planning and case management.

Wellness Assessment

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

Network Requirements

Clinical Network Development and Maintenance

Optum is responsible for arranging for the provision of a comprehensive spectrum of behavioral health services. To fulfill this responsibility, we administer a provider network including licensed qualified professionals in mental health and substance use disorder treatment. This network represents an array of clinical and cultural specialties and includes facility-based programs that offer a wide variety of services. The diversity of our network allows us to meet the clinical, cultural, linguistic and geographic needs of our members.

Participating Provider Agreement

A payor is defined as the entity or person that has the financial responsibility for funding payment of covered services on behalf of a member and is authorized to access mental health and substance use disorder services in accordance with the Participation Agreement.

Some patients may have access to the Optum network discounts through Network Lease Partners. All claims for members accessing your services through these arrangements are processed, paid by and the responsibility of the Network Lease Partners and not Optum. Please submit claims directly to these Network Lease Partners for processing. Claims submission information is available on the member's ID card.

Non-Discrimination

Optum 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 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 Participation Agreement should be read to contradict, or in any way modify, this long-standing policy and practice of Optum.

CAQH - Clinician Credentialing and Recredentialing

Optum uses **CAQH ProView®**, to obtain the data needed for credentialing and recredentialing of our network clinicians, unless otherwise required by law. The CAQH web-based credentialing tool streamlines the credentialing process by enabling you to complete your credentialing application online and share it with multiple payers.

This free service for healthcare professionals is available 24 hours a day, 365 days a year. 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 recredentialing is quick and easy.

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

Clinician Credentialing

The clinician credentialing process is used for clinicians who are individually contracted and for many clinicians who are contracted with us through a group practice. Optum 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:

- Current valid Independent license to practice without restrictions, conditions or other disciplinary action, in all states where the applicant practices
- For physicians, a completed psychiatric residency program or other clinical training and experience as appropriate for specialty
- Board certifications for physicians and advanced practice nurses, when applicable
- Current certification through the Federal Drug Enforcement Agency (DEA) for prescribing clinicians in each state in which they practice and unrestricted controlled substance certificate (CDS) if applicable in the state
- Professional liability coverage: A minimum of $1 million per occurrence/$1 million aggregate for master's-level and doctoral-level clinicians, and a minimum of $1 million /$3 million for physicians
    - Exceptions to these required insurance amounts may be made as required by applicable state laws.
- Free from any exclusion from any state or federal government program
- Attest to your areas of clinical specialty and appropriate training supporting the identified specialties.

For a more specific list of criteria, please refer to the Optum Behavioral Health **Credentialing Plan**.

Disclosure of Ownership – This form may be a mandated requirement for specific state Medicaid plans. If applicable, must be collected as part of new recruitment or continued participation process.

Release of Information – 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.

Specialty Areas: Optum has specific requirements for identified specialty areas. A comprehensive list of specialty areas is available in the online applications or on the **Clinician Expertise/Specialty Attestation** form. 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.

Credentialing Plan: 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 Provider Relations.

Clinician Recredentialing

In accordance with our commitment to the highest quality of clinical treatment, we recredential clinicians every 36 months, unless state law or client policies require a different recredentialing cycle. During recredentialing, 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 your:

- Federal Drug Enforcement Agency (DEA) certificate (if applicable) for each state in which you practice
- Professional liability insurance
- Controlled Dangerous Substances (CDS) certificate (if applicable)
- Curriculum vitae, if required by state

You may also be asked to 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 recredentialing and prevent your continued participation in the network.

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

Delegation of Credentialing in Groups

For contracted group practices that meet specific criteria, Optum may negotiate a Delegation Agreement that would allow the group to credential the providers within their group and report their credentialing and recredentialing activities to Optum. Optum conducts oversight of Delegated Group activities and retains final approval of all credentialing and recredentialing decisions. If your group is interested in pursuing a Delegation Agreement, contact Provider Relations for more information.

Facility/Agency Credentialing and Recredentialing

Optum follows the guidelines of NCQA for credentialing and recredentialing unless otherwise required by law. As part of the credentialing and recredentialing 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 required state licenses
- Current copies of all valid accreditations from an Optum-approved 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 for facilities and agencies** may be a mandated requirement for specific state Medicaid plans. If applicable, 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 onsite audit will be required prior to credentialing and again prior to recredentialing. 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. You may request that a paper copy be mailed to you by contacting your Facility Contract Manager.

Roster Maintenance – 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 the My Practice Info tool on the *Provider Express* secure portal or by submitting the **Agency Roster Update Form** to Provider Relations.

Credentialing and Recredentialing Rights and Responsibilities

As an applicant to the Optum network or as a network provider in the process of recredentialing, you are entitled to:

- Be informed of your rights
- Be informed of credentialing or recredentialing status upon request
- Review information submitted to support your credentialing or recredentialing 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 recredentialing application

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

Applied Behavior Analysis Network – Board-Certified Behavior Analyst and Applied Behavior Analysis Agencies

The Optum network includes two provider types that provide behavioral health treatment for children with autism spectrum disorders (ASD):

- Applied Behavior Analysis (ABA), and
- Intensive Behavior Therapies (IBT)

Qualified Behavior Analysts/Specialists are eligible to apply for participation in this unique Applied Behavior Analysis Network. Behavior Analyst/Specialist applicants must demonstrate expertise by meeting the minimum requirement of 6 months supervised experience or training in the treatment of autism spectrum disorders, in addition to an active Board-Certified Behavior Analyst (BCBA) certification from the national Behavior Analyst Certification Board and/or state license in those states that license behavior analysts/specialists.

Applied Behavior Analysis (ABA) organizations are also eligible to apply for participation in this ABA network if it uses a staff model including an individual Behavior Analyst/Specialist or independently

licensed behavioral health Clinician acting in a supervisory capacity to paraprofessional staff. Applicants must demonstrate expertise by meeting the minimum requirement for their supervisors of six months supervised experience or training in the treatment of ASD and active BCBA certification and/or applicable licensure, as well as the successful completion of an Agency medical record and site review.

Express Access Network

The Optum Express Access Network includes credentialed providers who offer routine mental health/substance abuse disorder appointments within 5 business days. Participation in the Express Access Network requires submission of an **attestation**.

Requirements for participation in the Express Access Network

Member Access to Care: Express Access providers ensure that members have timely and reasonable access to mental health/substance abuse disorder services and are, at all times, reasonably available to members as is appropriate. Express Access providers agree to offer routine appointments within 5 business days. If you, as an Express Access provider, are unavailable when members call, you must respond to the member within 24 hours. Express Access providers shall arrange for an answering machine or service that provides the office hours and emergency information and must be capable of receiving messages 24 hours a day.

Non-Compliance: Express Access providers understand and agree that if Optum receives a substantiated member complaint, it will be reviewed thoroughly and may result in removal from the Express Access program. Notification of program removal is not assured, but a provider removed from the program can resubmit a new attestation to be reconsidered for participation.

In addition, Optum may use a Secret Shopper program to periodically monitor appointment access and availability. If a provider is identified as unavailable or unable to meet the 5-day appointment expectation through a Secret Shopper outreach or through the Optum Data Validation program, Optum will remove the Express Access designator from the appropriate provider records. A provider removed from the program can resubmit a new **attestation** to be reconsidered for participation.

Either party may terminate or suspend participation in the Express Access network with 30 days advance written notice to the other party. Termination or suspension of services does not terminate or suspend your existing Participation Agreement.

All other terms and conditions as outlined in your existing Provider Agreement remain in full force and effect.

Telemental Health

The Optum network includes credentialed providers who offer telemental health (virtual visit) services. Telemental health can be delivered in a variety of settings and can include such services as initial evaluations, ongoing treatment and medication management.

All providers who wish to be considered for this service must attest to meeting our requirements for providing telemental health services in order to be listed in our provider directory as a virtual visit provider. Providers can attest to providing telemental health via the **Network Participation Request Form** at the time of initial credentialing. If you are already a participating provider with Optum, you can complete an attestation within the secure Transactions area of the *Provider Express* secure portal. You must be **a registered user** of the secure portal to complete this online attestation.

Providers with prescriptive authority must document their prescriptive authority requirements individually for each state in which they are licensed to prescribe or dispense prescriptions in accordance with applicable laws, rules and regulations.

Providers offering virtual visits must be licensed in the state where the member is located at the time of service. In addition, providers must comply with all licensing laws and telehealth regulations in the jurisdiction(s) where the provider is licensed and where the member is receiving treatment, including but not limited to specific telehealth documentation requirements, informed consent to treat via telehealth requirements, and other telehealth-specific laws and regulations.

Additional information regarding telemental health can be found on the *Provider Express* website.

Contractual Obligation to Update Provider Demographic Data

Up-to-date provider data is important to ensure accurate processing of Optum Behavioral Health claims and so the provider directory presents correct information to members.

Network providers are contractually obligated to notify Optum when there are changes to practice demographic information. Notification must occur within 10 days of the change, unless a different timeframe is otherwise required by state or federal law or the provider's Participation Agreement.

There are 2 ways for individual clinicians and groups to submit demographic updates:

Method	Details	Updates Completed
Online via the Provider Express secure portal	• Go to Providerexpress.com to log-in (upper right corner) with your user name and password • Select My Practice Info from the Menu at the top of the page, then select the type of information that needs to be updated from the drop-down menu Review the training guide for assistance	Most updates are made in real time in the secure portal. Directory updates are made nightly and will be reflected in your listing the next day.
Email	updatemyinfo@optum.com	48 hours
Provider Services Line	1-877-614-0484, 7 a.m. – 7 p.m., Monday – Friday	7-10 business days

Note: Facilities should submit demographic changes to their Provider Relations Advocate.

Changes that require modification and updates within 10 business days

Clinician Information
- Legal name of the provider
- Attested expertise/programs you offer (Services you provide must meet our credentialing criteria)

Practice Information by TIN
- Updates to Tax Identification Number (TIN) used for claims
- Changes in practice location, billing address, appointment phone number or secure fax number
- The *Accepting New Patients* status for each practice location

Licenses & IDs
- Changes in facility, agency or group ownership
- Changes in your privileges or affiliations
- Status of professional liability insurance
- Status of professional licensure and/or certification (Revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, debarment from any government program, monitoring or any other adverse action)
- Potential legal standing (Any malpractice action or notice of licensing board complaint filing)

Other information to review and update quarterly

Clinician or practice data
- Website and email addresses
- Virtual appointment availability
- Ethnicity
- Language(s) spoken
- Provider gender and sexual orientation

Training or focus on specific populations
- LGBTQA+/Transgender
- Blindness or visually impaired
- Homelessness
- Chronic illness
- Physical disabilities
- Co-occurring disorders
- Deafness or hard of hearing

Removal from network directory

The Consolidated Appropriations Act of 2021 requires all providers to review and attest to the accuracy of demographic information quarterly. Optum Behavioral Health may remove providers and facilities from our network directory if we are unable to verify demographic information. Please respond to notices from us within the time period indicated in the communication that we send to you.

Practice Locations and Contract Status

Individually Contracted Clinician

Your Participation Agreement is between you and United Behavioral Health. It is an agreement to see all members eligible to access the network. Your Participation Agreement with United Behavioral Health 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.

Clinicians Participating Under a Group Agreement

The Participation Agreement is between the group practice and United Behavioral Health. It is an agreement to see all members eligible to access the network at all locations affiliated with the group. The group must provide us with all practice locations and TIN(s) under which you may bill to facilitate proper reimbursement. Additional group TINs may require a contract amendment.

Facility/Agency Agreement

The Participation Agreement is between the facility/agency and United Behavioral Health. It is an agreement to see all members eligible to access the network. The Participation Agreement with United Behavioral Health 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.

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. Some common reasons for requesting unavailable status are extended illness, vacation or leave plans, and 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.

You are required to notify Provider Relations within 10 calendar days, unless otherwise required by state or federal law, of your unavailable status for new referrals. You may make this notification through secure the Transactions tool on the ***Provider Express*** secure portal or by contacting Provider Relations. 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 using the Transactions tool on the ***Provider Express*** secure portal or contact Provider Relations 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 using the Transactions tool on the ***Provider Express*** secure portal or notify Provider Relations.

Please note that while on unavailable status, your Participation Agreement remains in effect.

Group practices and facilities/agencies that wish to be made unavailable should contact Provider Relations.

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. 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.

Psychological Assistants and Interns

In accordance with the Participation Agreement, the services you bill must be provided directly by you for all members. Participating clinicians may not submit claims in their name for treatment services that were provided by a psychological assistant, nurse practitioner, intern or another clinician. For information regarding test administration by a psychometrician please refer to the APA Psychological and Neuropsychological Testing Billing and Coding Guide on the Provider Express website. This guide also addresses other procedures related to testing and report writing. You can also contact the appropriate Care Advocacy Center for assistance with such questions.

Physician Assistants and Residents in Facility Settings

Attending physicians must provide services directly to all members. In general, attending physicians may not submit claims in their name for treatment or psycho-diagnostic services that were provided by a resident, physician assistant or intern. We expect network physicians to be assigned as the attending doctor.

Termination or Restriction of Network Participation

A provider's participation with Optum can end for a variety of reasons. Both parties have the right to terminate the Participation Agreement upon written notice, as outlined in the Agreement.

If you need clarification on how to terminate your Participation Agreement, you may contact Provider Relations or your Facility Contract Manager.

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 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.

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 within 30 calendar days of the hearing date.

CMS Preclusion List

The Centers for Medicare and Medicaid Services (CMS) has a preclusion list effective for claims with dates of service on or after January 1, 2019. The Preclusion List applies to both Medicare Advantage plans as well as Part D plans. The preclusion list outlines prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Providers receive notification from CMS of their placement on the preclusion list, via letter, and will have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Optum or UnitedHealthcare.

Through the preclusion list, which CMS updates monthly, CMS advises Medicare Advantage and Part D plans of the date upon which providers' claims must be rejected or denied due to precluded status ("claim-rejection date"). As of the claim-rejection date, a precluded provider's claims will no longer be paid, pharmacy claims will be rejected, and the provider will be terminated from the Optum network; additionally, the precluded provider must hold Medicare beneficiaries harmless from financial liability for services or items provided on or after the claim-rejection date.

Continuation of Services after Termination

Network Clinicians, Group Practices and Agencies

If you want to withdraw from the Optum network, you are required to notify us, in writing in accordance with your Participation Agreement, at least 90 calendar days prior to the effective date of termination, unless otherwise stated in your Participation Agreement or required by applicable law.

With the exception of terminations due to 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. If a member elects continued treatment, treatment must be provided for up to 90 calendar days from the effective date of the contract termination, or as outlined in your Participation 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

Please note that state-specific laws will be followed when they provide for a different post-termination timeframe.

To ensure continuity of care, Optum will notify members affected by the termination of a clinician, group practice or agency at least 30 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 upon the earlier of the member's next appointment or prior to the effective termination date, in compliance with your Participation Agreement.

Network Facilities
Facilities that want to withdraw from the network are required to notify Optum, in writing in accordance with your Participation Agreement, at least- 120 calendar days prior to the date of termination unless otherwise stated in your Participation Agreement or required by state law. The Care Advocate may continue to issue authorizations for treatment during the termination period at the contracted rate, as provided by your Participation Agreement.

To ensure there is no disruption in a member's care, Optum has established a 120-calendar day transition period for voluntary terminations. If a facility's participation is terminated due to quality-related issues, fraud or change in license status requiring immediate transfer of a member to another facility, Optum and the facility will coordinate to ensure a safe and effective transition of care.

In some cases, you and the Care Advocate may determine it is in the best interest of a member to extend care beyond these timeframes. Optum will arrange to continue authorization for such care at the contracted rate. You may continue to collect all applicable co-payments and deductible amounts. The facility continues under contract at the existing rates through the completion of the episode of care at any level of care provided by the facility. Members may not be balance billed.

Benefit Plans, Authorizations, EAP and Access to Care

Introduction

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 Participation 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 on the Provider Express website or contact Provider Relations.

Care Advocacy

Licensed behavioral health Care Advocates are responsible for the administration of benefits including authorization of benefits when authorization is required. In addition, Care Advocates and cross-site functional areas focus on activities that impact member stabilization and recovery and promote active participation in their care. This approach consists of targeted interventions intended to reduce barriers in care, identify members who may be at risk, and to assist you in the coordination and delivery of care to members. This approach supports a collaborative relationship between you and the Care Advocate. Care Advocacy activity may include:

- Emphasizing the integration of medical and behavioral care by promoting communication among all treating providers involved in member 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;
- Assisting with appointment access within 7 days from the discharge date;
- Using the information on the Wellness Assessments to identify members who may be at-risk;
- Collaborating to identify barriers to care/community tenure and evaluation of gaps in prior discharge plans;

- Reaching out proactively to providers to discuss a member's care when an individual has been identified as being at-risk;
- Offering clinical consultations with Optum 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 including identifying support systems; and
- Referencing web-based and written information for members and treating clinicians regarding behavioral health conditions, designed to support informed decision-making.

Care Advocate Availability

Each Care Advocacy Center is open for standard business operations Monday through Friday from 8 a.m. to 5 p.m. in their respective time zones. In addition, Care Advocates are available 24 hours a day, 7 days a week, including holidays and weekends, to discuss urgent and emergent situations such as inpatient admissions, clinical benefit determinations and decisions, appeals, or any other questions about the care advocacy process.

Call the toll-free number on the member's ID card to reach the appropriate Care Advocacy staff member.

Affirmative Incentive Statement

Coverage determinations are based only on the appropriateness of care, as defined by applicable Clinical Criteria, the member's benefit plan and applicable laws.

You will find information about the **Clinical Criteria and Clinical Practice Guidelines** on the *Provider Express website* or you can receive a paper copy of Optum documents from Provider Relations.

Optum expects all treatment provided to members be outcome-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 under-utilization of services.

Eligibility Inquiry

The services a member receives are subject to the terms and conditions of the member's benefit plan. It is important that you inquire about what services are covered and the member's enrollment status before providing services.

We encourage you to use the ***Provider Express*** secure portal to check a member's eligibility. You may also inquire about eligibility by calling the phone number on the member's ID card. Be prepared to provide the following information: the member's name, address and identification number, as well as the subscriber's name and date of birth.

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 eligibility information at exactly the same time as the organization that controls the eligibility decisions. In addition, COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) rights, including election and payment grace periods, result in significant time during which Optum may not know the exact status of a member's coverage. Therefore, the member is often your best source for timely information about eligibility and coverage changes.

The Participation Agreement states that if an individual was not eligible for coverage for services rendered, those services shall not be eligible for payment by Optum. Members who are no longer eligible to access services under a benefit plan revert to the status of being a private paying patient, and you may bill them directly in accordance with applicable law.

Authorization or Notification for Inpatient and Sub-acute Services

In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state-specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining pre-authorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment).

Be prepared to provide information regarding clinical issues related to the member, such as: symptom severity, functional status, medical condition, treatment and engagement history, risk factors, recovery environment and discharge plan. You can access our **Guidelines/Policies & Manuals** on the ***Provider Express*** website. You may also request a paper copy of Optum documents from the Provider Service Line at **1-877-614-0484**.

Services provided to members in an inpatient psychiatric or substance use disorder unit are reviewed at the time of the initial request and may be reviewed concurrently by licensed clinicians. These reviews provide information regarding the patient's status and need for continued care. Optum reserves the right to require a direct conversation with the attending psychiatrist before authorizing benefits for admission or continued stay.

Emergency Admissions

In the event of an emergency admission for a member requiring immediate treatment and stabilization due to a mental health or substance abuse condition, facilities should stabilize and treat the member as soon as possible.

Circumstances that warrant an emergency admission are those in which there is a clear and immediate risk to the safety of the member or another person as a direct result of mental illness or substance use disorder.

After a member is stabilized in an emergency room, Optum requires notification within one business day after an admission for a facility to request a preauthorization, unless a longer period is required by contract or state-specific requirements.

Routine and Non-Routine Outpatient Services

Authorization or Notification for Mental Health/Substance Abuse Disorder Treatment Benefits

In accordance with the Participation Agreement and many benefit plans, most routine outpatient behavioral health services do not require an initial pre-authorization or notification.

Some non-routine outpatient services require ongoing authorization prior to providing services. These include:

- Outpatient Electroconvulsive Therapy
- Applied Behavioral Analysis for the treatment of Autism
- Transcranial Magnetic Stimulation (TMS) (for MDs only)
- Psychological Testing

Authorization for some non-routine services may be requested through either the Provider Express website, the Provider Express secure portal:

- ABA services: **Autism Corner: Autism/ABA Information**
  - **ABA Assessment Portal** (electronic authorization request submissions)
  - ABA Treatment Request Documents (please review webpage for specific forms)
- Psychological/Neuropsychological Testing
  - **Optum Psychological and Neuropsychological Testing Request Form** (electronic submission for Optum Behavioral Health, GHLP Michigan, Oxford plans)
  - **KanCare Psych Testing Request Form**
  - **Medica Psych Testing Request Form**
- Transcranial Magnetic Stimulation (TMS) & Electroconvulsive Therapy (ECT) (electronic submission)
  - **TMS & ECT Authorization Request Form** (electronic submission)

Additional Information
For authorization of other non-routine outpatient services, call the number on the member's ID Card. For more information refer to the **Psychological Testing** section of this manual.

For an unforeseen crisis for which there may be an unanticipated need for an extended office visit, you need to use the CPT code 90839 (psychotherapy for crisis services) to bill for the first 60 minutes of psychotherapy. Prior authorization is not required for crisis sessions. See the Extended Outpatient Psychotherapy section under **Behavioral Clinical Policies** for more information.

Authorizations for non-routine outpatient services are specific to the requesting clinician. The clinician will receive a copy of this authorization. When a written authorization lists a range of CPT and/or HCPCS codes, payment for any specific code is subject to ongoing medical necessity review.

When a member calls seeking referrals, Optum staff will collect demographic information, request coordination of benefits information, explain the services available under the member's benefit plan, and obtain a brief description of the presenting problem(s). Referrals are based on the clinical, cultural and geographic needs of the member.

The member website, **liveandworkwell.com**, is another avenue for members to locate in-network referral options for a full range of in-person and virtual clinical services. (Please note that the anonymous guest access code for you is "Clinician.")

The member is responsible for contacting the c to schedule an appointment. The member is advised of the number of sessions available under the benefit plan and any deductible, co-payment and/or co-insurance amount for which he or she will be financially responsible. The member will be given multiple clinician names and numbers from which to choose to schedule an appointment.

This initial session is also the time to administer the first Wellness Assessment. For greater detail about the Wellness Assessment, please see the **Wellness Assessments** section on page 41 of the manual or the **Wellness Assessment page** on the *Provider Express* website.

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

Clinical Outcomes Model

Optum is committed to working 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, outcome-based, cost-effective and clinically necessary treatment decisions.

The model uses member responses to a validated tool, the one-page Wellness Assessment, along with claims data. Both Wellness Assessment and claims information are analyzed through a set of algorithms to measure a member's behavioral health status and identify potential risks. In addition, the algorithms identify cases that may benefit from a review. Such reviews may include consideration of Clinical Criteria found at **Guidelines/Policies & Manuals** on the *Provider Express* website.

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.

Wellness Assessments

The Wellness Assessment 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.

Administration of the Wellness Assessment:

- Non-prescribers are required to offer the one-page assessment to each new Optum member or to the parent/guardian of a child or adolescent patient at the initial appointment.
- Return each completed Wellness Assessment to Optum as instructed on the form.
- A second Wellness Assessment is administered between session three and five.
- Optum reviews the assessment 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 Wellness Assessment will also be sent by Optum directly to the member approximately four months after the initial evaluation.

The information contained in the Wellness Assessment is confidential and will not be shared with the member's employer, medical benefit plan or medical clinicians without the member's consent.

A member may also decline to complete the assessment. If this occurs, submit a Wellness Assessment 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 Wellness Assessment. 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. Forms can be found on the **Wellness Assessment page** on the *Provider Express* website.

Practice Management

The clinical Practice Management team works with providers, groups and facilities, in coordination with other Optum departments, on the following:

- Managing outliers, through the identification of potential practice and/or billing 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 **Anti-Fraud, Waste and Abuse** section of this manual).
- Evaluating compliance with clinical processes and external clinical guidelines, Optum reimbursement policies and contractual obligations.

Practice Management employs intervention strategies to address potential practice and/or billing patterns of concern. Interventions may include 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, Performance Improvement Plans, referrals to Peer Review, non-coverage determinations, referral to Credentialing Committee for potential network termination and referral to 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.

WorkLife

A member who is actively engaged in an Employee Assistance Program (EAP) or in behavioral health treatment may also possess WorkLife (WL) benefits. In many cases, the WorkLife benefit can complement needs while in treatment by providing educational materials or verified community resources. Support groups, financial assistance programs and referral to community social service agencies are only some examples of what can be provided.

Please direct the member or family member to call their EAP/WL toll-free number. Members will be directed to a WorkLife Specialist who will assess and consult with the caller about how to best meet his or her needs.

Employee Assistance Program (EAP) Benefits and Authorization

The EAP benefit is designed to provide assessment and referral, as well as a brief counseling intervention for members and their families. The typical EAP benefit offers a limited number of sessions with a clinician and is not designed to provide a course of psychotherapeutic treatment. Not all Optum members have an EAP benefit, but those who do can generally see any contracted Optum clinician for EAP services. There are limitations around the use of EAP benefits with psychiatrists.

EAP benefits require pre-authorization
Authorizations for EAP services are required and must be initiated by members or network clinicians prior to the first appointment.

Member authorization request:
Members with an EAP benefit can request EAP authorization through the member website **liveandworkwell.com** or by phone. Most members have a dedicated EAP number listed on their member ID card.

- An EAP authorization letter is sent to the member and allows them to see any Optum network non-psychiatrist provider for the number of sessions authorized:
  - The member is instructed to bring a copy of the letter to the provider.
  - This letter includes the authorization number which should be included on the claim. You may also obtain the authorization number through the Provider Express secure portal using the Authorization Inquiry function.
- When a member presents for EAP services, you should inquire whether any of the authorized visits have already been used.

Provider authorization request:
To obtain an EAP authorization, call **1-866-248-4094.** You must obtain a new EAP authorization when a new benefit year begins.

Referrals

Optum makes every effort to refer members with EAP benefits to clinicians with EAP expertise. However, when a clinician with an EAP specialty is not available in the area, Optum will refer to an appropriate network clinician based on the member's presenting needs. As a clinician in the Optum network, you are expected to accept members who present with an EAP benefit in compliance with your Participation Agreement.

In an EAP benefit, all pre-authorized sessions are paid by Optum at 100% of the Optum contracted rate of reimbursement. The member has no financial responsibility (i.e., the member does not have a deductible, co-payment or co-insurance amount).

EAP Transition to Mental Health/Substance Abuse Disorder Treatment Benefits

Some members will have a managed behavioral health care benefit through Optum in addition to their EAP benefit.

In most cases, once a member has exhausted their EAP benefit, you may continue to see the member under their behavioral health care benefit, when indicated. Note that once a member's benefits have transitioned from EAP to mental health/substance abuse disorder coverage, his or her financial responsibility will vary according to the member's benefit plan. The member may be responsible for a deductible, co-payment and/or co-insurance amount.

EAP and Medication Management

Medication management services are rarely covered under EAP services and those that do require prior authorization or notification.

EAP and Wellness Assessments

If the member you are seeing has a combined EAP and mental health/substance abuse disorder benefit through Optum, administer the Wellness Assessment at the initial EAP session. If the member eventually transitions to mental health/substance abuse disorder benefits, it is not necessary to have them complete another initial Wellness Assessment at the time of the transition. However, you should administer the second Wellness Assessment between sessions three and five. For greater detail about the Wellness Assessment, please see the **Wellness Assessments** section on pages 41 of this manual.

Standard Behavioral Care

Standard Behavioral Care provides mental health/substance abuse disorder care advocacy services for UnitedHealthcare members enrolled in designated PPO benefit plans. You are contracted with Optum to provide mental health/substance use disorder services to members with these benefits.

Notification through Optum is required for inpatient, residential and partial hospitalization services. Outpatient services, including intensive outpatient programs and psychological testing, do not require notification.

Members covered under these plans can receive referrals to network clinicians and facilities from Standard Behavioral Care staff. Mental health/substance abuse disorder services for these members are reimbursed at Optum contracted rates. To receive payment at the network benefit level, claims for these outpatient mental health/substance abuse disorder services should be submitted to the Optum Claims office listed on the member's ID card.

Mental Health/Substance Abuse Disorder Medication Management Services

Psychiatrists and prescribing APRNs and PAs are not required to obtain prior authorization for the initial consult, routine medication management sessions and other routine outpatient services, such as the 90791, 90792, 90832, 90834 and evaluation and management codes, as applicable.

Pharmaceutical Management Services

Pharmacy benefits are not managed by the behavioral health plan. For information about formularies, pharmacy benefits and cost management programs, please contact the medical or pharmacy number on the member's ID card.

Lab Services

Patients with substance use disorders may require laboratory testing services in addition to the inpatient and/or outpatient psychotherapy and medical interventions included in their recovery plan. Urine drug testing services for a patient in an active Substance Use Disorder (SUD) treatment program may be needed to monitor levels of, and/or detect the presence of, prescribed therapeutic drugs, prescription drugs of abuse, and/or illicit drugs to support diagnosis and to assess adherence with the recovery plan.

Participating providers should refer to your Participation Agreement, which reflects contracted services and the associated fee schedule for acceptable billing codes. Unless otherwise specified in your Participation Agreement, lab charges are included in your contracted rates for services and will not be reimbursed separately. Claim submissions by participating providers which are not in compliance with your Participation Agreement will be denied.

Please identify and refer members to in-network labs based upon the particular member's benefit plan. When referring for lab services, providers are expected to refer to an in-network lab based on a member's benefits.

Applied Behavioral Analysis (ABA) Services

Coverage for Applied Behavioral Analysis (ABA) services usually requires prior authorization by an Optum Care Advocate. Please be aware that not all benefit plans provide coverage for ABA services. Prior to beginning care, network Qualified Behavior Analysts/Specialists and ABA agencies must contact Optum, via the number on the back of the member's ID card, to verify eligibility, review treatment plans and obtain authorization.

Complex Case Management

Optum offers a Complex Case Management program for members who may benefit from more intensive coordination of services. This program is intended to help members with complex behavioral health conditions connect with needed services and resources.

Behavioral Health Advocates work intensely with individuals in the development of a comprehensive plan of care. For more information, including criteria for inclusion in the program and referring a member, visit the **Complex Case Management Program** webpage.

Retrospective Review Process

In extenuating circumstances, and at our sole discretion, Optum reserves the right to retrospectively certify coverage of admissions for emergency services provided. Any certification is dependent upon the specific circumstances of each individual case. Optum reserves the right to deny coverage for all or part of an admission.

Requests for retrospective reviews must be received by Optum within 180 calendar days of the date the services were provided to the member unless applicable law mandates otherwise. A retrospective review occurs on those occasions when an initial request for authorization or notification, when required, is made after services have already been delivered but no claim has been filed.

Requests for retrospective review must include information regarding the reason or circumstances preventing required prior authorization or notification and include the medical record and will be processed at the sole discretion of Optum.

For all retrospective reviews, Optum will issue a determination within 30 calendar days of receipt of the request, unless otherwise required by applicable law or customer contract. Any retrospective review requests received outside the established time frame will not be processed by Optum.

The Important Message (IM) from Medicare

Hospitals must deliver valid, written notice of a Medicare beneficiary's rights as a hospital inpatient, including discharge appeal rights, using the standardized CMS-10065 form.

Medicare Outpatient Observation Notice (MOON)

Hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any Medicare beneficiary, including a Medicare Advantage Plan enrollee, who receives observation services as an outpatient for more than 24 hours. The hospital must provide the notice using the CMS-10611 form no later than 36 hours after outpatient observation services begin.

Pilot Projects Affecting Authorization Requirements

We may occasionally launch pilot projects that alter the pre-authorization requirements described above. We will advise you of any initiatives affecting authorization requirements in a separate communication. Follow the expected pre-authorization requirements unless you have received notification from us of your inclusion in a pilot project.

Psychological Testing

Psychological testing must be pre-authorized separately for both outpatient and inpatient services.

Psychological testing is considered after a standard evaluation (including clinical interview, direct observation and collateral input, as indicated) has been completed and one of the following circumstances exists:

- There are significant diagnostic questions remaining that can only be clarified through testing.
- There are questions about the appropriate treatment course for a patient or a patient has not responded to standard treatment with no clear explanation and testing would have a timely effect on the treatment plan.
- There is reason to suspect, based on the initial assessment, the presence of cognitive, intellectual and/or neurological deficits or impairment that may affect functioning or interfere with the patient's ability to participate in or benefit from treatment and testing will verify the presence or absence of such deficits or dysfunction.

In some cases where a member in need of testing has already received sufficient evaluation to conclude testing is necessary, it is permissible to conduct the initial interview intake on the same day of service as testing.

Generally, psychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered. Also not covered are tests performed routinely as part of an assessment. We recommend that you contact Optum before you deliver services to determine authorization requirements and procedures.

Access to Outpatient Mental Health and EAP Care

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 mental health/substance abuse disorder appointment must be offered within 10 business days of the request.
- An initial EAP appointment must be offered within 3 business days.
- Urgent appointments must be offered within required timeframes:
  - EAP – 24 hours
  - MH/SUD – 48 hours
- Non-life-threatening emergencies must be offered within 6 hours.
- An immediate appointment must be offered for any life-threatening emergencies.
- A mental health/substance abuse disorder outpatient appointment must be offered within 7 days of an acute inpatient discharge or emergency department discharge for a mental health or substance use disorder.

If more stringent time frames are required by applicable law or customer contract, we require that the network adhere to the more stringent time frames.

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 or an emergency department visit for a mental health or substance use disorder, Optum expects a follow-up outpatient appointment to occur with a behavioral health practitioner within 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 the number on his or her ID card so that he or she can obtain a new referral.

Treatment Philosophy

Introduction

We are committed to creating and maintaining relationships with 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. Based on more than 30 years of experience, we know it is the efforts of our clinical network that give 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 collaboration, we look to foster personally defined outcomes for members receiving behavioral health services.

In accordance with your Participation Agreement, you are required to provide services in a manner that is consistent with professional and ethical standards as set forth by national certification and state licensing boards and applicable law and/or regulation, regardless of a member's benefit plan or terms of coverage. Resources are available to you which outline the expectations for Optum network treatment quality.

This manual addresses assessment, 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 on the ***Provider Express*** website, including:

- **Clinical Criteria**
- **Behavioral Clinical Policies**
- **Clinical Practice Guidelines**
- **State-Specific Criteria**
- **Medicare Coverage Summaries**
- **Reimbursement Policies**

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

Clinical Criteria

Clinical Criteria are intended to promote optimal clinical outcomes and consistency in the authorization of benefits by Care Advocacy staff and peer reviewers.

For guidance on clinical criteria decisions for the treatment of behavioral health conditions, Optum uses:

- LOCUS – for adults (Level of Care Utilization System)
- CALOCUS-CASII – for children and adolescents ages 6-18 (Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Utilization System)
- ECSII – for children ages 0-5 (Early Childhood Service Intensity Instrument)

LOCUS/CALOCUS-CASII/ECSII were created and updated based on the changing landscape or evidence informed care, market and regulatory considerations, and feedback from stakeholders across the care system. They meet three main concepts that need to be considered and balanced in effectively managing behavioral health services: (1) Use of wrap-around services; (2) tailored to specific age of the member; and (3) adopts a system of care approach.

The ASAM Criteria are clinical guidelines designed by the American Society of Addiction Medicine (ASAM) to improve assessment and outcomes driven treatment and recovery services. It is also used to match patients to appropriate types and levels of care. Your Participation Agreement sets forth the levels of care for which you are contracted, and it may not cover all ASAM-defined levels of care.

Medicare Coverage Summaries

Our **Medicare Coverage Summaries** are intended to promote optimal clinical outcomes and consistency in the authorization of Medicare benefits by Care Advocacy staff and Peer Reviewers. Medicare Coverage Summaries offer the guidance found in CMS national coverage determinations, local coverage determinations, and CMS benefit policy manuals. They are available on the ***Provider Express*** website or you may request a paper copy by contacting the Provider Service Line at **1-877-614-0484**.

The Clinical Technology Assessment Committee

The Clinical Technology Assessment Committee meets at least quarterly, and as needed, to review current medical and scientific literature. An Optum medical director chairs this multidisciplinary committee. This committee consults 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. This committee examines the use of new technologies and new applications of existing technologies for the assessment and treatment of behavioral health conditions. The committee also reviews existing technologies when questions arise as to their application.

The committee recommends as proven those treatments for which there is peer-reviewed and published scientific evidence of efficacy and safety. This evidence includes randomized controlled studies of adequate sample size, published in established peer-reviewed journals, as well as guidance from state and federal agencies.

If you have a technology that you would like to have reviewed by this committee, please contact the Care Advocacy Center with which you most often work. Make your request to the medical director and he or she will notify the committee chair of your interest.

Assisting with Recovery

We support your efforts to assist 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 recovery, enhance self-management, including use of personally defined outcomes and support of broader recovery goals.

We encourage you to discuss all treatment options and the associated risks and benefits and solicit the member's input about their treatment preferences, regardless of whether the treatment is covered under the member's benefit plan. Nothing in this manual is intended to interfere with your relationship with members as patients.

Our **Recovery and Resiliency Toolkit** that contains resources for providers and the individuals and families you serve.

Assessment

A thorough clinical assessment is essential to treatment planning. You are required to document your assessment, including negative findings as applicable, in the member's clinical record. A clinical assessment must include:

- A biopsychosocial history, including previous medical and behavioral health conditions, interventions, outcomes, and lists of current and previous medical and behavioral health providers
- The mental status exam, including an evaluation of suicidal or homicidal risk
- A substance use screening should occur for members over the age of 11 years, noting any substances abused and treatment interventions
- Other areas to be covered in the assessment are:
  - Developmental history
  - Education
  - Legal issues
  - Social support

Your assessment should also consider:

- An evaluation of why the member is seeking treatment at this level of care at this time
- Services you can offer to meet the member's immediate needs and preferences
- Alternatives that exist in the service system to meet those needs
- The member's broader recovery, resiliency and well-being goals
- Unique cultural and spiritual needs of the member

For routine outpatient services, a **Wellness Assessment** is to be part of every new treatment episode. This screening tool helps to identify symptoms, conditions and co-morbidities that may be important to address in a comprehensive treatment plan.

Treatment and Discharge Planning

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. Optum expects that the provider will collaborate with the member during treatment, recovery and discharge planning whenever possible.

- Effective treatment planning should take into account significant variables such as age and level of development, the history of treatment, whether the proposed services are covered in the member's benefit plan and are available in the community, and whether community resources such as support groups, consumer-run services and preventive health programs can augment treatment.
- The provider should also take into account the member's preferences as directly expressed or documented in an advance directive or crisis plan, if applicable. For some members, treatment is part of a broader recovery and resiliency effort, so the recovery & resiliency goals which may be documented in a recovery plan should also be considered.
- Optum Care Advocates monitor discharge planning and are available to assist with identifying and facilitating access to available treatment services and community resources.

Member Reassessment

A change in the member's condition should prompt a reassessment of the treatment plan and selection of level of care:

- When a member's condition has improved, the reassessment should determine whether a less restrictive level of care may be adequate to treat the condition, or whether the member no longer requires treatment.
- When a member's condition has not improved or it has worsened, the reassessment should determine whether the diagnosis is accurate, if the treatment plan should be modified, or if the condition should be treated in another level of care.

Discharge Planning

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 provider anticipates the discharge date and forms an initial impression of the member's post-discharge needs.
- The initial discharge plan may evolve in response to changes in the member's condition and preferences.
- The final discharge plan should document the anticipated discharge date, the proposed post-discharge services, and the plan to coordinate discharge with the provider at the next level of care, when indicated.
- The discharge plan should also address ways 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.

Post-Discharge

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 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. Optum assesses the compliance of its network facilities in meeting this standard on an annual basis.

Communication with Primary Physicians and Other Health Care Professionals

When a member is receiving services by more than one professional, it is critical that the service providers collaborate and coordinate effectively to ensure that care is comprehensive, safe and effective.

Benefits of Care Coordination

Optum expects providers to make a good faith effort at coordinating care with other behavioral health clinicians or facilities and medical care professionals who are treating the member. Coordination of services may improve the quality of care to members in several ways:

- Allows behavioral health and medical providers to create a comprehensive care plan
- Allows a primary care physician to know that his or her patient followed through on a behavioral health referral
- Minimizes potential adverse medication interactions for members who are being treated with psychotropic and non-psychotropic medication
- Allows for better management of treatment and follow-up for members with coexisting behavioral and medical disorders
- Promotes a safe and effective transition from one level of care to another
- Reduces the risk of relapse

Communication Touchpoints

To coordinate and manage care between behavioral health and medical professionals, Optum expects that you will request 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). Coordination and communication should take place:

- At the time of intake
- During treatment
- At the time of discharge or termination of care
- At the point of transition between levels of care, and
- At any other point in treatment that may be appropriate

General Guidelines
The following guidelines are intended to facilitate effective communication among all behavioral health and medical professionals as appropriate to a member's care:

- During the diagnostic assessment session, request the member's written consent to exchange information with all appropriate behavioral health and medical professionals who are providing treatment
- After the initial assessment, provide other behavioral health and medical 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 medical professionals when there is a change in the member's condition or medication(s)
- Update other behavioral health and medical professionals when serious medical conditions warrant closer coordination
- At the completion of treatment, send a copy of the discharge summary to the other behavioral health and medical professionals
- Attempt to obtain all relevant clinical information that behavioral health and medical professionals may have pertaining to the member's mental health or substance use conditions

It is understood that some members may refuse to consent to release information to other behavioral health and medical professionals. Optum encourages its providers to discuss the benefits of sharing information and the potential risks of not sharing information, and to document the discussion in the member's clinical record.

Member Rights and Responsibilities

You will find a copy of our Member Rights and Responsibilities at the end of this manual. You may request a paper copy by contacting the Provider Service Line at **1-877-614-0484**. These rights and responsibilities align 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.

Services of Interpreters

It is typically your responsibility to arrange for the services of interpreters, when indicated, for members under your care. Financial responsibility for such services varies depending on the benefit plan and/or governing law; accordingly, these costs may be assigned to you, to Optum, to the member or may be shared between any or among all of these parties. You may contact a Care Advocate by calling the number on the member's ID card to determine who is financially responsible.

Treatment Record Documentation Requirements

Introduction

In accordance with your Participation 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, state licensing, Centers for Medicare and Medicaid Services (CMS) and/or national certification board standards.

In order to perform required utilization management, practice management, payment and quality improvement activities, we may request access 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.
- Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to Optum and its payors, customers, clinicians and facilities.

Onsite Audits

We may review your records during a scheduled onsite audit or may ask you to submit copies of the records to Optum for review. An onsite audit or treatment record review may occur for a number of reasons, including, but not limited to:

- Reviews of facilities and agencies without national accreditation such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF) or other agencies approved by Optum
- Audits of services and programs including, but not limited to, Applied Behavioral Analysis (ABA), services delivered through telehealth platforms, and Peer Support Services
- Audits of high-volume providers
- Routine audits
- Audits related to claims coding or billing issues
- Audits concerning quality of care issues
- Audits concerning potential practice or billing patterns

Audit Results
Routine, standard monitoring and quality of care 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 onsite audit.
- Onsite audit or treatment record review scores under 85% will require a written Corrective Action Plan.
- Scores under 80% require submission of a written Corrective Action Plan and a re-audit within 6 months following implementation of the plan. However, in some cases, a requesting committee may require a Corrective Action Plan and/or re-audit regardless of the scores on the audit tools.

Treatment Record – Content Standards

When billing services for more than one family member, separate treatment records must be maintained.

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

- The member's name or identification number on each page of the record.
- The member's address; employer or school; home and work telephone numbers, including emergency contacts; marital or legal status; appropriate consent forms; and guardianship information.
- The date of service, either start and stop time or total time in session (for time-based services), the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS)/Revenue (REV) code billed, notation of session attendees, the rendering clinician's name, professional degree, license and relevant identification number as applicable.
- Treatment record entries should be made on the date services are rendered and include the date of service. If an entry is made more than 24 hours after the service was rendered, the entry should include the date of service, date of the entry and a notation that it is a late entry.
- Clear and uniform modifications. Any error is to be lined through so that it can still be read, then dated and initialed by the person making the change.
- Clear documentation of medication allergies, adverse reactions and relevant medical conditions. If the member has no relevant medical history, this should be prominently noted.
- Clear and uniform medication tracking that provides a comprehensive summary of all medications taken by the member from the onset of care through discharge, including the following applicable for all prescribers:
  - Standing, as needed (PRN) and immediate (STAT) orders for all prescription and over-the-counter medications.
  - The date medications are prescribed along with the dosage and frequency.

  - Informed member consent for medication, including the member's understanding of the potential benefits, risks, side effects and alternatives to the medications.
  - Changes or rationale for lack of changes in medication and/or dosage should be clearly documented along with the clinical rationale for the changes.
  - Discharge summaries should specify all medications/dosages at the time of discharge.
- A clear summary of presenting problems, the results of mental status exam(s), relevant psychological and social conditions affecting the member's medical and psychiatric status, and the source of such information.
- Prominent documentation (assessment and reassessment) of special status situations, when present, including, but not limited to, imminent risk of harm, suicidal or homicidal ideation, self-injurious behaviors, or elopement potential (for all overnight levels of care). It is also important to document the absence of such conditions.
- A medical and psychiatric history including previous treatment dates, clinician or facility identification, therapeutic interventions and responses, sources of clinical data and relevant family information.
- The behavioral health history includes an assessment of any history of abuse the member has experienced.
- For adolescents, the assessment documents a sexual behavior history.
- For children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic).
- For members 12 years of age and older, documentation includes past and present use of nicotine or alcohol, as well as illicit drugs, prescribed or over-the-counter medications.
- Documentation of a DSM diagnosis consistent with the presenting problem(s), history, mental status examination and other assessment data.
- Medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of mental health condition.
- Treatment plan documentation needs to include the following elements:
  - Specific symptoms and problems related to the identified diagnosis of the treatment episode
  - Critical problems that will be the focus of this episode of care are prioritized; any additional problems that are deferred should be noted as such
  - Relates the recommended level of care to the level of impairment
  - Member (and, when indicated, family) involvement in treatment planning
  - Treatment goals must be specific, behavioral, measurable and realistic
  - Treatment goals must include a time frame for goal attainment
  - Progress or lack of progress towards treatment goals
  - Rationale for the estimated length of the treatment episode
  - Updates to the treatment plan whenever goals are achieved or new problems are identified
  - If the member is not progressing towards specified goals, the treatment plan should be re-evaluated to address the lack of progress and modify goals and interventions as needed

- Progress notes include:
  - Signature of the practitioner rendering services
  - The date of service
  - If provided through telehealth, documentation of the use of this technology
  - Member strengths and limitations in achieving treatment plan goals and objectives
  - Treatment interventions that are consistent with those goals and objectives noted in the treatment plan
  - Dates of follow up visits
  - Documentation of missed appointments, including efforts made to outreach the member
  - For time-based services only, either start and stop time or total time in session
- Documentation of on-going discharge planning (beginning at the initiation of treatment) includes the following elements:
  - Criteria for discharge
  - Identification of barriers to completion of treatment and interventions to address them
  - Identification of support systems or lack of support systems
- A discharge summary is completed at the end of the treatment episode that includes the following elements:
  - Reason for treatment episode
  - Summary of the treatment goals that were achieved or reasons the goals were not achieved
  - Specific follow up activities/aftercare plan
- Documentation of coordination of care activities between the treating clinician or facility and other behavioral health or medical clinicians, facilities or consultants. If the member refuses to allow coordination of care to occur, this refusal and the reason for the refusal must be documented. Coordination of care should occur:
  - At the time of intake
  - During treatment
  - At the time of discharge or termination of care
  - At the point of transition between levels of care, and
  - At any other point in treatment that may be appropriate
- Documentation of referrals to other clinicians, services, community resources, and/or wellness and prevention programs
- Telehealth Services: If the service is being provided virtually, this must be noted in the treatment record. Many states have specific documentation requirements for telehealth services. Please review the telehealth regulations in the states in which you are licensed to practice.
- Billing records should reflect all applicable fields as required for completion of the Form 1500 claim form or UB-04 claim form.
- The **Fraud, Waste, Abuse, Error and Payment Integrity** information page on the *Provider Express* website includes additional resources to support documentation requirements.

Guidelines for Storing Member Records

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

- Practice sites and facilities must have an organized system of filing information in treatment records.
- Treatment 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 7 years from the date of service, or in accordance with applicable state or federal law, whichever is longer. Termination of the Participation Agreement has no bearing on this requirement.
- Financial records concerning covered services rendered are required to be maintained from the date of service for 10 years or in accordance with applicable state or federal law, whichever is longer. Termination of the Participation Agreement has no bearing on this requirement.
- Providers with Electronic Health Records must have an established procedure to maintain a backup copy of all electronic health records.

Member Access to Medical/Mental 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.

Confidentiality of Records

Introduction

We strive to protect member confidentiality by complying with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, its implementing regulations, and other applicable federal and state privacy laws, including 42 CFR Part 2 (Part 2) and mental health/substance use disorder laws. It is our expectation that participating providers also follow these laws to protect the confidentiality of member records as well as:

- Providing us with protected health information as needed and permitted for treatment, payment and health care operations purposes;[1]
- Obtaining member consent when needed to provide requested information to us; and
- Notifying us whether and when you are providing or disclosing data that is covered by Part 2.

Release of Member Information

It is our policy to release information only to the member or to other parties designated in writing by the member, unless otherwise permitted or required by law.

A member may authorize release of his or her protected health information (PHI) by submitting a signed, dated and legally compliant Release of Information (ROI) that specifies what information may be disclosed, to whom, for what purpose(s), and during what period of time. A member's authorization for ROI is not required when PHI is being exchanged between a provider and Optum for the purposes of treatment, payment or health care operations, as provided in HIPAA and consistent with other applicable federal and state laws.[1]

Identification and Authentication

Anyone requesting access to protected health information must be reasonably authenticated:

- **Provider authentication:** To identify and authenticate you or your administrative staff, we may require certain information such as your federal tax identification number or physical address and member information.
- **Member verification:** Member information we may require for identification and authentication includes the member's full name, full date of birth, full address, and member number or subscriber number. If you or your administrative staff are unable to supply an identification or address, we may require the member's full telephone number or the last four digits of their Social Security Number.

[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.

Quality Improvement

Participation in the Optum Quality Improvement Program

We are committed to the highest quality of care provided in a manner consistent with the dignity and rights of members. Our Quality Improvement program monitors the following items:

- Accessibility
- Quality of care
- Appropriateness, effectiveness and timeliness of treatment, and
- Member satisfaction

The program is comprehensive and incorporates the review and evaluation of all aspects of the managed behavioral health care delivery system. If you have any feedback regarding QI projects and processes, please contact Provider Relations.

Compliance with the Quality Improvement program is required in accordance with your Participation Agreement, including cooperation with Optum and customers in their efforts to adhere to all applicable laws, regulations and accreditation standards.

Key Components Required of Network Providers

- Ensuring that care is appropriately coordinated and managed between you and the member's primary medical physician and other treating practitioners and/or facilities
- Cooperation with onsite 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 performance measurement programs such as the Facility Platinum Designation program or the ACE Clinicians program. (Please refer to the Facility Platinum Designation or the Achievements in Clinical Excellence (ACE) Clinicians sections 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
- Assisting us in maintaining various accreditations as appropriate and as requested
- Submission of information related to our review of potential quality of care concerns and sentinel events
- Helping to ensure members receive rapid follow-up upon discharge from an inpatient level of care

Upon request, Optum makes information available about the Quality Improvement program, including a description of the program and a report of our progress in meeting goals. Some of the activities that may involve you are described in more detail on the following pages.

Sentinel Events

Sentinel events 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/facility providing services. The event(s) has, or may have, deleterious effects on the member, including death or serious disability, that occurred during the course of a member receiving behavioral health treatment. If you are aware of a sentinel event involving a member, you must notify Optum Care Advocacy within one business day of learning about the occurrence by calling the number on the member's ID card.

We have established processes and procedures to investigate and address sentinel events. This includes a Sentinel Event Committee, chaired by medical directors within Optum. You are required to cooperate with sentinel event investigations.

Member Satisfaction Surveys

On at least an annual basis as customers allow, we conduct a Member Satisfaction Survey of a sample of members receiving behavioral health services within the Optum network. The results of the survey are reviewed and action plans are developed to address opportunities for improvement.

Clinician Satisfaction Survey

We regularly conduct a satisfaction survey of a sample of clinicians that delivered behavioral health services to members. This survey obtains data on clinician satisfaction with Optum services.

The results of the survey are compared to previous years for tracking and trending and action plans are developed to address opportunities for improvement.

Prevention Programs

Optum provides resources for early intervention in behavioral health problems. The interventions are for Major Depressive Disorder (MDD), Attention-Deficit/Hyperactivity Disorder (ADHD), and Alcohol and Substance Use Disorders. For each of these conditions, Optum offers member resources:

- A screening tool to help the member decide whether to seek care
- Articles about the behavioral health conditions and how they are treated
- A list of organizations the member can contact if they want more information about a condition and its treatment
- Contact information for self-help groups if the member wants to talk with others who can provide support and encouragement
- Information on how to contact us if the member has questions or concerns

These resources can be accessed at **prevention.liveandworkwell.com** by all members, medical providers, and Optum network practitioners and facilities.

Practice Guidelines

Optum has adopted **clinical guidelines** from nationally recognized behavioral health organizations and groups. Annually, Optum reviews standard HEDIS® measures as supplemental and measurable guidelines to inform ongoing quality initiatives.

Your feedback is encouraged on all guidelines and any suggestions on new guidelines to be considered for adoption are welcome.

Quality Assurance and Complaint Investigations

You are required to fully cooperate with Optum in any complaint investigations and in the Quality Assurance Review process.

Complaints staff, in conjunction with Quality Improvement and Provider Relations staff, monitor complaints filed against all practitioners and facilities. This includes soliciting information from them to properly address complaints and potential quality of care concerns.

In general, the resolution of most service complaints is communicated to the member when the complaint is received from, or on behalf of, the member. Clinical quality of care concerns initiated by members do not routinely include notification of resolution, except as required by applicable law or contractual agreement.

Record Requests

If we request written records for a Quality Assurance Review, you must submit these to Optum within 14 days or sooner, as requested to meet customer/regulatory guidelines). In matters involving member safety, immediate responses may be requested.

Complaints filed by members should not interfere with the professional relationship between you and the member. Even if you use a third-party medical records vendor or other unique contractual agreement, you are required to provide records in the requested timeframe to ensure that all customer/regulatory requirements are met.

Corrective Action Plans

We may require the development and implementation of an appropriate Corrective Action Plan for concerns discovered in the course of investigating complaints and quality assurance reviews. Such action may include, but is not limited to, having Optum:

- Require you to submit a written response and/or submit and adhere to a CAP
- Require you to participate in an onsite audit or treatment record review audit
- 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
- 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 practitioner or facility

- Terminate your participation status with Optum
- Report concerns to the appropriate entity, such as the licensing board

Unavailable Status
Cooperation with an unavailable status associated with complaint, quality of care or sentinel event investigations may include:

- Informing members of your unavailable status at the time of an initial request for services and identifying other network practitioners or facilities to provide services or referring the member to Optum for additional referrals
- Informing current members of your status and their option to transfer to another network practitioner or facility
- Assisting members with stable transfers to another network practitioner or facility at the member's request

Audits of Sites and Records

Onsite and record-only audits may occur with any contracted provider. Both types of audits involve reviewing a sampling of treatment records. The onsite audit also 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 facility or office site.

Optum representatives conduct site visits at clinician offices, agencies such as Community Mental Health Centers (CMHCs), facilities and group provider locations. Onsite audits are routinely completed with agencies and facilities 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 facility environment. Routine audits, either onsite or as a record-only review, may also occur in support of various health plan initiatives to monitor service delivery quality.

National Accreditation Considerations
Facilities and agencies that hold national accreditation through organizations such as the Joint Commission, CARF, COA, HFAP, NIAHO, CHAP and/or AAAHC receive credit for meeting those standards of care for the identified accredited services or programs without additional review prior to the initial credentialing process. When it is determined that a service or program is not part of the accreditation, we will audit that particular service or program.

Facilities and agencies that are not accredited will be required to participate in an onsite audit prior to credentialing and a recredentialing audit prior to their specified recredentialing timeframe. Any facility or agency, regardless of their accreditation status, may be subject to an onsite audit for any member complaints or suspected quality of care concerns brought to the attention of Optum.

Chart Documentation
During onsite and record-only audits for all types of providers, chart documentation is reviewed, including (but not limited to) the assessment (which is distinct from any questionnaire the member may complete), 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. 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. You can review the forms used during audits on the ***Provider Express*** website: Clinical Resources > Optum Forms > Site Audit Tools.

Member Education

We offer members convenient 24/7 confidential access to professional care, self-help programs and information and the member website ***liveandworkwell.com***. It's available around the clock, from the convenience of the member's desk or the comfort of their home. Best of all, it's absolutely free to members and their families.

Practitioners are also able to access these resources using the access code 'Clinician' on ***liveandworkwell.com***. From self-assessments to videos and apps, you'll find a variety of helpful educational materials for members. We encourage you to visit the site often and direct members to take advantage of these resources.

Facility Platinum Designation

Overview

The **Platinum Designation** is for facility-based programs. Formerly known as ACE Facility, Platinum is a facility measurement and recognition designation that acknowledges facilities for delivering both effective and efficient clinical care. Claims-based data for inclusion in the program is run annually and facilities are notified by mail when one or more of those programs have achieved the Platinum designation or when there is a change in the designation status.

Facilities are responsible for following prior authorization and discharge notification procedures associated with the Platinum Designation. Failure to notify Optum at time of discharge or when the patient is being stepped down to a lower level of care may result in claim processing delays or denials.

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Achievements in Clinical Excellence (ACE) Clinicians

Overview

The ACE Clinicians program recognizes network individual and group practices based on their effectiveness and efficiency metrics after the threshold for the volume of member Wellness Assessments has been met.

Criteria for Inclusion

Network clinicians must have a minimum of 10 cases and group providers must have a minimum of 20 cases for the 2-year measurement period (2 years) in which the initial Wellness Assessment for each of those measured in the clinical range for global distress. In addition, each of those cases must have submitted at least 1 follow-up Wellness Assessment attributable to each of the cases.

Automatic Enrollment

ACE will automatically evaluate qualified clinicians and group providers. However, due to state regulatory requirements, providers in some states are ineligible to participate in ACE. Clinicians and group providers in the excluded states are ineligible to receive Clinician directory recognition.

Access and Tracking ACE Scorecards

Practitioners can view their scores in the *Provider Express* secure portal. In the portal, go to the More menu, select Provider Reports, then click on Achievements in Clinical Excellence on the dashboard. Scores are available for viewing on or about November 1 of each year. For more information, please see our "**ACE Clinicians**" page on the *Provider Express* website.

Directory Recognition

When a clinician or group demonstrates consistency in meeting ACE metrics, they are recognized as a Platinum provider and are identified with a Platinum ribbon within their listing on the ***liveandworkwell.com*** member website and within other provider search directories available to members and care advocates.

Please note: Due to state regulatory requirements, providers in the following seven states may not be publicly recognized for their ACE designation within our online provider directories: California, Colorado, Maryland, Missouri, New York, Tennessee and Texas.

If your practice resides in one of the excluded states, it's very important that you continue submitting Wellness Assessments. Since measurement relies upon data that is collected over a two-year period, submitting the assessments allows us to have your data on hand if regulatory changes occur that allow us to recognize your excellent performance through the ACE program.

Compensation and Claims Processing

Compensation

Providers
The contracted rate for eligible outpatient visits is reimbursed to practitioners at:

- The lesser of your customary charge, less any applicable co-payments, co-insurance and deductibles due from the member, or
- The Optum contracted rate, less any applicable co-payments, co-insurance and deductibles due from the member.

Facilities
The contracted rate for facilities is referenced in the Payment Appendix of the facility Participation Agreement. The Appendix defines rates applicable to inpatient and/or higher levels of care rendered at the facility. When the contracted rates include physician fees, the facility is responsible for payment of all treating physicians and for notifying the physicians that payment will be made by the facility and not Optum. The contract rate for an admission to mental health/substance abuse disorder services is the contract rate in effect on the date the admission begins.

General Information
It is important that contracted providers follow your fee schedule to ensure proper payment of claims. Failure to follow the terms and conditions as set forth on your fee schedule may result in claim denial(s).

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 Participation Agreement has no bearing on this legal obligation.

Copayments, Coinsurance and Deductible

In most benefit plans, members bear some of the cost of behavioral health services by paying a copayment, coinsurance and/or deductible (the “member expenses”). Deductible amounts and structure may vary from plan to plan. To abide by applicable law, including without limitation, parity laws, some deductibles may be combined with medical services. Members should be billed for deductibles after claims processing yields a Provider Remittance Advice (PRA) or Explanation of Benefits (EOB) indicating member responsibility.

For copayments, we encourage you to require payment at the time of service. It is your sole responsibility to collect member payments due to you. Members are never to be charged in advance of the delivery of services.

Benefit plans often provide for annual copayment or coinsurance maximums. If a member states that he or she has reached such a maximum, call the telephone number listed on the member's ID card to confirm the amount and status of the member's copayment maximum. If a specific behavioral health number is not listed, call the medical number and follow the prompts for behavioral health.

Balance Billing for Covered Services Is Prohibited

Under the terms of your Participation Agreement, you may not balance bill members for covered services provided during eligible visits. This means you may not charge members the difference between your billed usual and customary charges and the aggregate amount reimbursed by Optum, and the member copayment, coinsurance or deductible amounts.

Billing for Non-Covered Services and No Shows

If you seek prior authorization of benefits for behavioral health services or authorization for continued treatment, and Optum does not authorize the requested services, the member may be billed under limited circumstances:

- If a written statement is signed by the member after the non-coverage determination and in advance of receiving such services. Please note that a financial responsibility waiver signed by the member at the onset of treatment or at the time of admission is not applicable.
- The signed statement must include:
  - A statement that you have informed the member that Optum is unable to authorize such services for coverage under the member's benefit plan.
  - The reason given by Optum for not authorizing the services.
  - A statement that, as a result, the member has been denied coverage for such services under their benefit plan and will be financially responsible for them.

We encourage you to use this **Patient Financial Responsibility Form** or a similar form when billing members for non-covered services.

In the event a member exhausts the covered benefits under the benefit contract, you may bill the member directly for those services. Members may be charged no more than the applicable network fee schedule or the facility contracted rate for such services.

No Show Appointments
Optum does not pay for sessions that a member fails to attend. You may not bill Optum for such sessions or services.

A member who misses a scheduled appointment may be billed directly, provided you have advised the member in advance that this is your policy and the member has acknowledged the policy in writing.

- The member should be billed no more than your applicable network fee schedule or facility contracted rate for such services.
- Note that some plan designs, including Medicaid and Medicare, prohibit billing members for no-shows under any circumstance. Members are never to be charged a deposit or advance payment for a potential missed appointment.

Failure to follow this or any other required billing practice may result in referral to the Optum Behavioral Credentialing Committee for termination.

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 include their NPI on all claims, whether electronic or paper claims. For more information about obtaining an NPI, you may contact the **Centers for Medicare and Medicaid Services**.

Claims Submission

Unless otherwise directed by Optum, providers shall submit outpatient claims using the current Form 1500 claim form (v 02/12) or facility-based claims using a UB-04 claim form, (its equivalent or successor) whichever is appropriate.

- Services billed using a CPT or HCPCS code must be billed on a current Form 1500 claim form and consistent with your fee schedule.
- Revenue codes or revenue codes with accompanying CPT or HCPCS codes should be billed on a UB-04 claim form.

The claim submission should all data elements necessary to process a claim, including:

- Applicable coding including, ICD diagnosis code(s), CPT, revenue and HCPCS coding
- Code modifiers and/or other identifiers requested by Optum
- The member ID number
- Customary charges for the MH/SUD services rendered to a member during a single instance of service,
- The provider's Federal Tax Identification Number (TIN), National Provider Identifier (NPI)

Billing inconsistent with the above or your contracted fee schedule will result in an initial claim denial. The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable state or federal laws.

In addition, you are responsible for billing of all members in accordance with the nationally recognized **CMS National Correct Coding Initiative** billing standards.

Although claims are reimbursed based on the network fee schedule or facility contracted rate, your claims should be billed with your usual and customary charges indicated on the claim.

For more information, review **Improve the Speed of Processing – Tips for Claims Filing.**

Claim Submission Options

1. **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 EDI.
   - Behavioral Health claims sent via EDI should be routed to Payor ID #87726. Because Optum has multiple claims payment systems, it is important to use this number so the claim goes to the correct system.

   Facilities may file claims through an EDI vendor and can view claim status on the ***Provider Express*** secure portal.

2. ***Provider Express secure portal*:** Submitting claims on the *Provider Express* secure portal closely mirrors the process of completing the Form 1500 claim form (v 02/12). The secure portal can be used by network clinician or group practices, or by out-of-network individual clinicians. Users must have a registered One Healthcare ID and password for the *Provider Express secure portal*. To obtain a One Healthcare ID, click on the **First-time User** link from our home page.

   EAP claims can also be submitted through the secure portal. The table below reflects the codes for services included in the EAP benefit:

90832 HJ	90834 HJ	90846 HJ	90847 HJ	90853 HJ

   EAP claims must use the standard "HJ" code in the first modifier field of section 24 D to differentiate between EAP and standard mental health/substance abuse disorder claims. For telemental visits, the place of service code "02" must also be used. Optum also recommends including an appropriate diagnosis code (e.g. "Z" code).

3. **Clinician claim forms:** Paper claims should be submitted to Optum using the Form 1500 claim form (v 02/12) or its successor form, as outlined in your Participation Agreement. Claims should include all itemized information, such as:

   - Member and subscriber names and dates of birth
   - Member identification number
   - ICD diagnosis code
   - Date(s) of service
   - Length of session
   - Type and duration of service
   - Clinician Information:
     - Name (i.e., individual who actually provided the service)
     - Credentials
     - Tax ID
     - NPI number

4. **Facility claim forms:** Paper claims for a facility should be submitted to Optum using the UB-04 claim form or its successor. The form includes all itemized information, including:

   - Member identification number
   - Date(s) of service
   - ICD diagnosis code
   - CPT procedure code(s) and/or revenue code(s)
   - Billed charges for the service(s) rendered
   - Name of facility
   - Facility federal tax ID number
   - Member name and date of birth

Updating Demographic Information

To ensure proper processing of claims, it is important to promptly contact Provider Relations if you change your Tax ID number or if your practice address. You may submit changes to your practice address online using the My Practice Info in the *Provider Express* secure portal.

Claims Help

Optum has dedicated service departments with staff available 5 days a week during regular business hours to assist network providers. The Provider Services Line for Behavioral Health providers is **1-877-614-0484**. You may also call the number listed on the back of the member's ID card.

Coordination of Benefits

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 that information to Optum.

If Optum is a secondary plan, you will be paid up to the Optum contracted rate. You may not bill members for the difference between your billed usual and customary charge and the amount paid by the primary plan(s) and Optum.

Claim Processing and Payment

Timely Filing

All information necessary to process claims must be received by Optum no more than 90 calendar days from the date of service, or as allowed by state or federal law or the member's specific benefit plan.

- Claims received after this time period may be rejected for payment due to timely filing requirements, 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, using the claim submission options previously noted. We strongly recommend that you keep copies of all claims for your own records.

Payment Timelines
Generally, claims that contain all required information and have the required authorization, if applicable, will be paid within 45 calendar days after Optum receives the claim, or as required by state and federal laws. This may exclude claims that require coordination of benefits determinations.

Payment Details

- 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 previous payments for services and may audit claims submissions and payments to ensure compliance with applicable policies, standards, procedures, including without limitation, the network provider manual, the Optum Behavioral **Credentialing Plan**, the provider's Participation Agreement, and state and federal laws.
- Optum may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law.

Retroactive Payments
Optum will not assign a retroactive effective date or pay claims retrospectively unless mandated by federal or state laws. This applies in the event a Participation Agreement with Optum has not been executed in a timely fashion or within a commercially reasonable amount of time is not provided to align Optum systems with a Participation Agreement.

No interest or penalty otherwise required under applicable law will be due on any claim which was initially processed timely and accurately, but which requires reprocessing as a result of the untimely execution of a Participation Agreement or amendment; or the inability to align Optum systems in a commercially reasonable period of time.

Insolvency
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 member's employer or Optum, your sole redress is against the assets of Optum or the applicable payor, not the member. You must agree to continue to provide services to members through the period for which premiums have been paid. Any termination of the Participation Agreement has no bearing on this requirement.

Payment Methods
You may choose to receive electronic payments by direct deposit into your business bank account (automated clearinghouse or ACH) or by virtual card payment (VCP). Review the **Optum Pay** webpage for more information.

The initial set-up of direct deposit, transition to VCP, or a change in banking information will take approximately 10 business days for processing and bank account validation.

Fraud, Waste and Abuse Prevention

Overview

Optum believes that providers are an integral part of our program integrity work. Protecting clients, providers and stakeholders through the prevention, early detection, investigation and ultimate resolution of potential fraud, waste and abuse issues is a fundamental component of quality care and sound clinical practice. We are pleased to work in consultation with providers to find solutions that address potential issues without adding unnecessary burdens to your office.

Special Investigations Unit
CMS requires payers establish a Special Investigations Units or their equivalents, as well as an develop an effective system for routine monitoring, auditing and identification of risks and to carry out appropriate corrective action.

At Optum, our Special Investigations Unit is called Program and Network Integrity. This group of professionals is committed to a balanced approach to potential fraud, waste and abuse, including open and clear communication with the provider community.

Program and Network Integrity is committed to appropriate corrective action on a continuum commensurate with the questionable activity. Actions include addressing simple mistakes and the need for education and addressing fraudulent activity and referral to law enforcement. There is also a requirement to recover payments. It is critical that dollars not appropriately directed get recovered while education and other appropriate action are under way.

Optum is committed to:

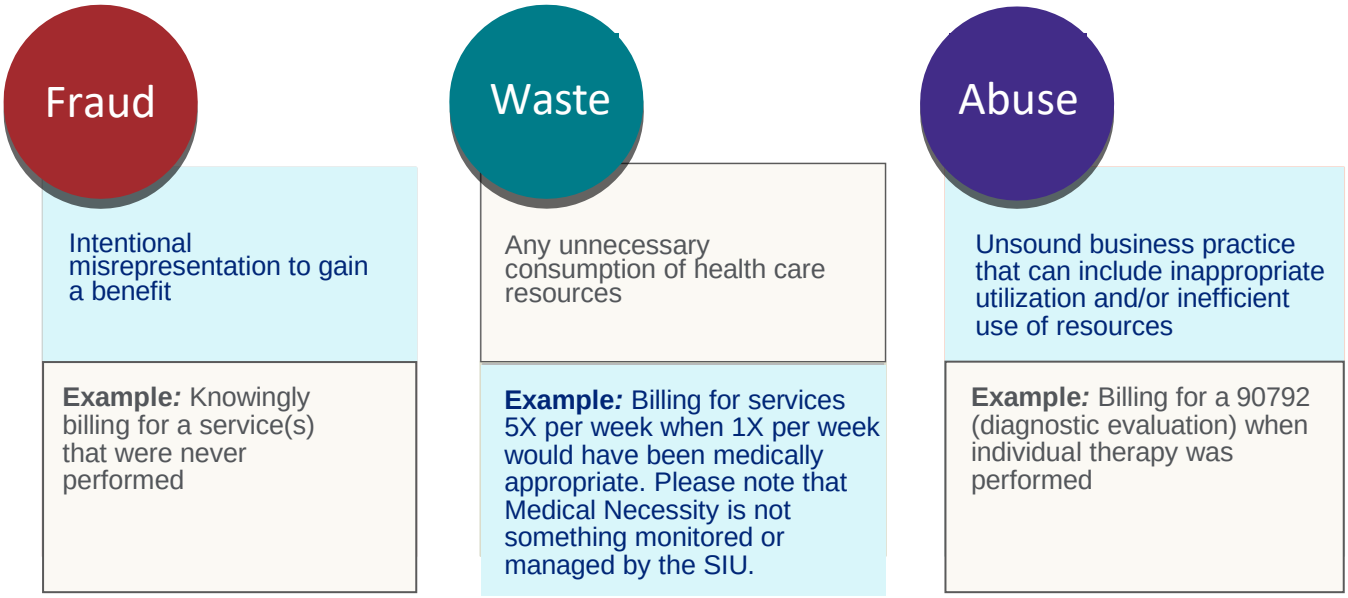
- A comprehensive view of how PNI interacts with you
- Building and sustaining trust in provider communities regarding FWA initiatives and activities
- Transparency into our activities
- Ensuring reliability and timeliness in our practice and methodology
- Overall education and awareness for the network
- Soliciting critical feedback from the network and professional associations in developing long-term strategies for identifying and avoiding potential FWA

In summary, Optum is committed to addressing and correcting questionable activity and known offenses, recovering inappropriately paid funds, improving overall fraud, waste and abuse prevention and partnering with both the network and state and federal agencies to educate, pursue and prosecute violators to the fullest extent of the law.

Program Introduction

Optum's fraud, waste and abuse efforts incorporate multiple components leveraging technology, expertise and collaboration in a proactive way. Program components include education and awareness, prevention, detection, investigation, system enhancement and capability, corrective action, and recovery and resolution. The Program and Network Integrity team consists of investigators, prospective intervention specialists, data analytics staff, certified coders and executive leadership.

Potential fraud, waste and/or abuse practices include, but are not limited to, the following:



The identification process includes, but is not limited to, examining claims to identify outlier claims billing patterns.

In the event potential fraud, waste and/or abuse is identified, appropriate corrective actions are implemented using a range of tools from education of providers to full recoupment of improperly paid funds. Possible interventions may include:

- Outreach meetings and/or written correspondence to providers
- Records review and/or site audit
- Individual case reviews, and
- Referral for further investigation

Providers 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 fraud, waste and abuse 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 sources outside your organization.

Providers and affiliates who meet the CMS fraud, waste and abuse 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 our responsibility to ensure that your organization is provided with appropriate training for your employees and applicable subcontractors. Review our **training and educational materials**.

In compliance with federal regulations, providers are required to administer the compliance and fraud, waste and abuse training materials to their employees and/or contractors. If your organization has already completed a CMS-compliant training program, either on your own or through a Medicare plan, we will accept documentation of that training. Providers 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 Prospective Process

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

Optum has a prospective 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 fraud, waste and abuse look-back period or period of claims reviewed is normally determined by state and federal regulation.

Retrospective Investigations and Corrective Action Plans

When potential fraud, waste and abuse is reported or detected, we conduct an investigation to determine potential corrective action. A sample of retrospective investigation actions may include:

- 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 regarding a corrective action plan and settlement of overpayment

Following an investigation, 2 actions may occur:

1. Timely payment is made, or,
2. A denial notification is issued which includes the provider's standard appeal rights.

Findings of billing inconsistent with our policies by 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 a Participation Agreement

In the case of retrospective review, Optum and our payors reserve the right to pursue up to full 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 fraud, waste and abuse. 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 their respective State Department of Insurance, licensing board(s) and any other regulatory agencies based on the outcome of the investigation and as required by 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 who work on Medicare Advantage, Part D or Medicaid programs, including contracted providers, must provide a copy of the UnitedHealth Group **Code of Conduct** to employees and contractors.

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. This review is intended 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:

- **List of Excluded Individuals/Entities** maintained by the U.S. Department of Health and Human Services – Office of the Inspector General (HHS-OIG)
- General Services Administration (GSA) **System for Award Management (SAM)**

What You Need to Do
All providers should review the applicable exclusion/sanction/debarment lists to ensure that none of your employees or contractors are excluded from participation in federal and state health care programs.

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

When medical records are requested, you will receive a letter outlining specific information required which may include:

- Counseling sessions start and stop times
- Medication prescription monitoring (if applicable)
- Modalities and frequencies of treatment furnished
- Results of clinical tests (if applicable)
- Any summary of the following: diagnosis, functional status, treatment plan and/or goals, prognosis and progress to date

Provider Reconsideration and Appeals Process

Introduction

Network providers will follow a 2-step process to disagree with the outcome of a Commercial or Medicare Advantage clinical prior authorization request or claim processing decision.* Providers should request reconsideration before filing an appeal.

	Step 1: Request Reconsideration	Step 2 (if needed): File an Appeal
When to Use	If you disagree with the outcome of a claim decision, you should first request reconsideration of the decision.	If you disagree with the outcome of the reconsideration decision in Step 1, you may submit an appeal.
Deadline	The 2-step process allows for a total of 12 months for submission for both steps (Step 1: Reconsideration and Step 2: Appeals). If a different deadline is required by state law or outlined in your Participation Agreement, that timeline supersedes the 12 months noted.	
Required Documentation	Include member-specific treatment plans, clinical records, payment appendices or other items that support why you believe our decision was incorrect. We make our review decision based on the materials available at the time of the review. **Proof of Claim Timely Filing** Include confirmation we received and accepted your claim within your timely filing requirement. Timely filing limits vary based on state requirements and contracts. Refer to your Participation Agreement for specific timely filing requirements.	
Submission Methods	**By mail:** Complete a **reconsideration request form** to outline the reason you disagree with our decision. Then mail the form and supporting documentation to: Optum Behavioral Health Solutions P.O. Box 30757 Salt Lake City, UT 84123	**Online** via the *Provider Express* secure portal: 1. Go to **Providerexpress.com** and click Log In (located in the upper right corner). Then, sign in to the secure portal with your One Healthcare ID and password. 2. In the secure portal, click Appeals, then click Appeals Summary & Submission 3. In the Appeals Submission section of the page, select Submit Claim Appeal to start the process. Be sure to include: • The factual or legal basis for appeal • Any additional information, clinical records or documentation that will help in the review of your request
Decision	Once each review is complete, you'll be notified in writing of the outcome: • **Overturned claim decisions:** If the claim requires an additional payment, the Provider Remittance Advice (PRA) will serve as notification of the review outcome. • **Upheld decisions:** If the original prior authorization denial or claim decision is upheld, you'll be sent a letter outlining the details of the review.	

**The reconsideration and appeal process applies to claim submissions for Commercial and Medicare Advantage benefit plans for dates of services July 5, 2023 or later. Your state rules and regulations, as well as the member's benefit plan, will govern whether reconsideration of claims decisions is available or whether claims decisions are to be resolved solely through the appeals process. The terms and conditions of your participation in a network administered by United Behavioral Health or its Affiliates and your reimbursement for covered services are determined by your Participation Agreement or the member's benefit plan. Should any item listed in this section conflict with your Participation Agreement or the member's benefit plan, the terms of your Participation Agreement or the member's benefit plan will control.*

Resolving Provider Concerns or Complaints

If after completion of the reconsideration and appeal process your concerns related to a prior authorization or claims decision are not resolved, please follow the dispute resolution process outlined in your Participation Agreement.

Member Appeals for Prior Authorizations

When a prior authorization request is denied, the member or an authorized representative may file an appeal when the member may:

- Incur financial liability beyond the normal cost share, or
- Experience a reduction in services requested.

The authorized representative may be the member's treating clinician at any level of care. The member appeals process, including any applicable requirements for the filing and handling of an appeal, is detailed in the Member Rights enclosure sent with the prior authorization request denial notice sent to the member and the authorized representative.

Member appeals decisions

If the appeal decision is to uphold a non-coverage decision, Optum will notify you and the member, or the member's representative, of the outcome and any additional levels of appeal that are available.

You may continue to provide service following a non-coverage decision, but the member should be informed of the non-coverage decision by you in writing. The member or the member's representative should be informed that the care will become the financial responsibility of the member from the date of the non-coverage decision. In order for the provider to receive payment from the member, the member must agree in writing to these continued terms of care and acceptance of financial responsibility. You may charge no more than the Optum contracted fee for such services, although a lower fee may be charged.

The consent of the member to receive such care and responsibility will not impact the appeals determination, but it will impact your ability to collect reimbursement from the member for these services. If the member does not consent in writing to continue to receive such care, and Optum upholds the determination regarding the cessation of coverage for such care, you cannot collect reimbursement from the member pursuant to the terms of your Participation Agreement.

Manual Updates and Governing Law

Manual Updates

This manual is updated periodically as procedures are modified and enhanced. The current version of the manual is always available on the ***Provider Express*** website. 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 the Provider Service Line at **1-877-614-0484**.

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 Participation 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 Participation Agreement shall govern.

Member Rights and Responsibilities

Member Rights

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

- Receive information about our services, network practitioners, and a member's rights and responsibilities
- Be treated with respect and recognition of his or her dignity, including a right to privacy
- Participate with network practitioners in making decisions about his or her health care
- Have a candid discussion of appropriate or medically necessary treatment options for his or her condition regardless of cost or benefit coverage
- Voice complaints or appeals about Optum or the services provided by Optum
- Make recommendations regarding our members' rights and responsibilities policies
- Obtain care that is considerate and that respects his or her personal values and belief system
- Expect personal privacy and confidentiality of information
- Be given 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 of age 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 rights and responsibilities 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 benefit provisions used in the determination
- Have decisions about the management of their behavioral health benefits made based on appropriateness of care. 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 our clinical guidelines and quality improvement 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; and
- Understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

Appendix A

Regulatory Requirements

The following state-specific or program-specific appendices set forth certain regulatory requirements that Behavioral Health network providers shall comply with, as applicable. These appendices apply to Medicaid, CHIP and federal/state Medicare-Medicaid (MMEE) enrollees. Click the appropriate bolded link to review the requirements:

- Medicare
  - **Medicare Advantage Regulatory Requirements**
  - **Medicare Advantage Regulatory Requirements UBH of New York IPA**
  - **Medicare Advantage Regulatory Requirements US Behavioral Health Plan California**
- Alabama
  - **Alabama Regulatory Requirements**
- Alaska
  - **Alaska Regulatory Requirements**
  - **Alaska State Program Regulatory Requirements**
- Arizona
  - **Arizona Regulatory Requirements**
  - **Arizona ACC Medicaid and CHIP Program Regulatory Requirements**
  - **Arizona Long Term Care Program Regulatory Requirements**
  - **Arizona Medicaid Comprehensive Medical and Dental Program Regulatory Requirements**
  - **Arizona Medicaid Developmentally Disabled Program Regulatory Requirements**
- Arkansas
  - **Arkansas Regulatory Requirements**
- California
  - **California Regulatory Requirements – Individual**
  - **California Regulatory Requirements – Group**
  - **California Language Assistance Program Regulatory Requirements – Individual**
  - **California Language Assistance Program Regulatory Requirements – Facility**
  - **California Regulatory Requirements – Third Amendment – Individual**
  - **California Regulatory Requirements – Third Amendment – Groups**
  - **California Regulatory Requirements – Fourth Amendment – Individual**
  - **California Regulatory Requirements – Fourth Amendment – Groups**
  - **California Regulatory Requirements – Fourth Amendment – Facility**

- Colorado
  - Colorado Regulatory Requirements
- Connecticut
  - Connecticut Regulatory Requirements
- Delaware
  - Delaware Regulatory Requirements
  - Delaware State Program Regulatory Requirements
- Florida
  - Florida Regulatory Requirements
  - Florida LTC Medicaid Program Regulatory Requirements
  - Florida Medicaid Regulatory Requirements
- Georgia
  - Georgia Regulatory Requirements
  - Georgia Medicaid and CHIP Regulatory Requirements
- Hawaii
  - Hawaii Regulatory Requirements
  - Hawaii State Programs Regulatory Requirements
- Idaho
  - Idaho Regulatory Requirements
  - Idaho Statewide Behavioral Health Medicaid Plan Regulatory Requirements
- Illinois
  - Illinois Regulatory Requirements
- Indiana
  - Indiana Regulatory Requirements
  - Indiana State Program Regulatory Requirements
- Iowa
  - Iowa Regulatory Requirements
  - Iowa State Program Regulatory Requirements
- Kansas
  - Kansas Regulatory Requirements
  - Kansas Medicaid and CHIP Regulatory Requirements
- Kentucky
  - Kentucky Regulatory Requirements
  - Kentucky State Program Regulatory Requirements
- Louisiana
  - Louisiana Regulatory Requirements
  - Louisiana Medicaid and CHIP Regulatory Requirements
- Maine
  - Maine Regulatory Requirements

- Maryland
  - Maryland Regulatory Requirements
  - Maryland Medicaid Regulatory Requirements
- Massachusetts
  - Massachusetts Regulatory Requirements
  - Massachusetts Government Programs Regulatory Requirements
  - MME Regulatory Rider
- Michigan
  - Michigan Regulatory Requirements
  - Michigan State Programs Regulatory Requirements
- Minnesota
  - Minnesota Regulatory Requirements
  - Minnesota State Program Regulatory Requirements
  - Minnesota Complementary Network Regulatory Requirements
- Mississippi
  - Mississippi Regulatory Requirements
  - Mississippi CHIP Regulatory Requirements
  - Mississippi Medicaid Program Regulatory Requirements
- Missouri
  - Missouri Regulatory Requirements
  - Missouri State Program(s) Regulatory Requirements
- Montana
  - Montana Regulatory Requirements
- Nebraska
  - Nebraska Regulatory Requirements
  - Nebraska State Programs Regulatory Requirements
- Nevada
  - Nevada Regulatory Requirements
- New Hampshire
  - New Hampshire Regulatory Requirements
- New Jersey
  - New Jersey Regulatory Requirements
  - New Jersey Medicaid, NJ FamilyCare Programs and NJ Medicaid Long Term Support Services Contract Requirements
- New Mexico
  - New Mexico Regulatory Requirements
  - New Mexico Centennial Care Regulatory Requirements

- New York
  - New York Standard Clauses
  - New York Medicaid and Child Health Plus Regulatory Requirements
  - New York Cures Act Notice of Amendment
  - MME Regulatory Rider
- North Carolina
  - North Carolina Regulatory Requirements
  - North Carolina State Program Regulatory Requirements
- North Dakota
  - North Dakota Regulatory Requirements
- Ohio
  - Ohio Regulatory Requirements
  - Ohio Medicaid and CHIP Regulatory Requirements
  - Ohio Department of Medicaid – Attachment A
  - Ohio Department of Medicaid – Attachment C
  - Ohio Department of Medicaid – Medicaid Addendum
  - MME Regulatory Rider
- Oklahoma
  - Oklahoma Regulatory Requirements
  - Oklahoma State Program Regulatory Requirements
- Oregon
  - Oregon Regulatory Requirements
- Pennsylvania
  - Pennsylvania Regulatory Requirements
  - Pennsylvania Government Programs Regulatory Requirements
- Puerto Rico
  - Puerto Rico Regulatory Requirements
- Rhode Island
  - Rhode Island Regulatory Requirements
  - Rhode Island Medicaid Program Regulatory Requirements
- South Carolina
  - South Carolina Regulatory Requirements
  - South Carolina State Program Regulatory Requirements
  - MME Regulatory Rider
- South Dakota
  - South Dakota Regulatory Requirements
- Tennessee
  - Tennessee Regulatory Requirements
  - TennCare Program Regulatory Requirements

- Texas
  - Texas Medicaid and CHIP Program Regulatory Requirements
  - MME Regulatory Rider
- Utah
  - Utah Regulatory Requirements
  - Utah Medicaid Program Regulatory Requirements (Tooele County)
  - Utah Medicaid Program Regulatory Requirements
- Vermont
  - Vermont Regulatory Requirements
- Virgin Islands
  - Virgin Islands Regulatory Requirements
- Virginia
  - Virginia Regulatory Requirements
  - Virginia State Program(s) Regulatory Requirements
- Washington
  - Washington Regulatory Requirements – Individual
  - Washington Regulatory Requirements – Group
  - Washington Regulatory Requirements – Facility
  - Washington State Programs Regulatory Requirements
- Washington DC
  - District of Columbia Regulatory Requirements
  - District of Columbia Medicaid and CHIP Regulatory Requirements
- West Virginia
  - West Virginia Regulatory Requirements
- Wisconsin
  - Wisconsin Regulatory Requirements
  - Wisconsin BadgerCare Plus and Medicaid SSI Regulatory Requirements
- Wyoming
  - Wyoming Regulatory Requirements