



Optum National Network Manual
Addendum
for
AllWays Health Partners

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Introduction

United Behavioral Health (UBH) operating under the brand Optum administers mental health and substance use disorder benefits for AllWays Health Partners in Massachusetts. Generally, the [Optum National Network Manual](#) applies to all types of business managed by Optum. There are some sections that may differ based on specific benefit plans. This addendum highlights areas in which AllWays Health Partners procedures, in order to meet regulatory requirements, supersede procedures set forth in the Optum National Network Manual.

Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. As we work together, you will find that we seek and pursue opportunities to collaborate with you to set the standard for industry innovation and performance.

We encourage you to make use of our industry-leading website, providerexpress.com where you can get news, access resources and, in a secure environment, make demographic changes at the time and pace you most prefer. The Optum National Network Manual is located on Provider Express. From the home page, select Clinical Resources > Guidelines/Policies & Manuals > Manuals > National Network Manual. We continuously expand our online functionality to better support your day-to-day operations. Visit us often.

Governing Law

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual conflict with the terms and conditions outlined in your Agreement, the subject matter shall first be read together to the extent possible; otherwise and to the extent permitted by, in accordance with, and subject to applicable law, statutes or regulations, the Agreement shall govern.

Authorization or Notification Information

Services Requiring Prior Authorization:

- Acute Residential Services/Treatment
 - Mental Health Residential (CBAT, ART, IART)

- Partial Hospitalization
- Intensive Outpatient
- Day Treatment
- Applied Behavioral Analysis (ABA) Services for Members with Autism Spectrum Disorder
- Electroconvulsive Treatment (auth obtained by phone only)
- Transcranial Magnetic Stimulation
- Specializing Services

Providers can obtain authorization for the above services by calling the number on the back of the member's identification card. Contracted providers may also request authorization for the services listed above online through Provider Express.

Services Requiring Notification to Optum (but not prior authorization):

- Acute Inpatient Hospitalization: In Massachusetts prior authorization is not required for emergent admissions, but providers are required to notify Optum of the member's admission within 24 hours or the next business day.
- Substance Use Disorder Acute and Residential (ASAM 4.0, 3.7, 3.5)
 - Optum complies with all requirements outlined in [Session Laws, Acts \(2014\), Chapter 258](#).
 - Note: auth requirements begin day 15. SUD Residential Rehabilitation no authorization is required for the first fourteen (14) days but providers are required to notify Optum of the member's admission within 48 hours.
- Residential Rehabilitation Services (RRS) (ASAM 3.1)
 - Must provide notification within 7 calendar days of admission
 - Authorization is not required for the first 90 days; concurrent review needed to request additional days past the initial 90 days.

Services that Do Not Require an Authorization or Notification:

- Standard Office Visit for Therapy or Medication Management
- Outpatient Opioid Treatment
- Extended Outpatient Treatment (90837) (note: out-of-network providers are required to obtain prior authorization for this service)

- Children’s Behavioral Health Initiative (CBHI) Outpatient Medicaid Services
- Behavioral Health Children and Adolescents (BHCA) Outpatient Services
- Neuropsychological Testing (note, billing for the testing episode from evaluation through final report should be submitted on a single claim)
- Routine outpatient services
- Optum does not require members to obtain prior authorization to be admitted to a facility to receive mental health inpatient treatment from an emergency department and/or after receiving emergency services if deemed appropriate by a provider, regardless of whether the member has been stabilized

Special Consideration for Program of Assertive Community Treatment (PACT):

- Providers must meet requirements set forth in Performance Specifications (a copy is posted on Provider Express) including clinical staff (Psychiatrist, Addiction Specialist, Nurses), bachelor’s-level and paraprofessional mental health workers, including a Peer Recovery Specialist and Housing Resource Specialist
- Providers contracted for PACT must hold a Department of Public Health License
- Authorization is required for this service (standard authorization processes apply)
- 90 units are authorized over 90 calendar days
- Services are comprehensive and highly individualized
- PACT providers who would like to obtain initial authorization and/or concurrent review for a member for this service must call Optum at 844-451-3519 to complete clinical review
- Standard billing guidelines apply
- Specific coding as noted:
 - PACT 50 – H0040 HT
 - PACT 80 – H0040, no modifier
- Members actively engage in a Community Support Program (CSP) or similar duplicative services are excluded

Special Considerations for Behavioral Health Children and Adolescents (BHCA) Intensive Care Coordination (ICC)

- Commercial Only
- Intensive Care Coordination should be implemented by providers when they are directly contacted by Optum’s CCM team and asked to perform this service

- Refer to the ICC Coverage Grid for additional information

Psychological Testing

- Psychological Testing requests for 5 hours or less (test evaluation 96130/96131 and administration-scoring 96136-96139 time combined):
 - Advanced Notification can be obtained by calling the Intake Department. Notification allows for review of members eligibility, member specific benefit coverage and any requirements that may supercede the members benefit coverage.
 - Testing can not be due to a court order, employment, or educational/school purposes; and no recent testing within the last 6 months.
- Psychological Testing requests for more than 5 hours service time (test evaluation 96130/96131 and administration-scoring 96136-96139 time combined):
 - Authorization is required.
- Written request must be submitted with clinical information by using the online portal located on Provider Express:
 - Provider Express > Clinical Resources > Forms > Optum Forms: Authorization > Massachusetts
- Note: providers should bill for the entire testing episode from evaluation through feedback session on a single claim submission.
- Base code billing: maximum of one unit for each base code is permitted one time per episode even if testing takes place over multiple dates of service.

Important Reminder: Covered services for Partners HealthCare Plan members seeing a contracted provider do not require authorization.

Timelines for Authorization Decisions:

- Authorization requests made while a member is in the emergency room are processed within 30 minutes of the request.
- Non-urgent authorization requests are processed within 24 hours.
- On-going review frequency is determined based on an individual's need and medical necessity criteria.

Consent for Treatment, Minors

In certain situations, according to state law, a minor is able to consent for treatment. Examples may include:

- Treatment for Drug Use: minors who are 12 or older, who have been found to be drug dependent by at least two doctors, may consent to substance use treatment (except for methadone maintenance therapy).
- Mental Health treatment: minors who are 16 or older may consent to admission at a mental health treatment facility.

Coordination of Care and Transition of Care

Coordination of Care Between Behavioral Health Providers and Primary Care Physicians or Other Health Professionals:

We expect behavioral health providers to coordinate care with the member's primary care physician as well as other treating medical or behavioral health providers. A signed release of information should be maintained in the clinical record.

In the event 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, education you provide regarding benefits and risks of coordinated care should be noted.

Coordination Between Behavioral Health Providers and State Agencies:

Behavioral health providers are expected to coordinate care with any relevant state agencies that are working with a member or member's family. This includes, but is not limited to the Department of Children and Families (DCF), Department of Youth Services (DYS), Department of Mental Health (DMH), Department of Transitional Assistance (DTA), Department of Developmental Services (DDS), and local education authorities.

Protocols for Transitioning Members from One Behavioral Health Provider to Another:

If a member transfers from one behavioral health provider to another, the transferring provider must obtain a release of information from the member and send a case summary, including the reason for the transition to the new provider.

MassHealth/ACO Covered Services

My Care Family (MassHealth/ACO line of business) offers care and coverage through MassHealth by Greater Lawrence Family Health Center, Lawrence General Hospital, and AllWays Health Partners. My Care Family is a patient-focused Accountable Care Partnership Plan designed to coordinate care, improve quality, and ensure patients get the care and help they need to meet their health goals.

The following behavioral health and substance use disorder services are covered for MassHealth/ACO members:

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth	ACO MassHealth Family Assistance	CarePlus
Inpatient Mental Health	X	X	X
Inpatient Substance Use Disorder Services (Level 4)	X	X	X
Observation/Holding Beds	X	X	X
Administratively Necessary Day (AND) Services	X	X	X
Community Crisis Stabilization	X	X	X
Community Based Acute Treatment (CBAT) for Children and Adolescents	X	X	
Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	X	X	X
Clinical Support Services for Substance Use Disorders (Level 3.5)	X	X	X
Transitional Care Unit (TCU)	X	X	
Residential Rehabilitation Services (Level 3.1)	X	X	X
Community Support Program (CSP)	X	X	
Partial Hospitalization (PHP)	X	X	X
Program of Assertive Community Treatment (PACT)	X	X	X
Psychiatric Day Treatment	X	X	X
Structured Outpatient Addiction Program (SOAP)	X	X	X
Intensive Outpatient Program (IOP)	X	X	X

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth	ACO MassHealth Family Assistance	CarePlus
Recovery Coaching	X	X	
Recovery Support Navigators	X	X	X
Family Consultation	X	X	X
Case Consultation	X	X	X
Diagnostic Evaluation	X	X	X
Dialectical Behavioral Therapy	X	X	X
Psychiatric Consultation on an Inpatient Medical Unit	X	X	X
Medication Visit (Office)	X	X	X
Couple/Family Treatment	X	X	X
Group Treatment	X	X	X
Individual Treatment	X	X	X
Inpatient-Outpatient Bridge Visit	X	X	X
Assessment for Safe and Appropriate Placement (ASAP)	X	X	
Collateral Contact	X	X	
Opioid Treatment Services	X	X	X
Ambulatory Detoxification	X	X	X
Psychological Testing	X	X	X
Special Education Psychological Testing	X	X	
Applied Behavioral Analysis for Members Under 21 Years of Age (ABA Services)	X	X	
Family Support and Training	X		
Intensive Care Coordination	X		
In-Home Behavioral Services	X		
In-Home Therapy Services	X	X	
Therapeutic Mentoring Services	X		
Emergency Services Program (ESP) Encounter	X	X	X
Youth Mobile Crisis Intervention	X	X	
Electroconvulsive Therapy (ECT)	X	X	X
Specializing – therapeutic services provided to a member in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual’s safety.	X	X	X

Children's Behavioral Health Initiative (CBHI) Services for MassHealth/ACO Members

The Children's Behavioral Health Initiative is an interagency undertaking whose mission is to strengthen, expand and integrate behavioral health services for children and adolescents. These services are mental health and substance use disorder services provided to youth under the age of 21 in a community based setting such as home, school or the community.

- Family Support and Training (no authorization required)
- Therapeutic Mentoring (no authorization required)
- Intensive Care Coordination (ICC) (no authorization required)
- In-Home Behavioral Services (no authorization required)
 - Behavior Management Therapy
 - Behavior Management Monitoring
- In-Home Therapy Services (no authorization required)
- Youth Mobile Crisis Intervention (no authorization required)
- CBAT/ICBAT (authorization is required)

CBHI services that do not require an authorization will be managed using our outpatient management strategy, Algorithms for Effective Reporting and Treatment (ALERT). Member claims data and service combinations are reviewed to identify services that occur at a frequency and/or duration that is higher than expected. A licensed care advocate will outreach the provider telephonically to:

- Review eligibility for service(s)
- Review the treatment plan/plan of care
- Review the case against applicable medical necessity guidelines

The review can lead to one of the following outcomes:

- Close the review and continue services as indicated (the member is eligible for services, the treatment plan/plan of care is appropriate and care is medically necessary)
- Modification to the treatment plan
- Referral to peer review (member may be ineligible for the service; treatment does not appear to be evidence based; duration and/or frequency of care does not appear to be medically necessary)

Additional information about ALERT is located on Provider Express. From the home page, select Clinical Resources > [ALERT Program](#).

Child and Adolescent Autism Services for MassHealth/ACO Members

Services are available for youth under the age of 21.

- Applied Behavioral Analysis (ABA) Services for Members with Autism Spectrum Disorder (authorization required)

Child and Adolescent Needs and Strengths (CANS) for MassHealth/ACO Members

The requirement to use the Child and Adolescent Needs and Strengths (CANS) is part of the Final Order resulting from the *Rosie D. v. Patrick* lawsuit (Civil Action Number 01-30199-MAP). This was a class action lawsuit filed in 2001 on behalf of children and adolescents with serious emotional disturbance. The lawsuit alleged that the Massachusetts Medicaid program, MassHealth, failed to meet the obligations of certain federal Medicaid laws, including the Early and Periodic Screening Diagnosis and Treatment (EPSDT) statute.

The Court's Final Order was issued on July 16, 2007. The requirement to use the CANS became effective on November 30, 2008.

All behavioral health clinicians treating children and adolescents who are enrolled in MassHealth and under the age of 21 must use the CANS tool as part of the clinical assessment process. The CANS must be updated every 90 days to ensure that treatment plans address strengths and needs as they evolve.

Services that Require Use of the CANS:

- Outpatient Therapy (diagnostic evaluations and individual, family and group therapy)
- In-Home Therapy Services
- Intensive Care Coordination

- The CANS must also be completed as part of the discharge planning process for the following 24-hour level of care services:
- Psychiatric inpatient hospitalization at acute inpatient hospitals, psychiatric inpatient hospitals and chronic and rehabilitation inpatient hospitals
- Community-Based Acute Treatment (CBAT) and Intensive Community-Based Acute Treatment (ICBAT)
- Transitional Care Units (TCU)

Important Reminders:

The CANS is not a clinical assessment tool; it is used to organize information gathered during the assessment process and to guide treatment planning. Clinicians must be trained and certified to use the CANS.

Additional information related to CANS requirement is located on the [Mass.Gov](#) website, including a [“Frequently Asked Questions about the CANS Requirements and Billing”](#) document.

Access Standards Specific to MassHealth/ACO Members

The access standards outlined below are applicable to MassHealth/ACO members.

Emergency Services:

Immediately, on a 24-hour basis, seven days a week, with unrestricted access to members who present at any qualified Provider, whether a Network Provider or a non-Network Provider.

ESP (Emergency Services Program) Services:

Immediately, on a 24-hour basis, seven days a week, with unrestricted access to members who present for such services.

If unable to respond within one hour of the request, the Emergency Department/ Emergency Room clinical staff can evaluate to determine clinical need.

Urgent Care:

Within 48 hours for services that are not Emergency Services or routine services.

All Other Behavioral Health Services:

Within fourteen (14) calendar days.

For Services Described in the Inpatient or 24-Hour Diversionary Services Discharge Plan:

- Non-24-Hour Diversionary Services: within two (2) calendar days of discharge;
- Medication Management: within fourteen (14) calendar days of discharge;
- Other Outpatient Services: within seven (7) calendar days of discharge; and
- Intensive Care Coordination Services: within the time frame directed by EOHHS (Executive Office of Health and Human Services).

Documentation Standards

You are required to maintain high quality medical records for all members that you serve; these are outlined below.

General Practice:

- All providers must have unique member charts that are stored in a secure location.
- All members must sign the appropriate releases of information to facilitate billing and review of the necessary member records.
- All behavioral health services require consents to treatment prior to any behavioral health service being rendered or paid.
- All providers must ensure that the consent to treatment, release of information, and any other forms meet all regulatory requirements, including 45 CFR Parts 160, 162, 164 and 42 CFR Part 2.
- Providers are responsible to obtain the appropriate order, referral, and/or determination of medical necessity for service.
- All documentation and medical record requirements must be legible with a unique identifier on every page.
- All requirements for documentation must be completed prior to the claim form submission date.

- All documentation must meet the requirements of the service codes that are submitted on the claims form. Best practice is for all progress notes and billing forms to be completed during the session or immediately after the session.
- Documentation of treatment should be individualized to the specific encounter. Copying and pasting from previous encounters should not occur.
- All encounters must have documentation to support the service billed.
- All amendments or changes to paper or electronic documentation must be signed and dated by the clinician amending or changing the documentation.
- All providers should provide a notice to all patients regarding clinic procedures, including the patient's rights to terminate treatment and the process for filing a grievance.
- All providers must have the following minimum documentation for the consent to treatment, assessment, treatment plan, progress notes, and discharge summary to receive payment for all claims billed:

Consent to Treatment:

Consent to treatment is obtained prior to initiating services and includes the following:

- Name and signature of the member, or if appropriate, the legal representative or guardian
- Name of the provider (should correspond with license)
- Type of services and/or treatment offered
- Benefits and any potential risks of treatment
- Alternative services and/or treatment that is discussed
- Date and time consent is obtained
- Statement that treatment and services were explained to member or guardian
- Signature of person witnessing the consent (clinician)
- Name and signature of person who explained the procedure to the member or guardian if different from the person witnessing (above)

Release of Information:

- Signed and dated by Member and Clinician
- In accordance with all federal regulations, including 45 CFR Parts 160, 162, 164 and 42 CFR Part 2.

Assessment:

Depending on the scope of the assessment, the following components may require multiple visits and/or be completed by multiple clinicians involved in the care of a member and should be entered into an integrated medical record.

- Presenting concerns
- Current treatment for presenting concerns, including medications
- Treatment history
 - Medical history
 - Psychiatric history, including previous medication trials
 - Therapy history
- Substance use history, including any treatment for SUD
- Risk assessment including Overdose Risk Assessment, when applicable
- Developmental history (for children and adolescents)
- Family history
- Allergies/adverse reactions
- Mental status exam
- Member strengths
- Clinical formulation informed by clinical data
- Clinical formulation is validated by clinical data
- Diagnosis is validated by clinical data
- CANS administered and integrated (for members under the age of 21) as applicable by CANS certified clinician
- Outcome assessment tool(s) administered and integrated, as applicable
- Initial treatment plan/next steps
- Documentation of time spent and duration of assessments
- Clinician's signature, credentials, and signature date

Other Clinical Documentation Expectations

- Evaluations must meet clinical practice standards
- Releases of information are valid and signed by the clinician and member

Individual Treatment Plan or Plan of Service

- Must be completed according to service requirements
- Date of treatment plan initiation
- Diagnoses and/or symptoms being addressed
- Clinician's signature, credentials and signature date
- Member or guardian's signature and signature date (or acknowledgement that the member or guardian participated in the development of the plan)
- Evidence that the member or guardian participated in the development of the treatment plan or plan of service, including the member's statement of desired goal(s) or outcomes from treatment and/or member or guardian's signature and signature date
- Goals and objectives based on assessment, diagnosis, and behavioral health strengths and needs
- Treatment goals are measurable and person-centered
- Treatment objectives describe an integrated program of therapies, activities, experiences, and appropriate education designed to meet stated goals
- Treatment plan or plan of service has established time frames for goal attainment
- Treatment plan or plan of service includes references to less restrictive treatment alternatives that were considered
- Treatment plan or plan of service is easy to read and understand
- Treatment plan or plan of service documents the necessity for services
- Treatment plan or plan of service documents the services to be provided
- Treatment plan or plan of service documents the utilization of services
- Treatment plan or plan of service is reviewed in accordance with clinical standards

Progress Notes

- Each billable encounter is documented with a progress note
- Documentation for each progress note includes the following
 - Name and/or unique member identification number
 - Date of service that matches the date the claim is billed
 - Duration of session in minutes or stop and start times of services to support the procedure code billed

- Number of units matches the information on the claim
- State the specific location of services provided. Place of service on the claim is supported in the documentation (including specific locations for community services)
- Reason(s) for the session or encounter
- Documentation supports the procedure code that is billed
- Group counseling and group educational session progress notes may describe the session in general, but must also include specific comments on the client's participation and progress in the group
- Documentation in support of the treatment plan or plan of service goals, objectives, and interventions
- Documentation of current symptoms and behaviors as well as problems addressed, related interventions, and response to treatment
- Updated Risk Assessment, including Overdose Risk Assessment when appropriate
- Next steps and progress in treatment plan or plan of service
- Narrative with clinical justification to support utilization and time billed
- Supporting documentation for intervention development and indirect services is attached to the progress note
- Clinician's signature, credentials and signature date

Discharge Summary

All services should be provided prior to the discharge summary date.

- Summary, including date range, of services provided
- Status towards meeting goals
- Diagnosis at the time of discharge
- Reason for discharge
- Medications prescribed (when applicable) during course of treatment and at discharge
- Risk assessment completed with any remaining risk issues identified and documented
- Documentation of referrals
- Identification of aftercare options
- Clinician's signature, credentials and signature date

We may review your records during a scheduled on-site audit or may ask you to submit copies of records to Optum for review. Reviews may occur for a number of reasons, including, but not limited to:

- On-site reviews of facilities and agencies without national accreditation such as the Joint Commission, Commission on Accreditation of Rehabilitation (CARF) or other accrediting organizations approved by Optum
- Audits of services and programs including, but not limited to, Applied Behavioral Analysis, CBHI and Residential Rehabilitation Services (RRS)
- Audits of high-volume providers
- Routine audits
- Audits related to claims, coding, or billing issues
- Audits concerning quality of care issues

Adverse Incident Reporting

When an adverse incident occurs, the provider must complete the applicable Adverse Incident Report form and submit it to Optum within 24 hours of discovery of the incident; if the incident occurs on a holiday or weekend, the form must be submitted on the next business day.

All reporting forms are available on Provider Express. From the home page, select Our Network > Welcome to the Network > Massachusetts > AllWays Health Partners > Adverse Incident Report Forms. Forms are faxed to Optum once they are complete. The fax number is **1-844-814-5698**.

Behavioral Health reportable adverse incidents include, but are not limited to, the following:

- Any absence without authorization (AWA)
- Any contraband found that is prohibited by provider policy
- Any death (including cause of death if known)
- Any physical assault or alleged physical assault on or by a covered individual or by staff
- Any serious injury resulting in hospitalization
- Any sexual activity in a 24-hour level of care facility
- Any sexual assault or alleged sexual assault

- Any treatment or illness requiring transportation to an acute care hospital for treatment while in a 24-hour program
- Any violation or alleged violation of the Department of Mental Health physical restraint and/or seclusion regulations
- Accidental injuries
- Any unscheduled event that results in the evacuation of a program or facility
- Fall
- Fire Setting
- Homicide
- Medication abuse or error
- Property damage
- Seizure
- Self-Injury
- Substance use
- Suicide attempt or gesture

Network Requirements

Network Requirements are outlined in the Network Requirements section of the [Optum National Network Manual](#).

Member Rights

- Member rights are outlined in the Member Rights and Responsibilities section of the [Optum National Network Manual](#). Members who receive benefits through AllWays Health Partners have the right to file a grievance if they have an unsatisfactory experience with either Optum or a provider who is contracted with Optum. All grievances will be reviewed by one or more people who were not involved in the problem or situation that the grievance involves. If the grievance involves a clinical matter, a health care professional will review the grievance.
- Members may file a grievance by calling the customer service phone number on the back of their identification card.

Appeals (Provider Disputes)

Non-Urgent (Standard) Appeals:

- Non-urgent appeals for commercial members must be requested within 180 days from receipt of the notice of an adverse determination. Non-urgent appeals for MassHealth/ACO members must be requested within 60 calendar days from receipt of the notice of an adverse determination. All appeal determination decisions will be made within 30 calendar days of receipt of the request.

Urgent (Expedited) Appeals:

- Urgent appeals must be requested as soon as possible after the adverse determination. All appeal determination decisions will be completed and you will be notified of the decision within 72 hours of receipt of the request.

Submission Information:

Fax: **1-855-312-1470**

Address: Optum
Appeals & Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512

Phone: **1-866-556-8166**

Claims Information

- Claims must be submitted within ninety (90) days of the date of service. Clean claims will be adjudicated within forty-five (45) days of receipt of the claim.
- Claims may be submitted in three (3) ways:
- Online via Provider Express
- Online via Electronic Data Interchange (EDI)
- Paper claims via US Mail

Mailing addresses for paper claims:

Commercial Claims	Medicaid Claims
Optum P.O. Box 30757 Salt Lake City, UT 84130-0757	Optum P.O. Box 30760 Salt Lake City, UT 84130-0760

Process for Communication of Policy and Process Changes

When there is a change to an existing policy or process, information will be communicated to providers in multiple ways:

- Provider Alerts sent via email, fax and/or mail.
- Posting on Provider Express: from the Home Page, select Our Network > Welcome to the Network > Massachusetts. All information related to AllWays Health Partners is on the right side of the screen.