



UnitedHealthcare Community Plan
Louisiana Medicaid Behavioral Health
2015

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Introduction

Welcome!

We are pleased to have you working with us to serve the individuals covered under Louisiana Medicaid. We are focused on creating and maintaining a structure that helps people live their lives to the fullest. At a time of great need and change within the health care system, we are energized and prepared to meet and exceed the expectations of consumers, customers and partners like you.

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 Provider Express, 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. We continuously expand our online functionality to better support your day-to-day operations. Visit us often!

Important Notice

Optum provides this manual as a more focused resource for clinicians serving the Louisiana Medicaid membership. This manual does not replace the primary national Network Manual. Rather, this manual supplements the Network Manual by focusing on the core service array, roles and responsibilities as well as process and procedures specific to the State of Louisiana Medicaid programs. In addition, some sections of the primary Network Manual are repeated for convenience. The National Manual can be directly accessed [here](#) or by going to providerexpress.com: (Provider Express > Quick Links Guidelines/Policies > Network Manual > 2014 Network Manual).

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.

Clinical Overview

Effective December 1, 2015, UnitedHealthcare Community Plan (The Plan) will manage mental health and substance use disorder services to help adults and children enrolled in Louisiana Medicaid access the most effective treatment for their needs. Optum and UnitedHealthcare are working closely with the state of Louisiana, consumers, family members, providers and community stakeholders to develop, implement and maintain a utilization management program for Louisiana Medicaid to monitor the appropriate utilization of covered services and to:

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

Our focus is on improving access to treatment, expanding the array of covered services and improving the quality of care and treatment outcomes. Our goal is to enhance the statewide behavioral health system and make it easier for people to access care. In addition to adding more behavioral health care providers and programs, Optum plans to increase services available in rural areas to ensure that Members are able to get the care they need in their community.

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

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

Louisiana Medicaid Benefits

UnitedHealthcare Louisiana administers behavioral health managed care benefits for Louisiana Medicaid Members. All Medicaid Members shall be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other members in their care.

The following covered services are available and accessible to all Medicaid Members:

Service	Authorization Requirement
23-Hour Observation Bed	Yes (<i>Requests must be telephonic</i>)
Assertive Community Treatment (ages 18 and above)	Yes
Community Psychiatric Supportive Treatment (CPST)	No
Crisis Intervention	Yes
Electroconvulsive Therapy (ECT)	Yes
Family Psychotherapy	No
Functional Family Therapy (FFT) (under age 21)	No
Group Psychotherapy	No
Homebuilders (under age 21)	No
Individual Psychotherapy	No
Inpatient Hospitalization	Yes (<i>Requests must be telephonic</i>)
Intensive Outpatient Program (IOP)	Yes
Multi-Systemic Therapy (MST) (under age 21)	No
Neuropsychological Testing	No
Outpatient Therapy	No
Peer Support Services	Yes
Pharmacologic Management (all ages)	No
Psychiatric Residential Treatment Facilities (under age 21)	Yes
Psychological Testing	Yes
Psychosocial Rehabilitation (PSR)	No
Residential Substance Use Services in Accordance with the American Society of Addiction Medicine (ASAM) Levels of Care	Yes (<i>Requests must be telephonic</i>)
Therapeutic Group Homes (under age 21)	Yes
Treatment Plan Development	No

Behavioral Health Specialists:

- Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, Family Psychiatric & Mental Health, or a Certified Nurse Specialist in Psychosocial, Mental Health Rehabilitation Services)
- Licensed Addiction Counselors (LAC)
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage and Family therapists (LMFT)
- Licensed Mental Health Professionals (LMHP)
- Licensed Professional Counselors (LPC)
- Licensed Psychologists
- Medical Psychologists
- Psychiatrists

Emergency services may be rendered without the requirement of prior authorization. Payment cannot be denied for treatment of what constitutes an emergency behavioral health condition on the basis of a behavioral health diagnosis or symptoms.

Description of Behavioral Health Services

The complete Louisiana Behavioral Health Partnership (LBHP) Service Definitions Manual maintained by the Louisiana Department of Health and Hospitals (DHH) is accessible online. The summary below serves as a quick reference guide. All providers need to be familiar with this manual. The current version of the manual is located here:

<http://new.dhh.louisiana.gov/index.cfm/page/538>

*Denotes authorization requirement

Service	Service Description
Addiction Services*	Includes an array of individual-centered outpatient, intensive outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use symptoms and behaviors
Assertive Community Treatment (ACT)*	Interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a serious mental illness or co-occurring addictions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community
Case Conference*	A case conference is a scheduled face-to-face meeting between two or more providers to discuss the treatment
Community Psychiatric Supportive Treatment (CPST)	Community Psychiatric Supportive Treatment (CPST) are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individualized treatment plan
Crisis Intervention (CI)*	Crisis intervention (CI) services are provided to an individual who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience; via a preliminary assessment, immediate crisis resolution & de-escalation, and referral & linkage to appropriate community services to avoid more restrictive levels of treatment

Electroconvulsive Therapy (ECT)*	Electroconvulsive Therapy (ECT) is a standard psychiatric treatment in which seizures are electrically induced to provide relief from psychiatric illnesses
Family Psychotherapy	Family members can talk with a behavioral health care professional about emotional problems they may be having and learn coping skills the family can use to manage them
Functional Family Therapy (FFT)	Targeted for youth between ages 10 and 18 primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning
Group Psychotherapy	A group of people with similar emotional issues meet with a behavioral health care professional; the group members share experiences and practice coping skills in order to learn how to manage issues as independently as possible
Homebuilders [®]	Homebuilders is an intensive, in-home evidence-based program (EBP) utilizing research based strategies (e.g. Motivational Interviewing, Cognitive and Behavioral Interventions, Relapse Prevention, Skills Training), for families with children (\leq age 17) at imminent risk of out of home placement (requires a person with placement authority to state that the child is at risk for out of home placement without Homebuilders), or being reunified from placement. Homebuilders is provided through the Institute for Family Development (IFD)
Individual Psychotherapy	Individuals can talk with a behavioral health care professional about emotional issues they may be having and learn coping skills to manage them
Inpatient/Hospital-based Care*	The need for one or more nights in a hospital for emergency treatment which cannot otherwise be treated in the community by a provider
Multisystemic Therapy [®] (MST)	Multisystemic therapy (MST) provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement
Outpatient Therapy	Individual, family, group psychotherapy and mental health assessment, evaluation and testing
Peer Support	Provided by a Peer Support Specialist (who received behavioral health services themselves) to help individuals learn to manage difficulties in their lives
Pharmacologic Management	Individuals meet with a doctor or nurse to discuss medications they are or may take

Psychiatric Residential Treatment Facility (PRTF)*	A PRTF is any non-hospital facility which provides inpatient services to individuals under the age of 21 ensuring that all medical, psychological, social, behavioral and developmental aspects of the individual's situation are assessed and treated
Psychological/Neuropsychological Testing*	Individuals complete written, visual or verbal tests that are administered by a psychologist measuring thinking and emotional abilities
Psychosocial Rehabilitation (PSR)	Psychosocial Rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness
Therapeutic Group Home (TGH)*	Therapeutic Group Homes (TGHs) provide a community-based residential service in a home-like setting of no greater than eight beds, under the supervision and program oversight of a psychiatrist or psychologist.

For services requiring an authorization, if we deem the service medically necessary, the service authorization will begin on the date of the request for the service.

Medication Management Services

Psychiatrists, prescribing APRNs and Medical Psychologists are not required to obtain prior authorization for the initial consultation, routine medication management sessions and other routine outpatient services, such as: 90791, 90792, 90833, 90834 and evaluation & management (E&M) codes as applicable.

Inpatient Services

Emergency services may be rendered without the requirement of prior authorization. Payment cannot be denied for treatment of what constitutes an emergency behavioral health condition on the basis of a behavioral health diagnosis or symptoms.

We require notification of inpatient emergency admissions within 24 hours of admission. We reserve the right to deny a claim for payment based solely on lack of notification.

We are staffed with independently licensed staff 24 hours a day/7 days per week (including weekends and holidays) to respond to authorization requests.

Residential Services

Authorization for both Substance Abuse Residential Treatment and Psychiatric Residential Treatment Facilities needs to be requested prior to the Member's admission to those levels of care when possible. If prior notification cannot occur, notification of admission is required within one (1) business day (Monday – Friday) of admission.

Psychological Testing

Psychological testing must be pre-authorized. Psychological testing is considered after a standard evaluation (CPT code 90791 or 90792 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 impairments 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

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 Provider Services Line at **(866) 675-1607** to determine authorization requirements and procedures.

For information regarding test administration by a psychometrist, psychometrician or psychologist-extender, please refer to the **Psychological/Neuropsychological Testing Guidelines** located on *Provider Express* (Home > Clinical Resources > Guideline/Policies & Manuals > Psychological/Neuropsychological Testing Guidelines) This guide also addresses other procedures related to testing and report writing. You can also contact the Care Advocacy Center at **866 675-1607** for assistance with any questions.

Care Advocacy

The Behavioral Health Care Advocacy Center (CAC) focuses on activities that impact Medicaid Members' stabilization and recovery and promote active participation in their care. This approach consists of targeted interventions intended to facilitate Member services, identify Members who may be at risk, and 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 Members' care

- Ensuring that Members being discharged from facility-based care have appropriate discharge plans, that they understand them and that they are able to access and afford the recommended services
- Proactively reaching out to providers to discuss Members' care when an individual has been identified as being at-risk
- Offering clinical consultations with medical staff
- Reaching out to Members in some circumstances to educate, evaluate risk, and offer assistance
- Supporting Members to actively participate in treatment and follow-up care
- Referencing web-based and written information regarding behavioral health conditions for Members and treating providers designed to support informed decision making

Care Advocate Availability

The Optum Care Advocacy Center in Baton Rouge is open for standard business operations Monday through Friday from 8 a.m. to 5 p.m. Central Standard Time. In addition, we are staffed 24 hours a day/7 days per week (including weekends and holidays) to discuss urgent and emergent situations (such as potential inpatient admissions), to handle Members in crisis, or any other questions about the care advocacy process.

Affirmative Incentive Statement

Care Advocacy decision-making is based only on the appropriateness of care as defined by the **Coverage Determination Guidelines, Level of Care Guidelines, Psychological and Neuropsychological Testing Guidelines**, The Plan, and applicable state and federal laws. The Level of Care and Psychological and Neuropsychological Testing Guidelines are sets of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support Members' recovery, resiliency, and wellbeing. Optum's Coverage Determination Guidelines are intended to standardize the interpretation and application of terms of the Member's Benefit Plan including terms of coverage, Benefit Plan exclusions and limitations. You will find these, along with the Best Practice Guidelines Coverage Determination Guidelines at providerexpress.com or you can receive a paper copy from Network Management.

Optum expects all treatment provided to Optum Members be outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. Optum does not reward its staff, practitioners or other individuals for issuing denials of coverage or service care. Utilization management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

Eligibility Inquiry

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

Utilization Management Begins at Intake

Optum believes that a “no wrong door” approach is the best way to ensure that Members or their families can access services at the time they first recognize symptoms. Therefore, we have intake policies that facilitate immediate access to treatment:

- A Member can contact a network provider’s office and request an appointment
- A family member can contact a network provider’s office and request an appointment for a Member

The Member Service Line (**866-675-1607**) is available 24 hours a day, 365 days a year, and provides a Member or family member with immediate contact with someone who can help identify a network provider most appropriate to the Member’s needs and preferences. If requested, we will contact the provider, on the Member’s behalf, and finalize arrangements to help the Member get to the provider’s office or access emergency/crisis services.

Home and Community Based Services

This is a home or community-based program available to adults, adolescents and children who are recovering from a Severe and Persistent Mental Illness that promotes recovery, assists the member to integrate with their community, and provides services aimed at helping the member improve their quality of life.

This service uses network providers to help Members develop skills needed to increase their capacity to thrive in their home, employment, school or social environments. These services target skills that may have been lost due to the Member’s behavioral health condition. The services vary in intensity, frequency, and duration in order to support Members in managing functional difficulties, or to otherwise realize recovery goals.

Peer Services and Supports

This is a form of community support service in which a Certified Peer Specialist utilizes their training, lived experience and experiential knowledge to assist the Member/Member’s parent or legal guardian with achieving the recovery and resiliency goals. Assistance can take a variety of forms such as by providing information about services or self-care, supporting the development of skills, and facilitating access to services and resources.

These services may be delivered while the Member is receiving behavioral health treatment, in advance of the start of behavioral health treatment in order to facilitate engagement in care, or as part of the Member’s transition from other services.

The services help the Member/Member’s parent or legal guardian become more socially connected and increase engagement in treatment and empowerment.

Assisting with Recovery

We encourage you 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 support decision-making, promote participation in treatment, enhance self-management, and support broader recovery goals.

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

Assessment

Thorough clinical assessments are required, and should be included in the clinical record. The initial diagnostic assessment includes a biopsychosocial history that provides information on previous medical and behavioral health conditions, interventions, outcomes, and lists current and previous medical and behavioral health providers. The mental status exam includes an evaluation of suicidal or homicidal risk. A substance use screening should occur for Members over the age of 12 years, noting any substances abused and treatment interventions. Other areas to be covered in the assessment are developmental history, education, legal issues, and social support. Cultural and spiritual considerations should be covered. A note should also be made of any community resources accessed by the Member. A culmination of these assessment aspects, including negative findings, will yield a DSM-5 diagnosis (ICD-10 is used for billing purposes).

Treatment, Recovery & Resiliency and Discharge Planning

The treatment plan stems from the Member's condition, and is used to document realistic and measurable treatment goals as well as the evidence-based treatments that will be used to achieve the goals of treatment. Effective treatment planning should take into account significant variables such as age, level of development and the history of treatment. Other variables to consider are whether the proposed services are covered in The Plan and are available in the community. Finally, you should also consider 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 expressed or documented preferences in a psychiatric advance directive or crisis plan. For some Members, treatment is part of a broader recovery & resiliency effort, so the recovery & resiliency goals documented in a recovery plan should also be considered.

A change in the Member's condition should prompt a reassessment of the treatment plan and selection of level of care. When the condition has improved, the reassessment determines 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 has worsened, the reassessment determines whether the diagnosis is accurate, the treatment plan requires modification or a change in the level of care.

Effective discharge planning enables the Member's safe and timely transition from one level of care to another, and documents the services they will receive post-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 documents the:

- Anticipated discharge date
- Proposed post-discharge services
- Plan to coordinate discharge with the provider at the next level of care (when indicated)
- Plan to reduce the risk of relapse
- Agreement by the Member with discharge plan

As the Member transitions from one level of care to another, we expect that the first appointment at the next level of care will be scheduled according to the Member's needs. The first post-discharge appointment following inpatient care should occur no later than seven (7) days from the date of discharge. This timeframe is in accordance with the Health Effectiveness Data and Information Set (HEDIS[®]) standard for follow-up treatment after discharge from inpatient care.

Optum's Behavioral Health Care Advocates and Field Care Advocates monitor discharge planning and are available to assist with identifying and facilitating access to treatment services and community resources. Optum expects that the provider will collaborate with the Member during treatment, recovery and discharge planning whenever possible.

Coordination of Care

Communication with Primary Physicians and Other Health Care Professionals

To coordinate and manage care between behavioral health and medical professionals, we require that you seek to obtain the Member's consent to exchange appropriate treatment information with medical care professionals (e.g., primary physicians, medical specialists) and/or other behavioral health providers (e.g., psychiatrists, therapists). We require that coordination and communication take place at: the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate. Coordination of services improves the quality of care to Members in several ways:

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

To facilitate effective communication between treatment professionals involved in a Member's care, Optum requires network providers to coordinate services with the Member's primary care physician (PCP) at a minimum, by applying the following standards for care coordination:

- During the diagnostic assessment session, request the Member's written consent to exchange information with all appropriate treatment professionals
- After the initial assessment, provide other treating professionals with the following information within two weeks:
 - Summary of Member's evaluation
 - Diagnosis
 - Treatment plan summary (including any medications prescribed)
 - Primary clinician treating the Member

Attempt to obtain all relevant clinical information that other treating providers may have pertaining to the Member's mental health or substance use problems

- Update other behavioral health and/or medical clinicians when there is a change in the Member's condition or medication(s)
 - When serious medical conditions warrant closer coordination
 - At the completion of treatment, send a copy of the discharge summary to the other treating professionals

Some Members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum, as well as accrediting organizations, expects you to make a "good faith" effort at communicating with other behavioral health providers and any medical care providers who are treating the Member as part of an overall approach to coordinating care.

Management of Outpatient Services

Outpatient Management

The goal of our outpatient management program is to reduce administrative burden through the use of Practice Management and the Algorithms for Effective Reporting and Treatment (ALERT) Program. For services that are in-scope, the precertification requirements have been removed. The in scope Services include:

- Individual/Group/Family Therapy
- Psychosocial Rehabilitation
- Community Psychiatric Support & Treatment
- Homebuilders
- Multi-Systemic Therapy
- Functional Family Therapy
- Outpatient Addiction Services (ASAM Level 1)

The ALERT Program uses claims data and service combinations to identify Members who have a frequency or duration that is higher than expected. When this occurs, a licensed care advocate will contact the provider telephonically to:

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

There are three potential outcomes of this review:

- Close case (Member is eligible, treatment plan/plan of care is appropriate, care is medically necessary)
- Modification to plan (e.g., current care is not evidence based but there is agreement to correct)
- Referral to Peer Review (e.g., Member appears ineligible for service; treatment does not appear to be evidence based; duration/frequency of care does not appear to be medically necessary)

Quality Improvement

We are committed to the highest quality of care provided in a manner consistent with the dignity and rights of Members and to meeting or exceeding customer expectations. Our Quality Improvement (QI) Program is outlined in the UnitedHealthcare Louisiana Administrative Guide. In addition to the activities previously outlined, the QI Program monitors: accessibility; quality of care; appropriateness, effectiveness and timeliness of treatment; and Member satisfaction. The QI Program is comprehensive and incorporates the review and evaluation of all aspects of behavioral health care. If you have any feedback regarding QI projects and processes, please contact Network Management.

Compliance with the QI Program is required in accordance with your Agreement, including cooperation with Optum and customers in our efforts to adhere to all applicable laws, regulations and accreditation standards.

The key components of the QI Program required of you as a participating provider include, but are not limited to:

- Ensuring that care is appropriately coordinated and managed between you and the Member's primary care physician (PCP) and other treating clinicians and/or facilities
- Cooperation with on-site audits and requests for treatment records
- Cooperation with the Member complaint process (e.g., supplying information necessary to assess and respond to a complaint)
- Responding to inquiries by our Quality staff
- Participation in Quality 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

- Helping to ensure Members receive rapid follow-up upon discharge from an inpatient level of care

Some of the activities that may involve you are described in more detail below.

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, which has, or may have, deleterious effects on the Member, including death or serious disability, that occurs during the course of a Member receiving behavioral health treatment. If you are aware of a sentinel event involving a Member, you must notify us within one business day of the occurrence by calling the number on the back of the Member's ID card.

We have established processes and procedures to investigate and address sentinel events. This includes a Provider Advisory Committee, chaired by a medical director, and incorporates appropriate representation from the various behavioral health disciplines as needed. You are required to cooperate with sentinel event investigations.

Member Satisfaction Surveys

On at least an annual basis as required by contract, we conduct a behavioral health Member Satisfaction Survey of a representative sample of Members receiving behavioral health services within the network. The results of the survey are reviewed. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Provider Satisfaction Surveys

We regularly conduct a satisfaction survey of a representative sample of clinicians delivering behavioral health services to Members. This survey obtains data on clinician satisfaction with our services including Care Advocacy, Network Services and claims administration.

The results of the survey are compared to previous years for tracking and trending. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Practice Guidelines

We have adopted clinical guidelines from nationally recognized behavioral health organizations and groups. The Best Practice Guidelines and Level of Care Guidelines are available through *Provider Express*: Home page > Quick Links > Guidelines/Policies & Manuals > Best Practice Guidelines or Level of Care Guidelines. Your feedback is encouraged on all guidelines and any suggestions on new guidelines to be considered for adoption are welcome. If you would like a paper copy of these guidelines please contact Network Management.

Complaint Investigation

Providers may file a complaint by contacting the Provider Services Line at **(866) 675-1607**. The complaint or dispute will be documented and resolved; resolution will be communicated to the provider. Please refer to the UnitedHealthcare Louisiana Administrative Guide for additional information about the complaint process.

Treatment Record Documentation and Quality Audits

The **Treatment Record Documentation Requirements** are outlined in the Optum network Manual (Provider Express > Clinical Resources > Guidelines/Policies & Manuals > Optum Network Manual > Treatment Record Documentation Requirements). In addition to the requirements outlined in that manual, the following requirements are specific to Louisiana Medicaid:

- Member demographic data should be collected including, but not limited to ethnicity, race, gender, sexual orientation, religion, and social class
 - The intent of collecting this information is to allow providers to better respond to the cultural needs of Members
 - Members must be given the opportunity to voluntarily provide this information, it cannot be required
- A current medical screening is documented; at minimum, options for documenting the screening include (but are not limited to):
 - Healthy Living Questionnaire 2011
 - Primary and Behavioral Health Care Integration (PBHCI) Medical Short Screening Form

Licensed Mental Health Professional (LMHP) Treatment Record Review Process

LMHPs treating 50 or more Members annually will participate in a treatment record review at least once every two years. The purpose of the review is to ensure that LMHPs provide high quality services that are documented to established standards. The documentation standards will be made available to all LMHPs.

Assertive Community Treatment (ACT) Fidelity Monitoring Process

Organizational Providers who provide ACT services will participate in regular Fidelity Monitoring, which will include periodic site visits, and ongoing monitoring. The purpose of the monitoring will be to ensure that providers operate using evidence-based practices. The standards will be made available to all ACT providers.

Prescription Management Program (PMP), Required Documentation by Prescribers

All prescribers must use the Prescription Monitoring Program (PMP) to conduct Member specific queries at the time when an initial prescription for a controlled substance is written. Queries must then be completed annually. The prescriber shall print the PMP query and file it in

the Member's treatment record. We will complete random chart reviews to verify compliance with this process. Prescribers may complete additional queries at their discretion.

The goal of the program is to improve the state's ability to identify and inhibit the diversion of controlled substances and drugs of concern in an efficient and cost-effective manner that shall not impede the appropriate utilization of these drugs for legitimate medical purposes.

Confidentiality

Providers must comply with all requirements related to protection of Personal Health information, including but not limited to requirements set forth in Chapter 42 of the Code of Federal Regulations (CFR) Section 431.306 (42 CFR §431.306) regarding Release of Information.

Network Requirements

Network providers are required to support Members in ways that are culturally and linguistically appropriate, and to advocate for the Member as needed.

Network providers are required to notify us at providerexpress.com within ten (10) calendar days whenever you make changes to your practice including office location, weekend or evening availability, billing address, phone number, Tax ID number, entity name, or active status (e.g., close your business or retire).

Providers are prohibited from balance billing any Member for any reason for covered services.

Optum requires that providers not employ or contract with any employee, subcontractor or agency that has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Credentialing

Optum will complete initial credentialing of a provider within 60 days of receipt of a completed credentialing application. A completed credentialing application includes all necessary documentation, attachments, and a signed Agreement.

Physician Addictionologists must be certified by the American Society of Addictions Medicine (ASAM) or the American Board of Addiction Medicine (ABAM) or have added qualifications in Addiction Psychiatry through the American Board of Psychiatry and Neurology (ABPN).

Network Training Requirements

Providers are required to participate in a comprehensive provider training and support program to gain appropriate knowledge, skills, and expertise to comply with the requirements.

The annual training program will address the following areas:

- Orientation to Optum
 - Credentialing and Recredentialing
 - Provider Website Orientation
 - Member Eligibility Verification
 - Claims and Billing Guidelines
- Clinical Model
 - Crisis Management
 - Treatment Planning
 - Use of Evidence-Based Practices
 - Care Coordination
- Cultural competency
- Documentation requirements
- Utilization requirements

Access to Care

On-Call and After-Hours Coverage

You must provide or arrange for the provision of assistance to Members in emergency situations 24 hours a day, seven days a week. You should inform Members about your hours of operation and how to reach you after-hours in case of an emergency. Each Member's treatment plan must also include a crisis plan that informs the Member what to do in the case of an emergency. In addition, any after-hours message or answering service must provide instructions to the Members regarding what to do in an emergency situation. When you are not available, coverage for emergencies should be arranged with another participating provider.

Access to Outpatient Mental Health and Substance Use Disorder Services

To ensure that all Members have access to appropriate treatment as needed, we develop, and maintain a provider network with adequate types and numbers of providers. We require that network providers adhere to specific access standards, which are outlined as follows:

- Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of the request
- Urgent Care must be available within twenty-four (24) hours of the request
- Routine, non-urgent appointments shall be arranged within fourteen (14) days of referral
- An outpatient appointment for behavioral health or substance abuse must be offered within seven (7) days of an acute inpatient discharge

Optum expects that Members will generally have no more than a 45 minute wait time for their appointment in your office; this includes time spent in the waiting room and consultation room.

If the provider is delayed Members should be notified immediately. If the wait is anticipated to be longer than 90 minutes, Members should be offered a new appointment time. 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.

Members who walk-in seeking an appointment and do not have an urgent need should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Optum will monitor compliance with appointment access standards and the provision of after-hours coverage through monitoring of Member complaints and telephonic assessment of appointment availability.

If you are unable to take a referral, immediately direct the Member to contact us at **866 675-1607** so that they can obtain a new referral.

Geographic Access Standards

Optum is expected to meet certain geographic access standards; these standards must be met for 90% of the membership we serve.

Provider Type	Urban	Rural
Psychiatrists	15 Miles	30 Miles
Behavioral Health Specialists	15 Miles	30 Miles
	Statewide Access Requirement	
Psychiatric Residential Treatment Facilities (PRTFs)	200 Miles	
	Adults	Adolescents
ASAM Level III.3/5 Clinically Managed High Intensity Residential	30 Miles	60 Miles
ASAM Level III.7 Medically Monitored Intensive Residential Co-Occurring Treatment	60 Miles	N/A
ASAM Level.III7D Medically Monitored Residential Detoxification	60 Miles	N/A

Billing and Claims

Billing Guidelines

- Keep your NPI handy.
 - You will need to bill your registered NPI on your claims
 - The NPI you need to bill is the servicing provider ID assigned to you, as an individual
 - The NPI is placed in box 24J of your HCFA claim form.
- Billing Limitations (it is important that providers acquaint themselves with the current billing restrictions):
 - Some of the services are not able to be billed on the same day as other Covered Services

- Most codes have a daily or annual limit to the amount of services that may be provided
- Reminder: ICD-10 codes became effective on 10/1/2015. Claims billed with ICD-9 codes will be rejected
- Report the provider doing the service, using that provider's registered NPI in box 24J of the HCFA form.
 - Include your Tax ID number, Service Location (where service was rendered) and Billing Information

Example below:



24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To						EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID, QUAL.	RENDERING PROVIDER D. #
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER	PONTER					
1													NPI	
2													NPI	
3													NPI	
4													NPI	
5													NPI	
6													NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX ID, NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rev'd for NUCC Use	
		<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		\$			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()					
SIGNED			DATE			a. NPI		b. NPI				

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

- All claim submissions must include:
 - Member name, Medicaid identification number and date of birth
 - Provider's Federal Tax I.D. number
 - National Provider Identifier (NPI) (unique NPI's for rostered clinicians)
 - Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at www.cms.gov

Claims Submission

Claims may be submitted in different ways:

- Online (www.unitedhealthcare.com)
- Electronic Data Interchange (EDI) using any clearinghouse
 - Payer ID is 87726
 - More information is available on www.unitedhealthcare.com

- U.S. Mail
 - UnitedHealthcare Community Plan of Louisiana
P.O. Box 31341
Salt Lake City, UT 84131-0341

Contact Us

You can contact us at **866-675-1607** with questions about claims, benefits and eligibility, authorizations, credentialing, network services and other professional services.

Technical Support for Provider Express (providerexpress.com)

For questions about using this site, issues with requesting a user ID and password, or for technical issues, call the Provider Express Support Center at 866 209-9320 (toll-free) from 7 A.M. to 9 P.M. Central time.