Network Notes

OptumHealth News and Updates for USBHPC-Contracted Clinicians and Facilities Fall 2018

Understanding Employee Assistance Program Benefits

Employee Assistance Program (EAP) is a health and wellness benefit provided by one's employer. The EAP benefit is designed to provide assessment and referral, as well as a brief counseling intervention for members. The typical EAP benefit offers a limited number of routine, weekly sessions with a clinician for brief counseling services, but is not designed to provide an ongoing course of psychotherapeutic treatment. Typically, EAP benefits also cover such things as legal and financial resources, 24/7 Nurse-line support, and Work Life resources. The OptumHealth Behavioral Solutions of California (OHBS-CA) network of clinicians offers members assistance with small questions, big problems, and everything in between.

EAP services are a benefit paid for by the member's employer and remain confidential. The member has no financial responsibility–**no deductible, co-payment or coinsurance** amount. OHBS-CA reimburses you directly at your contracted rate for authorized counseling sessions.

Not all members served by OHBS-CA have an available EAP benefit but those who do can generally see any contracted OHBS-CA clinician for EAP services. The benefit is provided by a member's employer and may be separate from the member's behavioral health insurance policy. Many members who have EAP benefits through OHBS-CA also have OHBS-CA insurance, allowing for a smooth transition into ongoing counseling, if needed, once a member has exhausted their EAP sessions.

Can you offer EAP services?

OHBS-CA does not have a separate EAP network. All OHBS-CA contracted therapists are allowed to provide and bill for EAP services. Accepting EAP members can help build your practice and create word-of-mouth referrals. Your contracted rates are the same for EAP services as for routine outpatient therapy services. (Note that there are limitations around the use of EAP benefits with a psychiatrist).

Are you an EAP specialist? Are you looking for more EAP referrals?

If you have at least 2 years of experience in the delivery of EAP core technology (as defined by the Employee Assistance Professionals Association) and at least one annual training in any of the eight EAP content areas, you can log in to providerexpress.com and attest to the Employee Assistance Program specialty.

EAP Authorizations, Billing, & Claims

Authorizations are required for EAP services and may be initiated by either the member or the provider prior to the first appointment. To request authorization, call the behavioral health number on the back of the member's insurance card. EAP authorization letters are sent directly to the member via e-mail or postal mail. When a member presents for EAP services, inquire about the EAP authorization code number,

effective dates and expiration dates, and whether any of the authorized visits have already been used.

The easiest way to bill for EAP services is to submit claims on providerexpress.com. You may need a subscriber ID for OHBS-CA EAP members. If the member also has OHBS-CA for behavioral health coverage, their subscriber ID is often the same for EAP. If the member does not have OHBS-CA behavioral health coverage you may call into Optum EAP 24/7 to confirm their subscriber ID.

All EAP Claims must include an HJ modifier following the CPT code to be processed and paid correctly. When billing on providerexpress.com, you will be prompted to select BH or EAP. If you select EAP, the HJ modifier will automatically populate. If the services are provided virtually, the GT modifier must also be included on the claim. OHBS-CA EAP always allows the following procedure codes:

90832HJ	30-37 min individual therapy
90834HJ	38-52 min individual therapy
90846HJ	Family therapy without the patient in attendance
90847HJ	Family therapy with the patient in attendance
90853HJ	Group therapy other than family

Note: extended therapy visits (90837) are not covered by Optum EAP. There are occasions in which a formal diagnostic assessment (90791) is covered. Please call to discuss further.

Reach out to Optum EAP 24/7

Find EAP resources on: Provider Express > Admin Resources > EAP Resources. In addition, if you need assistance with EAP-related issues, you can contact the number on the back of the member's ID card or call Optum EAP 24/7 at 1-800-358-8515.

Timely Access to Care

More and more attention has been given lately to challenges people encounter in accessing health care. This is true in both the medical and the behavioral healthcare fields. Some of the challenges involve the number of practitioners in a particular area, scheduling conflicts, desires for specific areas of expertise, and cultural or language needs. OHBS-CA is working to improve access to care through a variety of mechanisms, including expansion of the virtual visit (telehealth) and Express Access networks, and by periodically reminding providers of our access standards. We rely on you to comply with these required standards as a part of your business practice.

Standard	Criteria	Anticipated Compliance
Non-Life-Threatening Emergency	A situation in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm to self or others	100% of members must be offered an appointment within 6 hours of the request for the appointment
Urgent	A situation in which immediate care is not needed for stabilization but, if not addressed in a timely way, could escalate to an emergency situation	100% of members must be offered an appointment within 48 hours of the request for the appointment
Routine (non-urgent)	A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others	100% of members must be offered an appointment within 10 business days of the request for the appointment
After-Hours Answering System & Messaging	Messaging must include instruction for obtaining emergency care	100%
Network Clinician Availability	Percentage of network clinicians available to see new patients	90%
Clinician Timely Response to Enrollee Messages	Clinicians shall provide live answer or respond to enrollee messages for routine issues within 24 hours	90%

Please note:
The time for a particular, non-emergency appointment may be extended if it is determined* and documented that a longer waiting time will not have a detrimental impact on the member's health. Rescheduling of appointments, when necessary, must be consistent with good professional care and ensure there is no detriment to the member.

Interpreter Services:
Interpreter services are available to members at the time of the appointment if requested by the member or provider. To request interpreter services contact us at 1-800-999-9585. Language interpretation services are available at no cost to the member.

Clinician Timely Response to Member Messages: To date in 2018, and as we found in 2017, one of the most frequent complaints we receive related to appointment access and availability is the failure of a clinician to promptly return a member's call. See the following article on this topic.

After-Hours Answering System and Messaging: Please review your answering machine message to ensure that it includes instructions to members regarding what they should do in an emergency situation. If you change your message due to vacation or leave of absence, remember to include the instructions in your new message. Even if you have provided written instructions to your clients, consider that they may not have those instructions close at hand in a crisis situation. The guidance you provide through your phone message could be critical to aiding a member in crisis.

If you are unable to see new members due to a full practice or leave of absence, please let us know. You can easily update your own availability status online at Provider Express. This reduces inappropriate referrals and frustration for members. You may remain unavailable for up to six months. Changes to your availability status can also be made by:

- Calling Network Management at 1-877-614-0484
- Emailing us at **bnswest@optum.com**
- Faxing change to Network Management at 1-855-833-3724.

We know you share our commitment to offering clinically appropriate and timely access to care pursuant to Section 1367.031 of the California Health and Safety Code. You may contact OHBS-CA for assistance by calling 1-800-999-9585. Additionally, the DMHC Help Center may be contacted at 1-888-466-2219 to file a complaint if the member is unable to obtain a timely referral to an appropriate provider. Thank you for making these standards a part of the quality care provided by the OHBS-CA network.
In 2016, we invited approximately 5,700 Network clinicians in California to participate in a web-based survey to measure clinician satisfaction with areas of service including:

- Authorization process
- Network services staff
- Claims/Customer service,
- Credentialing
- Website usage

Overall satisfaction with OHBS-CA and with the Claims/Customer Service area showed improvement over the prior year, while satisfaction with the Authorization Process declined slightly. Satisfaction with Network Services remained consistent with the prior year.

The information you provide through the web-based survey helps us identify what we are doing well, and where we need to improve our service. Thank you to all of you who took the time to participate in the survey and provide us with valuable feedback.

Telemental Health is Now "virtual visits"

Offering virtual visits is easier than ever with our new Telemental Health Platform to support the services:

- Easier access for consumers
- Complete attestation available online
- See step-by-step process for delivery of virtual visit services to OHBS-CA members

Provider Express – Clinical Resources – Optum Telemental Health Platform

* An extension to the time for a non-emergency appointment may be determined by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and is consistent with professionally recognized standards of practice.

Members Want to Hear From You. Email Can Make it Easier!

Did you know that you can give us a publishable, secure email for display in our online directory? This offers members an option to contact you by email and gives you a convenient way to respond. One of the most common complaints we receive from members is "The provider never called me back". While your contract requires that you respond to members within 24 hours, we understand that many providers use "after hours" times to catch up with administrative tasks and it may not be convenient to call a member at those time. Sometimes, other issues make it difficult to return a call. The message may be unclear or the caller forgets to leave a return number. By promoting the use of email, you can more effectively manage your member responses when it's most convenient to you and meet your contractual requirements.

You can add an email address, specifically for display in the directory, through Provider Express secure Transactions or by contacting

us at 1-877-614-0484. The addition of a publishable email is a relatively new feature. It might not have been an option when you originally joined the network. We encourage you to check your practice information on Provider Express and see if you have designated a publishable email for the directory. If not, we would suggest adding an email address for this purpose.

Don't forget that, if you are unable to accept new members, you can also designate your practice as "unavailable" for up to six months through providerexpress.com.

During that time, this information is clearly displayed in the directory and Optum staff will not refer new members to you. Having this information clearly visible will reduce the number of phone messages or emails to which you have to respond.

Thank you for sharing our commitment to providing quality care to the members we serve and for responding promptly to their requests for your help.

Add Your Website to Our Directory

Have you developed a website for your practice? We now have the ability to display a link to your website in our online directory. This gives members an easy link to learn more about your practice, services, and treatment approach. Take advantage of this option by adding your website to your provider profile through providerexpress.com or by calling 1-877-614-0484.

Quality Achievements

The Quality Management (QM) Program monitors access to care and availability of clinicians, quality of care and services, patient safety, and appropriate utilization of resources. Each year, an in-depth evaluation of the QM Program is performed. This includes a review of the processes that support these components of care along with OHBS-CA overall structure. The findings of the most recent evaluation conducted in 2017 include:

- Outstanding performance in the areas of network availability and accessibility
- High performance in the areas of customer service call response time and claims payment accuracy, and turn-around times for claims processing, provider disputes, and non-coverage determinations.

- Appointment for emergent care (non-life threatening) offered within 6 hours was at 100%
- Appointment for urgent care offered within 48 hours was at 100%
- Member complaints remain below the performance threshold, with 100% of complaints resolved within 30 days of receipt.

An Executive Summary of the most recent QM performance evaluation is available by calling toll-free 1-877-614-0484.

Members Highly Satisfied with Treatment and Services

OHBS-CA administers the Member Satisfaction Survey to a sample of members who receive services from an OHBS-CA network clinician. Results are analyzed annually and the findings are used to identify opportunities to improve the member experience.

The 2017 survey assessed member satisfaction along multiple domains including:

- Obtaining referrals or authorizations
- Accessibility and acceptability of the clinician network
- Customer service; treatment/quality of care
- Overall satisfaction

Results of the survey indicate that members experience high overall satisfaction with treatment received. 87% of members indicated that they would use these services

again. 92% of members indicated that they were able to find care that was respectful of language, cultural, and ethnic needs. 89% of the members surveyed reported that the treatment they received from their clinician helped them better manage their problems. Overall member satisfaction with services received from OHBS-CA was 89%.

Express Access Network Can Bring You More Referrals

Joining the Express Access Network can bring more referrals your way! Learn more about this innovative approach and how to join this network on Provider Express > Clinical Resources > Express Access Network!

Provider Appointment Availability Survey

Each year, all full service and mental health plans in California are required to submit reports to the Department of Managed Health Care (DMHC) regarding their timely access compliance pursuant to California Health and Safety Code section 1367.03(f)(2). The ultimate goal of the DMHC is to ensure that reliable data is easily accessible to consumers to help them compare the relative compliance of behavioral health plan networks with the state-required timely access standards.

For the measurement year of 2018, OHBS-CA's vendor is surveying the network regarding urgent and routine appointment availability using a combination of an online survey tool, phone calls and faxes in accordance with DMHC's methodology. Opportunities for improvement will be determined based on our analysis of the survey results. If we identify the need for corrective action, we will provide advance written notice to any impacted providers.

If you are selected for the survey, we ask that you please respond promptly. Thank you for your cooperation.

Join in our Commitment to the Public Sector

OHBS-CA provides the behavioral health benefits for members served through the UnitedHealthcare Community Plan of California (UnitedHealthcare) Medi-Cal program. UnitedHealthcare has announced plans to expand participation in the Medi-Cal program in the following counties when the state releases the Medi-Cal Managed Care Request for Proposal in late 2019 or early 2020. In preparation for that plan, we are currently expanding our Medi-Cal network in all of the counties listed below:

Alameda	Riverside
Fresno	San Bernardino
Kings	San Diego
Madera	Santa Clara

If you share our commitment to helping the disadvantaged and medically underserved population in California, please join our Medi-Cal network.

What Do You Need to Do?

Step One: The Department of Health Care Services (DHCS) requires that all providers treating Medi-Cal members enroll with the DHCS. If you are not enrolled, you can do so at the DHCS Provider Application and Validation for Enrollment site.

Step Two: Contact Network Services at bnswest@optum.com to obtain the Medi-Cal Attestation. This is simply a form we will ask you to sign stating that you agree to see Medi-Cal members. This ensures that our online directory for Medi-Cal includes only providers who have committed to serving this vital membership.

In accordance with your existing Agreement, you will be able to provide services to eligible UnitedHealthcare Medi-Cal members beginning with the effective date of their coverage through UnitedHealthcare. Copies of your Agreement, Medi-Cal Addendum and current Medi-Cal rates can be requested from OHBS-CA Network Management at bnswest@optum.com.

Clinicians Provide Valuable Feedback

In 2017, we are pleased that 1,875 Network clinicians in California responded to our Provider Satisfaction Survey that measures clinician satisfaction with areas of service including the authorization process, Network Services staff, the Authorization Process, Claims/Customer Service, Credentialing, web site usage and Net Promoter Scores (NPS).

Satisfaction with Network Services staff remained consistent with 2016, while Claims/Customer Service, the Authorization Process, Credentialing, and NPS showed some decline. Satisfaction with Provider Express remained high.

The information you provide through the web-based survey helps us identify what we are doing well, and where we need to improve our service. Thank you to all of you who took the time to participate in the survey and provide us with valuable feedback.

Monitoring Network Availability

We have developed standards to ensure that members have appropriate availability of behavioral health clinicians and facilities within a defined geographic distance.

	Standard (within number of miles from member)			
Clinician Type	**Urban**	**Suburban**	**Rural**	**Performance Goal**
Physician (M.D./D.O.)	10 miles	20 miles	30 miles	95%
Ph.D./Master's Level	10 miles	20 miles	30 miles	95%
Child/Adolescent Clinician	10 miles	20 miles	30 miles	95%
Acute Inpatient Care	15 miles	15 miles	15 miles	90%
Intermediate Care/Partial Hospitalization	15 miles	30 miles	60 miles	90%
Intensive Outpatient Care	15 miles	30 miles	60 miles	90%

The most recent results are in for the compliance measurement of the standards for geographic availability for the OHBS-CA network. Clinicians and facilities are in geographic positions of availability to provide services to membership in all urban, suburban and rural areas of California with the exception of acute care facilities. There is an overall scarcity of behavioral health facility programs throughout California, especially in rural areas. We continue to monitor these areas for new programs that are willing and able to contract with us to enhance the availability of services for the members we serve.

If you are aware of providers who might be interested in joining the OHBS-CA network, please refer them to Provider Express > Our Network > Join Our Network > California for a list of recruitment activities, including for specific areas of expertise, language skills or cultural expertise.

The Importance of Coordination of Care

Learn more about this critical element in providing effective treatment through communication with all of a member's treating providers. Find valuable resources on Provider Express > About Us > Navigating Optum > Authorizations & Benefits > Coordination of Care.

Maintaining Accurate Practice Information

We continue to emphasize the importance of maintaining current, accurate demographic and practice information. In accordance with California Senate Bill 137 (SB-137), which became effective July 1, 2016, OHBS-CA has made modifications to our online provider directory to ensure that current information is displayed to those seeking information about your services. Online users can report possible inaccurate, incomplete or misleading information through a direct link online, by email to **provider_feedback@optum.com**, or by calling 1-800-999-9585.

Please make it part of your practice to periodically review and update your practice information through the secure Transactions section of *Provider Express*.

As required in SB-137, we also reach out to you to verify the accuracy of your information. Individually contracted clinicians must be contacted every six months and groups are contacted at least once each year. The regulations require that we obtain a response from you within 30 days, either verifying that your information is accurate or providing any needed updates. Thank you for cooperating and responding promptly to these outreach efforts.

OHBS- CA Language Assistance Program

The OHBS-CA **Language Assistance Program** includes provisions for both the provider network and OHBS-CA to ensure that members with limited English proficiency can obtain language assistance when needed:

- Requirements for clinicians and facilities
- Tips for working with interpreters
- Tips for working with members with limited English proficiency
- Grievance forms and notices of language assistance

Learn more on Provider Express > Admin Resources > California Language Assistance Program.

Public Policy

In accordance with California law, U.S. Behavioral Health Plan, California ("USBHPC") dba OptumHealth Behavioral Solutions of California ("OHBS-CA") has a Public Policy Committee to provide a formal structure for the comments and participation of covered members, and employer and health plan representatives. This committee consists of at least three subscriber enrollees of OHBS-CA, one contracted clinician and one member of our Board of Directors.

Responsibilities of the Public Policy Committee include:

- Evaluating care and service proposals
- Defining public policy in accordance with the state's Knox-Keene Act
- Reviewing and discussing member grievance data
- Examining member and provider satisfactions survey results
- Reviewing the company's financial condition
- Making recommendations to the USBHPC Board of Directors regarding quality of care and service

The Public Policy Committee meets quarterly, and reports to our Board of Directors. For more information regarding committee membership, please contact Tonya Shean, Compliance Consultant, at 1-415-547-5541.

What Channel are YOU Watching?

Have you tuned in to the Provider Express Video Channel? We offer a variety of videos, most less than 10 minutes in length, to assist you in learning how to more effectively and efficiently interact with Optum. And you can watch any time, at your convenience! Take a look at Provider Express > Video Channel.

OptumHealth Behavioral Solutions of California Important Reminders

Affirmative Incentive Statement

Care advocate 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, Behavioral Clinical Policies, the member's Benefit 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 well-being. OHBS-CA'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 Best Practice Guidelines and the Supplemental and Measurable Guidelines, at Provider Express > Guidelines / Policies & Manuals.

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

Care Advocacy Process Provides Peer Review Discussion

Our care advocacy process offers every clinician the opportunity to discuss a potential adverse benefit determination based on medical necessity with an appropriate peer reviewer at OHBS-CA before a final determination is made. You may request a discussion with a peer reviewer at any time during the decision process or after the decision has been made. You may reach a peer reviewer by calling the number shown in the certification letter or an adverse determination letter or by calling the number on the back of the member's identification card and requesting to speak with a peer reviewer.

University of California Employee Claims

We encourage all clinicians to submit claims electronically, either through our secure web site, providerexpress.com, or via Electronic Data Interchange (EDI). However, if you do not submit your claims electronically, please remember that claims for employees of the University of California must be submitted to their designated claims address:

Optum
PO Box 30760
Salt Lake City, UT 84130-0760

If you submit your claims electronically, no special handling is required. For more information on electronic submission of claims, see Provider Express > Admin Resources > Electronic Payments and Statements (EPS).