OPTUMHealth™

Behavioral Solutions of California

California

Network Notes

OptumHealth Behavioral Solutions of California – News and Updates for Contracted Providers **Fall 2021**

What Makes the Optum EAP Program Different

Optum's Employee Assistance Program (EAP) is different from many other payors because we pay you your same contracted rate for EAP services as for routine outpatient therapy services. The member has no financial responsibility – no deductible, co-payment or coinsurance amount. We pay you directly, at your contracted rate, for authorized counseling sessions.

EAP benefits are designed to provide assessment and referral, as well as a brief counseling intervention for members and their families. The typical EAP benefit offers a limited number of sessions with an MH/SUD clinician but is not designed to provide an ongoing course of treatment. However, it is not unusual for the member to transition to routine therapy services with the same provider. Optum members can see any contracted Optum therapist for EAP services.

How EAP sessions are authorized

Authorizations must be initiated by the member or the network provider prior to the first appointment. When a member presents for EAP services, you should inquire whether any of the authorized visits have already been used.

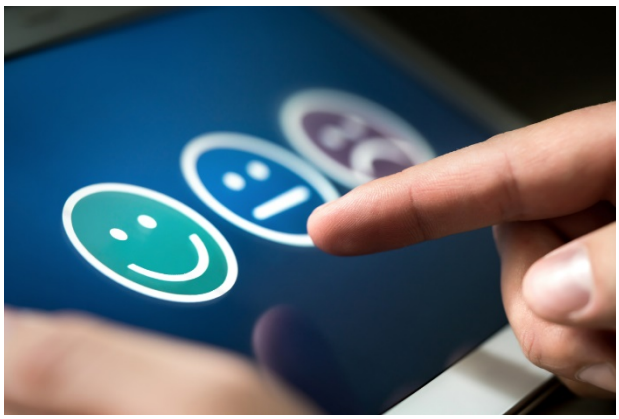
Visit the **Provider Express EAP page** to learn more about this great way to expand your practice.

Improvements Noted in Clinician Satisfaction

In 2020, 1,796 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, Claims/Customer Service, Credentialing, web site usage and Net Promoter Scores (NPS).

For the third year in a row, OHBS-CA saw improvement in overall provider satisfaction and in NPS. In addition, we noted improvement in satisfaction with Credentialing, Claims/Customer Service, and the Authorization Process. Satisfaction with the Network Services staff and Provider Express remained high.

We greatly appreciate the valuable feedback you provide through the web-based survey. Your responses help 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.



U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

Make the Most of Your Directory Profile

It is extremely important for you to ensure that your provider profile is always current and is as robust as possible. One critical reason is to allow the online directory to reflect the cultural diversity of our network clinicians and increase your opportunity to engage, assess, and treat clients from diverse backgrounds. Another important component of your provider profile is offering members a variety of ways to contact you.

By including your email, as well as your phone number, in the directory, you increase the ability of members to access behavioral health services.

We ask that you review your provider profile and, if you haven't already done so, include your ethnicity, any additional languages spoken, and your directory email as part of your profile. Additionally, Optum can list your website in our online provider directory, which can help members learn more about you, your practice, and your treatment approach.

Once logged in to **providerexpress.com,** you can update languages spoken and ethnicity under My Practice Info > Clinician Information. Your email and/or website can be updated under My Practice Info > Practice Information. Please confirm that all other information is correct and update if needed. Additional training on updating your demographic information is available at this **video link.**

Monitoring Network Availability

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

An analysis of the results of the annual measurement of OHBS-CA network geographic availability for 2020 shows that clinicians and facilities are in geographic positions of availability to provide services to membership in all urban, suburban and rural areas of California, except for acute inpatient care facilities.

There is an overall scarcity of inpatient 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.

Provider Type	Standard (Urban)	Standard (Suburban)	Standard (Rural)	Performance Goal
Prescribers (MD, DO, RN w/ prescriptive authority, PA)	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/Residential	15 miles	30 miles	60 miles	90%
Intensive Outpatient Care	15 miles	30 miles	60 miles	90%
Medication Assisted Treatment (MAT)	15 miles	30 miles	60 miles	90%

Medi-Cal Network Adequacy Standards in San Diego County		
Provider Type	**Timely Access Standard**	**Time and Distance Standard (Dense)**
Psychiatric Care (Adult & Pediatric)	Within 15 business days of request	15 miles or 30 minutes from beneficiary's residence
Mental Health (Non-psychiatry)	Within 10 business days of request	15 miles or 30 minutes from beneficiary's residence

Quality Achievements

The Quality Improvement (QI) 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 QI 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 2020 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, appeals, 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

- Excellent performance in measures of Clinician Satisfaction, with Overall Clinician Satisfaction at 93%

If you are interested in obtaining a copy of the Executive Summary of the most recent QI performance evaluation, please call **1-877-614-0484**.

Members Highly Satisfied with Treatment & Services

OHBS-CA administers the Member Satisfaction Survey to a sample of members who receive services from an OHBS-CA network clinician or facility. Results are analyzed annually.

The 2020 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:

- 89% of surveyed members indicated that we answered their calls in a reasonable time
- 92% of members indicated that they were able to find care that was respectful of language, cultural, and ethnic needs
- 95% of those surveyed reported that the treatment they received from their clinician helped them better manage their problems
- 88% indicated that they would use these services again
- Overall member satisfaction with services received from OHBS-CA was 86%

The findings from the survey are used to identify opportunities to improve the member experience.

Timely Access to Care

OHBS-CA continues to work on Improving and expanding member access to care. As the public health care emergency has extended throughout 2021, this has created ongoing challenges throughout the health care industry in providing members with access to a choice of providers who meet their needs.

In accordance with the Notice of Enforcement Discretion from the Office for Civil Rights at the Department of Health and Human Services ("**Notice**"), we have temporarily expanded telehealth access to help accommodate members' needs during the public health emergency as it has been extended during 2021. Our **virtual visits** (telehealth) network, has expanded, helping members to easily connect with providers through convenient, secure, virtual connections that extend access to providers throughout California. Our online attestation process makes it easier for you to notify us of your capability to deliver services virtually.

We also offer a virtual visits platform, which allows use for nearly all payers and insurance companies. Once a provider is registered, clients can view their virtual visit schedule and book appointments. For more information, visit the **virtual visits** page on Provider Express.

If you are unable to see new members, please let us know. You can update your availability status online at **Provider Express.** You may remain unavailable for up to six months. CA regulations require you update us within 5 days of changes to your availability and 10 days for any demographic change to your practice.

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. 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.

It is important for you to be aware of and comply with our access standards (shown below).

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	Clinician shall provide live answer or respond to enrollee messages for routine issues within 24 hours	90%

Additional services available

Interpreter services are available at no cost to members or providers. Call **1-800-999-9585**.

Assistance for those with hearing and/or speech impairment is available at **1-800-842-9489** (TTY).

Reminders for all contracted providers

Clinician Timely Response to Member Messages: Please return all member calls within 24 hours.

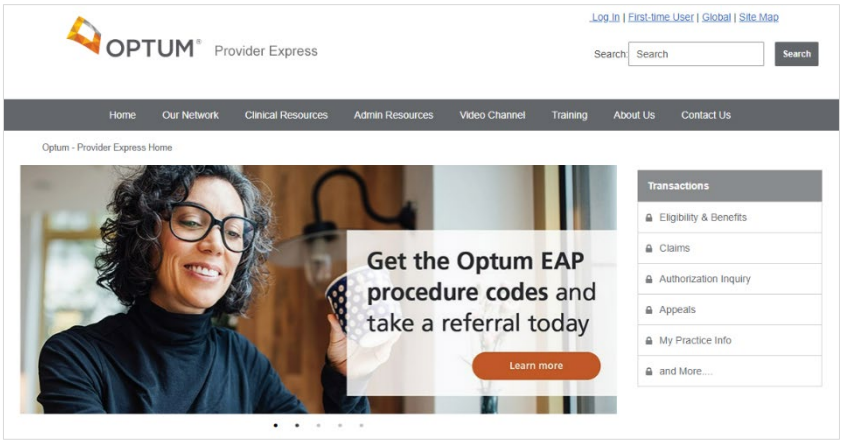
After-Hours Answering System and Messaging:

Be sure your answering machine message includes instructions to members regarding what they should do in an emergency situation.

Provider Express: Your Most Valuable Optum Resource

Have you visited **Provider Express** lately? If not, you may have missed important updates on:

- **Web browser compatibility** – If you are still using Internet Explorer, be sure to take a look at this information about updating your web browser
- **COVID-19 Updates** – New or updated information about temporary telehealth flexibilities and other provisions related to the public health emergency will be found in our COVID-19 pages
- **Provider Remittance Advices (PRA)** – 24 months of payment information is now available in the secure Transactions section of Provider Express



While you're visiting the site, be sure to log in and check to be sure your demographic profile is complete and current. If you haven't provided us with your email address, please remember to add it so we can easily keep you informed about new initiatives, process changes, and other Optum updates.

Public Policy Committee

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 and we are actively recruiting for additional committee members. For more information regarding committee membership, please contact your Provider Relations Advocate or call **1-877-614-0484**.

ABA Corner

ABA CPT Codes and Modifiers

Beginning in 2020, we implemented the use of CPT codes for Applied Behavior Analysis (ABA) services. The CPT codes allow for the use of modifiers, shown below, to reflect the credentials of the staff who are delivering services and allow for accurate and efficient claims processing.

Modifier	Credentials of staff
No Modifier	BCBA
HN	BCaBA
HM	Behavior Technician

When submitting charges for services rendered by a BCBA, please do not include any modifiers on the claim. Other health plans may be using an "HO" modifier to indicate when a service has been rendered by a BCBA but OHBS-CA is not. To avoid claim denials, please do not include an HO modifier in a claim for BCBA services.

If you have any questions regarding claims please contact the Provider Service Line at **1-877-614-0484**.

If you have questions regarding your fee schedule, CPT codes or modifiers, please reach out to your assigned Provider Relations Advocate or send an email to **ca_abanetwork@optum.com**.

San Diego County Medi-Cal Provider Training

OHBS-CA must ensure that all providers who provide services to members covered under the Medi-Cal Managed Care program comply with the state's Medi-Cal training requirements.

Autism/ABA providers are expected to review the training materials within **10 days** of their credentialing effective date.

The training, along with the online attestation regarding training completion, can be found on the **California Medi-Cal ABA Program** page on Provider Express

- **CA Medi-Cal ABA Provider Orientation**
- **Medi-Cal Provider Training Attestation**

Visit the **Autism/Applied Behavior Analysis page** on Provider Express for additional resources.

U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

Important Reminders

Affirmative Incentive Statement

The clinical guidelines 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 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. Utilization management decision making is based only on the appropriateness of care and service and existence of coverage. 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 ID card and requesting to speak with a peer reviewer.

Enrollee Rights and Responsibilities

OHBS-CA requests that you display the Enrollee Rights and Responsibilities in your waiting room or have some other means of documenting that these standards have been communicated to Optum and OHBS-CA enrollees. All enrollees benefit from reviewing these standards in the treatment setting.

You can find a copy of the Enrollee Rights and Responsibilities, in English and in Spanish, in the Appendices of the **OHBS-CA Network Manual** at providerexpress.com.

Resources for OHBS-CA Providers

You have 24/7 access to a wide variety of resources and information through our provider website, **Provider Express**.

Through the publicly accessible area, you have access to:

- **OHBS-CA Network Manual**
- **Information on virtual visits platform & attestation**
- **COVID-19 information**
- **Clinical criteria**
- **Video channel**
- **Training information**
- **Optum Pay™ information**

Through the secure "**Transactions**" section (sign-in required), you can:

- Check benefits and eligibility
- Request authorizations
- Submit claims, check their status, submit claim appeals
- View and download claim payment information
- Make updates to your demographic profile

California 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.**