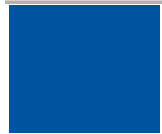


Welcome to Provider Orientation



Agenda



TERM 9:00 a.m. – 10:00 a.m.



Provider Services 10:00 a.m. – 10:30 a.m.



Claims 10:30 a.m. – 10:55 a.m.



TERM Only Providers are dismissed 10:55 a.m. – 11:00 a.m.



Utilization Management 11:00 a.m. – 11:50 a.m.



Quality Improvement 11:50 a.m. – 12:10 p.m.



Questions & Answers 12:10 p.m. – 12:30 p.m.

New Provider Orientation

Provider Services



Objectives


When you leave here today you will know how to....

- ✓ Understand the role of the various departments
- ✓ Access provider materials online
- ✓ Keep your credentialing up to date
- ✓ Request authorization
- ✓ Submit a claim


Provider Services


- ✓ Optum contracts with Providers for participation on two distinct panels, Fee for Service (FFS) and Treatment and Evaluation Resource Management (TERM)
- ✓ FFS deals with Medi-Cal funded clients. The primary point of clinical contact will be the Utilization Management Department
- ✓ TERM deals with Child Welfare Services (CWS) funded clients. The primary point of clinical contact will be the TERM Department.
- ✓ Provider Services assists with any issues related to Credentialing, Recredentialing, Contracting and Provider Relations

Contract Requirements

 You must have an active contract with Optum prior to treating any client. If you do not, you run the risk of not being reimbursed for services provided.

 Confirm client eligibility. Optum will provide an eligibility PIN.

 Ensure that your treatment and billing is in line with what you are contracted to provide and bill.

 Complete Child and Adolescent Needs and Strengths (CANS) training and certification if rendering individual therapeutic services to clients between the ages of 0 and 21

 Make sure Provider Services has your current contact/referral information

- Address, phone numbers, business email, fax and if applicable a secure email for clients.
- Changes in availability such as, closure due to vacation, or your practice is full.
- Clinical changes such as additional specialties or certifications.

Continued on next page

Contract Requirements (Continued)

Attestations



Complete registration for Optum ID and Optum San Diego Website to access the secure provider portal that enables you to review your personal provider profile information and complete the required attestations for demographics, clinical specialties and wait times. Registration instructions will be provided with your fully executed contract.



Provider Profile: Verify and validate the accuracy of your practice information including changes in contact information, areas of clinical expertise and whether or not you are accepting new Fee For Service (FFS) Medi-Cal clients/patients every 6 months.



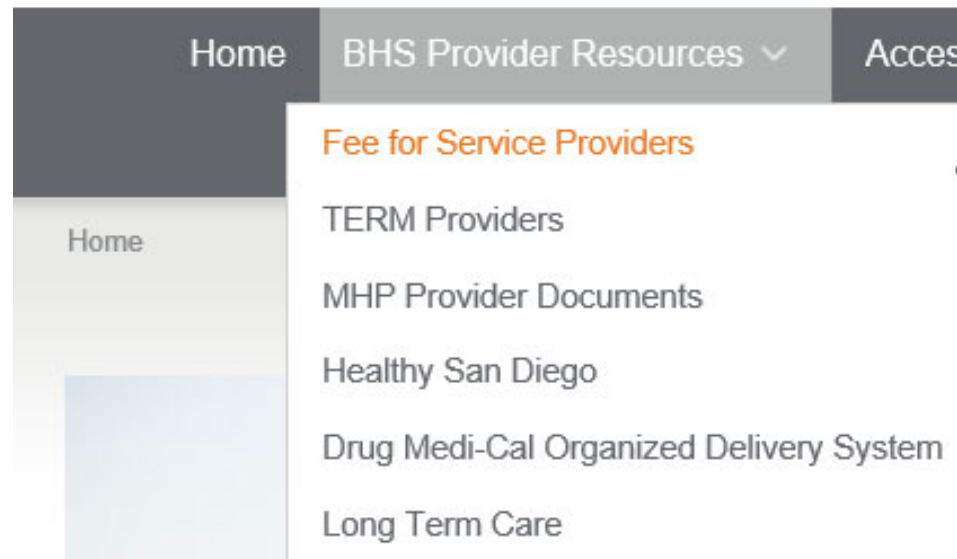
Wait Times: (Open Office(s) Only) Report the current Wait Times for both Urgent (in Hours) and Routine/Non-Urgent (in Business Days) appointments if a client were to call in today to schedule an appointment



Cultural Hours: Completion of four (4) cultural training hours every fiscal year (July 1-June 30).

Accessing Materials

www.optumsandiego.com



Accessing Materials

www.optumsandiego.com

Fee for Service Providers

TERM Specialty Network Applications

This page is utilized by Fee For Service MediCal Providers to obtain documentation related to participation on the MediCal panel and continued authorizations for treatment.



- Applications
- Beneficiary Materials
- Claims
- Communications/Updates
- Forms
- Manuals**
- Quick Reference
- Review - Outpatient
- Review - Inpatient
- Review - Medication Quality Assurance
- QI Corner
- Training
- CANS/PSC
- COMPS
- Provider Services Info

Manuals

Name	Description	Date
FFS Operations Handbook (pdf)	Revised 01/31/2021	2021-01-13
Inpatient Operations Manual (pdf)	Revised 01/15/2020	2020-02-03

The FFS Provider Operations Handbook is part of your contract.

Note: The FFS Provider Operations Handbook is updated regularly. Please visit the website for a current copy.

Client Initial Contact



Beneficiary Materials and Beneficiary Materials Order Form may be found at www.optumsandiego.com



Materials to be provided to your clients during the initial session include:

- Beneficiary Protection and Freedom of Choice Information - (Guide to Medi-Cal Mental Health Services Booklet)
- Mandated reporting requirements
- The review of records by third party payers for authorization or payment purposes
- Clients' rights to review and obtain their medical records (HIPPA)



You must post the Grievance and Appeal Poster (s) and the Limited English Proficiency Poster (s)



Ensure your Informed Consent covers the following elements and has a space for the client to **sign and date**

- Confidentiality Agreement
- Exceptions to Confidentiality including submission of information to Optum

Documentation Standards

Documentation must be timely, legible, include the components required by Medi-Cal and support the claims information submitted to Optum Public Sector for provider reimbursement.

Audits are completed once every credentialing cycle and include a review of clinical records, billing practices, and an inspection of provider offices

Providers are urged to review the online form [Record Keeping and Medical Record Requirements](#).

Providers are required to complete the free FFS Medi-Cal Documentation Training on OptumSanDiego.com.

[FFS Medi-Cal Documentation Training \(optumsandiego.com\)](http://OptumSanDiego.com)

Complaints

Your clients have the right to file a complaint about services as well as request a change in providers.

When your client contacts Optum with a complaint, we will reach out to you to get your understanding of the situation that occurred. We will only be able to tell you the client's name if they have agreed.

It is important that you return all calls and respond to requests promptly to ensure an appropriate resolution.

At your recredentialing period, every three (3) years from the original credentialing date, any complaints and resolutions are brought to the Credentialing Committee.

Quality of Care

- ✓ Review due to the Death or Suicide of a client.
- ✓ Optum's policy is to look into any case of suicide of a client within 60 days of seeing a FFS provider. These are routine investigations. The fact that there is an investigation may not be the result of a complaint and may not, in itself, imply any wrongdoing.
- ✓ We may ask you for clinical records to get a stronger understanding of the treatment.
- ✓ It is very important that your notes include treatment goals and progress in treatment. When clinically appropriate Suicide Assessments and Safety Plans must be included in your progress notes.

Reminders

- ✓ Providers are required to maintain all client records and documentation in secure, locked storage for a minimum of ten (10) years.
- ✓ Fax machines that receive client information must be kept in a secure location away from unauthorized viewing.
- ✓ The Mental Health Plan requires providers to inform clients and families, through written information, about clients' rights, the legal limits of confidentiality, and to obtain the client's (or conservator/ legal guardian's) signature acknowledging understanding of these limits.
- ✓ Check Medi-Cal eligibility for each client *monthly* (www.medi-cal.ca.gov or call 800-541-5555).
- ✓ Keep your information current with Provider Services and complete attestations!

New Provider Orientation

Claims Department



Claims Overview

Claims Basics

Eligibility

Claims Submission

Timeliness of Claims

Forms and Handouts

Medi-Cal Eligibility Verification Request Form

Pregnancy Confirmation (for Pregnancy Aid Code only)

CMS-1500 Forms (pre-filled sample and blank forms)

List of Procedure Codes

Provider Handbook Claims Tip Sheet

Claims Basics - Eligibility

Eligibility – The client must be Medi-Cal eligible under San Diego County, Subscriber County (37) to receive reimbursement for services.

Exception: Out of County Adopted or Foster Care clients

When to verify eligibility:

1. Before rendering initial service.
2. Every month.

How to verify:

1. Call the provider line 800-798-2254, Option 2 (Claims)
 - Staff will check eligibility.
2. Fax an Eligibility Form at the beginning of the month.
 - Staff will check eligibility and fax results within 24 hours.

Claims Basics – Eligibility (Continued)

Client with Medicare or Other Health Insurance:

1. Refer or bill the Other Health Insurance first.
2. For Medicare and Medi-Cal clients. You must bill Medicare first before billing Medi-Cal.
 - a. Any Medicare deductibles and/or co-payments billed to Medi-Cal on behalf of the client are considered Medicare/Medi-Cal crossover claims and must be billed directly to the address below:

Department of Health Care Services (DHSC) Fiscal Intermediary
Attn: Crossover Unit
P.O. Box 15700
Sacramento, CA 95852-1700
Phone: 1-800-541-5555

Eligibility - Sample

Sample of Eligibility Verification Response

Name:		
Subscriber ID:		
Service Date:	Subscriber Birth Date:	Issue Date:
07/01/2013		07/22/2013
Primary Aid Code:	First Special Aid Code:	
60		
Second Special Aid Code:		Third Special Aid Code:
Subscriber County:	HIC Number:	
37 - San Diego		
Primary Care Physician Phone #:	Service Type:	
	OIM PDV	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message:		
SUBSCRIBER LAST NAME: . EVC #: CNTY CODE: 37. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. OTHER HEALTH INSURANCE COV UNDER CODE V. CARRIER NAME: BLUE SHIELD OF CA. ID: . CARRIER NAME: ANTHEM BLUE CROSS. ID: . COV: OIM PDV.		

Claims Basics – Claim Submission

- ✓ Claim Submission – A CMS-1500 form must be completed and submitted in order to receive reimbursement of service.
 - Sample of a completed CMS-1500.

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) Q-MBPVA (Q-MBPVA) GROUP HEALTH PLAN (GROUP HEALTH PLAN) FECA (FECA) OTHER (OTHER)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
DOE, JOHN

3. PATIENT'S BIRTH DATE
12 12 1945 M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)
1000 1ST STREET

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No. Street)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT? (Current or Previous) YES NO
 b. AUTO ACCIDENT? YES NO (PLACE State)
 c. OTHER ACCIDENT? YES NO
 10c. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
 Signature on File
 SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
 Signature on File
 SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (AMP)
 MM DD YY

15. OTHER DATE QUAL.
 15a. MM DD YY
 15b. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
 QUAL.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
 FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
 Corrected Claim (FFS) : Intern's Name (CWS)

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-C to service line below (24E)) ICD 10S
 A. _____ B. _____ C. _____
 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM TO MM DD YY MM DD YY	24. B. ICD 10S	24. C. PROCEDURE, SERVICE, OR SUPPLY (Relate A-C to service line below (24E))	24. D. DIAGNOSIS POINTER	24. E. \$ CHARGES	24. F. CPT CODE	24. G. PAYOR	24. H. QUAL	24. I. PROVIDER ID #
01 04 2015	11	90791	A	70 00	1	NPI		1234567899
01 07 2015	11	90832	A	50 00	1	NPI		1234567899

25. FEDERAL TAX ID NUMBER 99-989998 SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE \$ 120 00

29. AMOUNT PAID \$

30. Reserved for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
 Sign and date _____

32. SERVICE FACILITY LOCATION INFORMATION
 Address where services was rendered _____

33. BILLING PROVIDER INFO & PH # ()
 Provider Name or Group Name Complete Billing Address _____



Claims Basics – Timeliness of Claim

- ✓ Timeliness of Claim – A completed CMS-1500 form must be timely received at Optum in order to receive service payment .
 - Original claim must be received within 60 days from service date.
 - Corrected claim must be received within 60 days from Optum EOB (Explanation of Benefits) but no later than 4 months from service date.
 - The claim must be received at the correct address:

Medi-Cal FFS Claims:
Optum
P.O. BOX 601340
San Diego, CA 92160-1340

CWS Claims:
Optum
P.O. BOX 600340
San Diego, CA 92160-0340

Thank you for joining us and becoming part of the
Optum network!

TERM Only Providers Thank you for attending Provider Orientation

You may be dismissed



New Provider Orientation

Utilization Management
Department



Agenda-Utilization Management (UM)

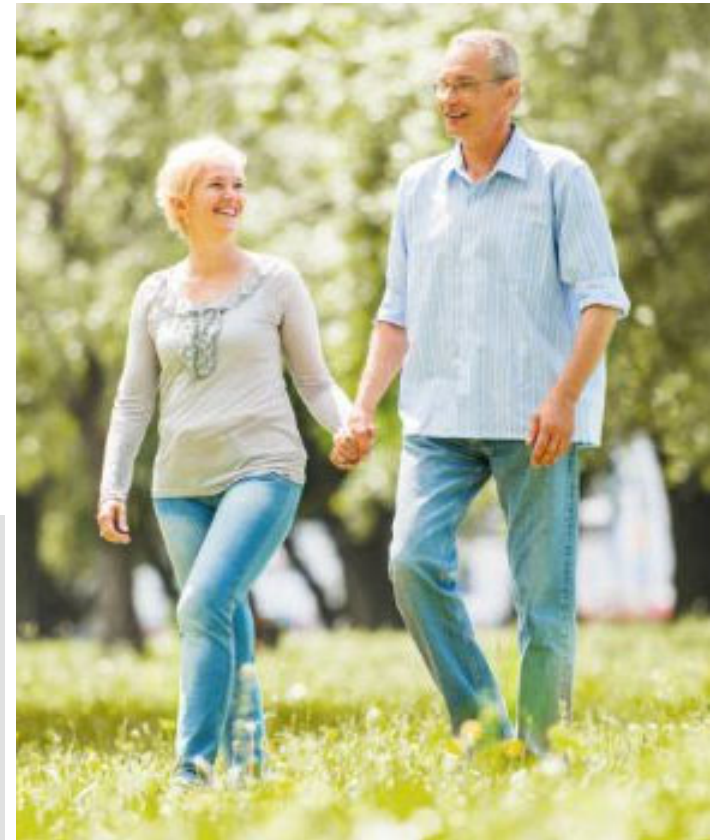
- ✓ Who is Optum?
- ✓ Utilization Management Team
- ✓ Medi-Cal Managed Care Plans (MCP)
- ✓ Verifying Eligibility
- ✓ Title 9 Medical Necessity
- ✓ Treatment Philosophy and Populations of FFS Network
- ✓ Adult Mental Health Severity Analysis
- ✓ Authorization Increments and Billing Codes
- ✓ Accessing Needed Forms
- ✓ The Outpatient Authorization Request form
- ✓ Referrals and Screening
- ✓ Initial Authorization & Continuing Authorization
- ✓ UM's role in TERM treatment plans
- ✓ Notice of Adverse Benefit Determinations (NOABD) & Appeals

Who is Optum Public Sector?

Optum is the Administrative Service Organization for the County of San Diego, Behavioral Health Division.

Contract includes, but not limited to: Operation of the San Diego County Access and Crisis Line (ACL) and Utilization Management (UM).

Through the ACL, Optum provides 24 hour crisis intervention, suicide prevention and referrals. Through UM, Optum provides authorizations for Inpatient Psychiatric Hospitalization, Outpatient Fee for Service Services, Crisis Residential, Long Term Care, and Residential Substance Use Disorder Treatment.



Utilization Management Team

- ✓ Clinically reviews mental health services and treatment provided to San Diego Medi-Cal consumers and discerns whether presentation meets California Title 9 medical necessity for reimbursement.
- ✓ Multidisciplinary UM Department consists of support staff and approximately 30 clinicians: LCSWs, LMFTs, PsyDs, RNs, LPCCs under the supervision of our Medical Director, Dr. Michael Bailey and Associate Medical Director, Dr. Diane Panton.



- ✓ Michael J. Bailey, M.D., F.A.P.A.
- ✓ Board Certified Psychiatrist
- ✓ Medical Director, Optum Public Sector
- ✓ Regional Medical Director, Optum



- ✓ Diane Panton, M.D.
- ✓ Board Certified Psychiatrist
- ✓ Associate Medical Director, Optum Public Sector

Medi-Cal Managed Care Plans

There are seven Managed Care Plans (MCPs) who provide Health Plan options to San Diego Medi-Cal beneficiaries.

Aetna, Blue Shield of California Promise Health Plan, Community Health Group, Health Net, Kaiser, Molina, United Healthcare Community Plan of CA.

Covers beneficiaries' medical needs and mild (non-TERM) outpatient behavioral health and Applied Behavioral Analysis Treatment.


Beneficiaries may change Managed Care Plans, and in rare circumstances, they may not have a MCP; County will assume responsibility if there is no assigned MCP.



Contact Information for MCP Behavioral Health

Health Plan	Medi-Cal Managed Care Plan Behavioral Health Services
Aetna Better Health	Aetna Better Health (855) 772-9076
Blue Shield of California Promise Health Plan	Beacon Health Options (855) 321-2211
Community Health Group	Behavioral Health Services (800) 404-3332
Health Net	Managed Health Network (MHN) (888) 426-0030
Kaiser Permanente	Kaiser Permanente, Department of Psychiatry (877) 496-0450
Molina Healthcare	Molina Healthcare (888) 665-4621
United Healthcare	United Healthcare (866) 270-5785


Medi-Cal: Verifying Eligibility & Ensuring Payment




Eligibility could change from when the first appointment was arranged. If Medi-Cal is good for the first of the month, it is usually good for the entire month.



MFT/LPCC may contact the Provider Line, Option 2 (Claims), to check eligibility.



MD, PNP, LCSW, PsyD, PhD: access the State Automated Verification Eligibility System (AVES). To set up a temporary pin, call (800) 541-5555. More information is on page 50 of your Provider Operations Handbook. Provider services will set it up.



After Assessment appt., Medi-Cal funded cases must have an ICD-10/DSM diagnosis listed in CA Title 9 Regulation that is the focus of Tx. Exclusions are listed in the Provider Operations Handbook and in the Regulation.



If you see a client with Medicare and Medi-Cal, you must be contracted with both networks. Medicare pays first; exception is MFT's and LPCC's.

Medical Necessity Criteria

Title 9, California Code of Regulations

- ✓ Available on DHCS website:
https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr01-01_enclosure1.pdf
- ✓ Requires a significant impairment in an important area of life functioning or for children developmental progress is at risk.
- ✓ The focus of treatment must be on a primary DSM IV diagnosis, exclusions include, primary substance use disorders, Anti-Social Personality Disorder, and mental health issues due to a known medical condition. Autism and PMDD recently added to approved list.
- ✓ The intervention will diminish the impairment, prevent deterioration, and support the child to progress developmentally.
- ✓ The condition would not be responsive to physical health treatment.
- ✓ For children and youth up to the age 21, a lower threshold of impairment (as defined by EPSDT) is applied.

Medi-Cal only (non-TERM referrals)



Treatment Philosophy of the Fee for Service Network

The Recovery Model: Clinical improvement and self-sufficiency is possible, but challenges during the process may occur along the way.

The role of the provider is to stabilize the client utilizing goal-focused treatment to target the specific mental health condition.

The treatment intervention will diminish the impairment or prevent deterioration.

Authorizations-based on Title 9 Medical Necessity regulations

Available on DHCS website:

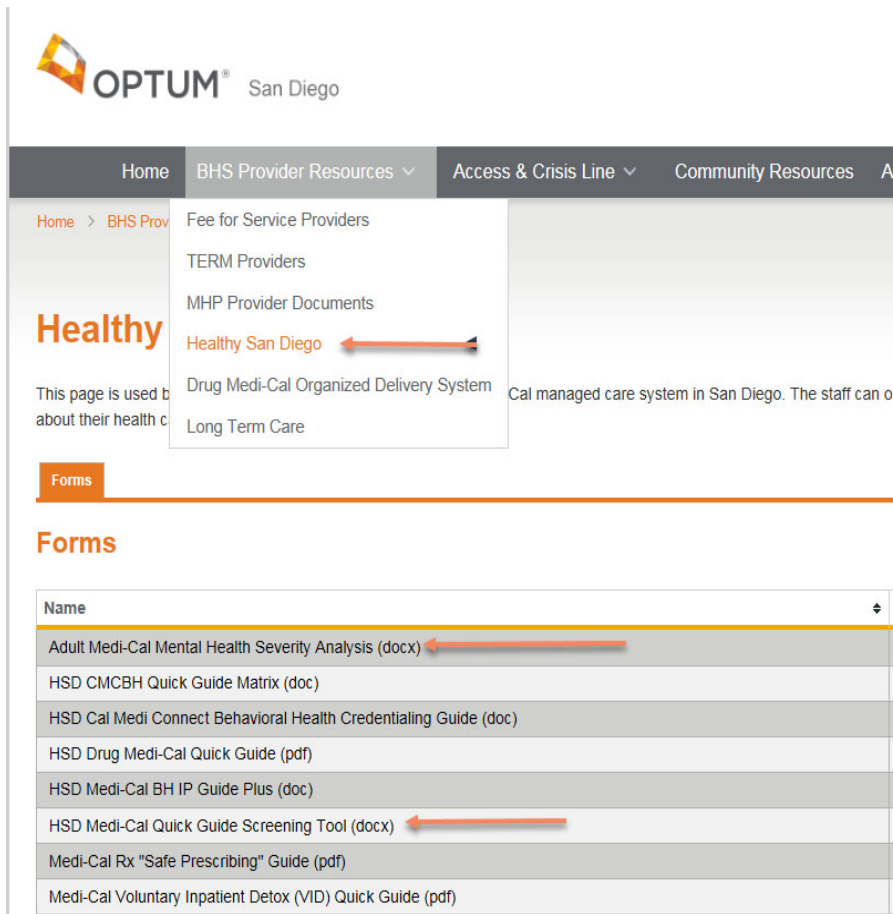
https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr01-01_enclosure1.pdf

Fee for Service (FFS) Population

- ✓ Adults with serious and persistent psychiatric illness requiring complex biopsychosocial services to maintain stability
- ✓ Adults and children with an approved DSM IV diagnosis and the focus of treatment must be on the DSM IV diagnosis
- ✓ Adults with a significant impairment in an important area of life functioning and the condition would not be responsive to physical health treatment
- ✓ Children with behavior inappropriate to the child's age according to developmental norms and a substantial impairment in an area of life functioning
- ✓ Adults with an impairment that will most likely last more than six months
- ✓ Adults presenting with clinical risk: psychosis, suicidal ideation, and/or violence

The Adult Mental Health Severity Analysis/Screening

- The severity index and other information on target population is available at: optumsandiego.com



- The County of San Diego and the Medi-Cal MCPs worked together to develop criteria and tools
- A shared conceptual framework and a useful guide regarding mild, moderate, and severe criteria to assess with clinical perspective
- The Severity Analysis Tool is not applicable to children
- Uses four elements: Risk, Clinical Complexity, Life Circumstances, and Benefit of Integrated Care
- Use of guide is recommended to ensure assessment alignment across System of Care, all determinations are based on Title 9 Medical Necessity

Adult Medi-Cal Mental Health Severity Analysis

Adult Medi-Cal Mental Health Severity Analysis

Mental Health Plan will follow Medical Necessity Criteria for Medi-Cal Specialty Mental Health Services described in Title 9, CCR

Element	Mild (1)	Moderate (2)	Severe (3)	(0) N/A
Risk (suicidal/violent, high risk behavior, catastrophic illness/loss, criminogenic behavior, impulsivity, insight, ego discordance)	Passive ideation or fantasy—no danger to self/danger to others (DTS/DTO) history Good impulse control Minimal criminal background. Good insight Ego dystonic (refers to thoughts, impulses, and behaviors that are viewed as unacceptable, distressing, or inconsistent with one's self-concept)	Passive ideation or low level active with DTS/DTO history Rare loss of impulse control Mid-level nonviolent arrests, brief jail time Fair insight Ego dystonic	Recent or current active ideation, intent or plan Poor impulse control Violence related arrests, jail or prison time Poor insight Ego sytonic (refers to instincts, ideas, and behaviors that are viewed as acceptable to one's self, are compatible with one's values and ways of thinking or are consistent with one's fundamental personality or beliefs)	
Clinical Complexity (serious & persistent mental illness vs situational/reactive, recovery status, functional & cognitive impairment, treatment resistance, medication complexity, frequent hospitalization, co-occurring medical and alcohol or drug disorder (AOD))	Adjustment reaction Minor depression/anxiety Grief, job loss, marital distress, relationship difficulty No cognitive impairment No prior serious mental illness (SMI) history Limited AOD use	Schizophrenia, major mood or anxiety disorder - stable on medications, baseline function, sustained recovery Prior history of effective treatment, uncomplicated management Minimal cognitive impairment No recent hospitalizations AOD misuse (e.g., multiple emergency room visits at different hospitals)	Schizophrenia, major mood or anxiety disorder, recent instability or worsening function, precarious recovery, cognitive impairment Recent/repeated hospitals AOD dependence Prior history of treatment resistance or complexity (e.g., polypharmacy)	
Life Circumstances (biopsychosocial assessment, availability of resources, environmental stressors, family/social/faith-based support, resilience)	Emotional distress arising in the course of normal life stresses Adequately resourced & supported Resilient	Intermittent emotional distress as a manifestation of a mental illness which is worsened by life stresses Limited resources & support Strained resilience	Persistent emotional distress a manifestation of chronic mental illness Relies on behavioral health system for resources & support Limited resilience	
Benefit of Integrated Care (optimal for stable patients with co-occurring mild to moderate physical and mental illness, limited transportation or unique clinical/cultural needs not well suited for split care)	High (1) Already established, effective care in primary care setting for chronic stable medical + co-occurring mild mental illness/emotional distress	Medium (2) ← High medical, low behavioral High behavioral, low medical→	Low (3) Already established (or pending) care with County provider for complex SMI Relies on behavioral health system for resources & support Low recovery	
Total:	Tier 1 (0-4)	Tier 2 (5-8)	Tier 3 (9-12)	
Referrals	Augmented Primary Care Provider (PCP)-Impact Health Plan Network: -Federally Qualified Health Center (FQHC) -Health Plan Behavioral Health (BH) Network	Health Plan Network: -FQHC -Health Plan BH Network	County Mental Health Plan (MHP): -County Clinics -FQHC -Organizational Provider -Optum Fee-for-Service (FFS) Provider	

Adult Mental Health Severity Analysis – Symptom Examples

FFS and/or other County Providers

- ✓ Acute risk for SI/harm to others
- ✓ Psychosis
- ✓ Cognitive Impairment
- ✓ Impulsive/Aggressive
- ✓ Seriously incapacitated in daily activities
- ✓ Many Mental Health hospitalizations
- ✓ On conservatorship
- ✓ Chronic Mental Health conditions

MCP Behavioral Health

- ✓ Situational issue: loss, break-up, major life change
- ✓ Disruption in relationships resulting in extreme distress
- ✓ Excessive truancy or suddenly failing school
- ✓ Likely to be resolved in 6 mo. or less
- ✓ Stable on meds for 1 yr. or longer

San Diego County Access and Crisis Line 888-724-7240
Operates 24 Hours a day, 7 days per week
Provides Suicide Prevention, Crisis Intervention and Referrals

The Process-Authorization Increments

Non-TERM cases, assessments do not require pre-authorization.

Follow up sessions –12 sessions (therapy), 26 sessions (psychiatry) per request; provider requests frequency and clinical documentation would need to support that frequency to be approved.

Group sessions available, but should focus on the client's diagnosis and impairment; follow TERM process for TERM group sessions.

The code clusters are in your Provider Operations Handbook. Please refer to your contract, signed with Provider Services, for the most updated billable codes.

Optum Public Sector does not authorize retroactive outpatient authorizations except in extraordinary circumstances. Any exception must be requested within 30 days of date of service.

Accessing Forms & Manuals

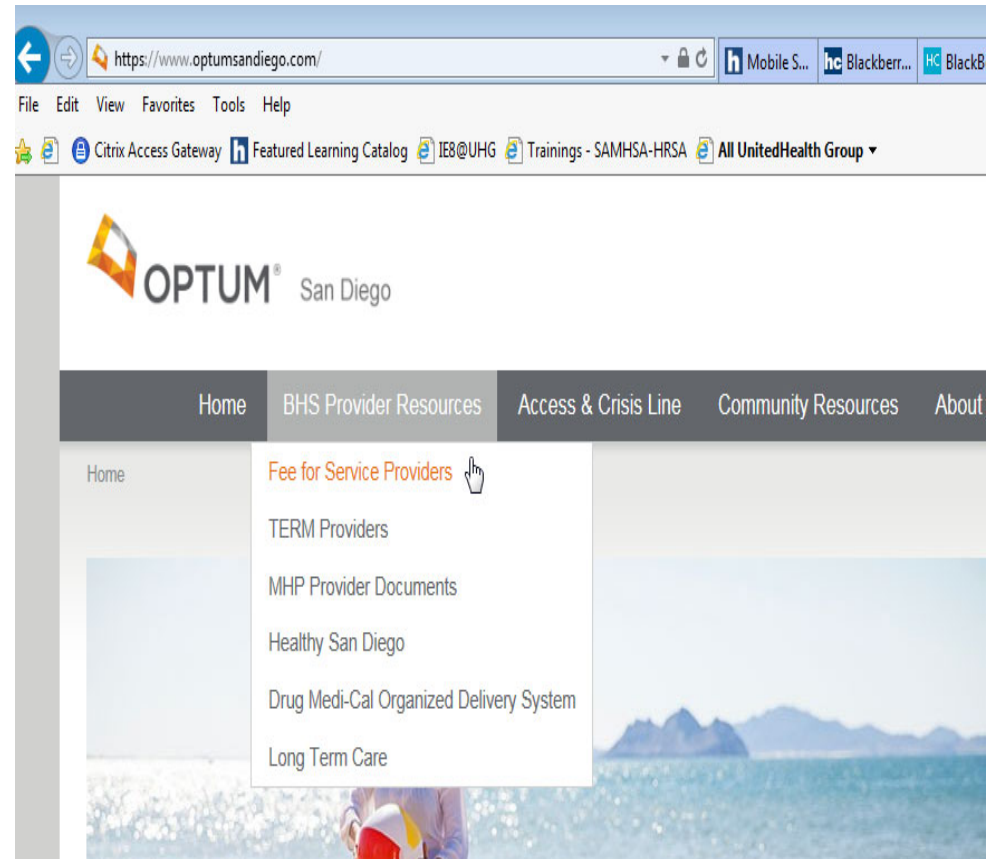
Website: www.optumsandiego.com

Select: "BHS Provider Resources"

Then, select: "Fee for Service Providers"

Or, select: "TERM Providers"

Click on: "Forms" or "Manuals"



Forms-Interpreter Services

Client's Address:	
ZIP Code:	
Medi-Cal Number:	
Date of Birth:	
Gender:	
Specialty:	

Client Information:

The County of San Diego, HHSA has authorized the following interpreting services for:

Name(s) of participant(s):	<input type="checkbox"/> Mr. or <input type="checkbox"/> Ms.
If any participants are under age 18, please indicate age of minor(s):	
Language(s) requested:	
Nature of appointment:	
Interpreter gender:	<input type="checkbox"/> Male or <input type="checkbox"/> Female Is gender required?

Service Information:		
Section A:		
Date:	Requested:	
	Start Time	End Time

Requester Information:

Requester	
Name:	Print Name:
Phone:	Signature:
Fax:	Service Site:
E-mail:	

- ✓ The MHP covers the cost.
- ✓ Request for Interpreter Services Form on our website- www.optumsandiego.com, BHS provider Resources, Fee For Service Providers, Forms.
- ✓ Must be submitted via fax **AT LEAST 2** business days prior to appt., or as soon as appt. is set.
- ✓ Incomplete forms will be sent back and will cause delays in processing.
- ✓ Do not sign the document-Optum is the entity approving the service.
- ✓ Follow the instructions and fill out **ALL** highlighted areas (2pages)-complete "form fill" online or print out in color.
- ✓ Submit form to Optum **before** 1st appt.

Forms-Demographic Form (At Initial Auth & When Updates Occur)

San Diego County Mental Health Services
Demographic Form

Client Name: Case #: Program Name:

Effective Date: Admission Status: Pre-Registered Registered Admit

CLIENT IDENTIFYING INFORMATION:

HIM Staff Only (HIM Staff to indicate deceased): Deceased Date of Death:

***Birth Date:**

Last Name: First Name:
Middle Name: Suffix:

Birth Name (if different from above):

Last Name: First Name:
Middle Name: Suffix:

Physical Address:

Street Address:
City/State/Zip: County:
Home Phone: *OK to call home? Yes No
Work Phone: Ext: Cell Phone:

Mailing Address:

Street Address:
City/State/Zip: County:

Social Security #: Declines or Unable to provide Social Security #

*Gender: M-Male F-Female O-Other U-Unknown

*Currently Pregnant or Post Partum?
 Pregnant Post Partum up to 12 mos. Unknown Not Pregnant

*Birth Date: Actual Estimated

Born in US: Yes No If No, Country where born:

Born in California: Yes If Yes, County where born: No If No, State where born:

Client Marital Status (Select one only):
 1-Never Married 2-Married 4-Divorced 7-Domestic Partner 5-Separated 3-Widowed 6-Unknown

Ethnicity (select one only):
 1-Not Hispanic 2-Hispanic - Mexican American/Chicano 3-Hispanic - Cuban 4-Hispanic - Puerto Rican
 6-Hispanic - Dominican 7-Hispanic - Salvadoran 5-Hispanic - Other/Latino 9-Unknown/Not Reported

Race Rank 1 to 5 as needed with 1 being primary:

A-White/Caucasian	J-Japanese	S-Sanson
B-Black/African American	K-Korean	T-Sudanese
C-Cambodian	L-Lao/Laotian	U-Urdu/Urdu
D-Chinese	M-Mexican	V-Vietnamese
E-Eskimo/Alaskan Native	N-Native American	W-Ethiopian
F-Filipino	O-Other Non-White/ Non-Caucasian	X-Somali
G-Guatemalan	P-Other Pacific Islander	Y-Yemeni
H-Hawaiian Native	Q-Quiang	Z-Zenji
I-Asian Indian	R-Other Asian	9-Unknown/Not Reported

San Diego County Mental Health Services
Demographic Form

Language (Complete both client languages. If there is a caretaker, complete caretaker language)

Client Primary: Client Preferred: Caretaker Preferred:

Interpreter Needed? Yes No (If either preferred language is other than English, an interpreter is needed)

Employment Status (Check only one value. Starting with "A" check the first one that applies to client):

<input type="checkbox"/> A-Comp Job 35+ hrs per week	<input type="checkbox"/> G-Full Time Job Training	<input type="checkbox"/> M-Retired
<input type="checkbox"/> B-Comp Job 20-34 hrs per week	<input type="checkbox"/> H-Part time Job Training	<input type="checkbox"/> N-Unemployed/Seeking Work
<input type="checkbox"/> C-Comp Job < 20 hrs per wk	<input type="checkbox"/> I-Full Time Student	<input type="checkbox"/> O-Unemployed/Not Seeking Work
<input type="checkbox"/> D-Rehab 35+ hrs per wk	<input type="checkbox"/> J-Part Time Student	<input type="checkbox"/> P-Not in the Labor Force
<input type="checkbox"/> E-Rehab 20-34 hrs per wk	<input type="checkbox"/> K-Volunteer	<input type="checkbox"/> Q-Resident/male
<input type="checkbox"/> F-Rehab < 20 hrs per wk	<input type="checkbox"/> L-Homemaker	<input type="checkbox"/> U-Unknown

Living Arrangement (Check only one value from the list below):

<input type="checkbox"/> A-House or Apartment	<input type="checkbox"/> J-AMH Rehab Ctr (Adult Locked)	<input type="checkbox"/> S-Group Home-Child (Level 1-12)
<input type="checkbox"/> B-House or Apt with Support	<input type="checkbox"/> K-SNFC/IFMD	<input type="checkbox"/> T-Residential Tx Ctr-Child (Level 13-14)
<input type="checkbox"/> C-House or Apt with Daily Supervision	<input type="checkbox"/> L-State Hospital	<input type="checkbox"/> U-Unknown
<input type="checkbox"/> D-Other Supported Housing Program	<input type="checkbox"/> M-Correctional Facility	<input type="checkbox"/> V-Genes Tx Facility (Child Locked)
<input type="checkbox"/> E-Board & Care - Adult	<input type="checkbox"/> N-Residential Tx Ctr-Child STRTP	<input type="checkbox"/> W- Children's Shelter
<input type="checkbox"/> F-Residential Tx Crisis Ctr - Adult	<input type="checkbox"/> O-Other	<input type="checkbox"/> XX-Homeless/In Shelter
<input type="checkbox"/> G-Substance Abuse Residential Rehab Ctr	<input type="checkbox"/> R-Foster Home-Child	<input type="checkbox"/> YY-Homeless/Out of Shelter
		<input type="checkbox"/> ZZ-Homeless/Living w Others(s)

Number of children less than 18 years of age that the client cares for at least 50% of the time:

Number of adults 18 years or older that the client cares for at least 50% of the time:

Education (last grade or years completed): **Religion:**

*Does the client have Regional Center involvement? Yes No Refuse/Cannot Access

*Military Service: Yes No Decline Unable to Answer **Branch:**

If 18, has client been offered the National Voter's Registration form? Yes No Decline

Mother's First Name:

ALIA(S)(ES) (List other names you have used. A first & last name must be included for each alias)

Last Name:	First Name:	Middle Initial:
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

LEGAL INFORMATION/LEGAL CONSENT (check only one box in the lists below):

Self Consent	Conservator	Minor	Juvenile Court
<input type="checkbox"/> A-Adult / Self Consent	<input type="checkbox"/> I-Temporary	<input type="checkbox"/> B-Parental Consent	<input type="checkbox"/> F-Dependent
<input type="checkbox"/> E-Minor / Self Consent	<input type="checkbox"/> J-Permanent	<input type="checkbox"/> C-Guardian/Caregiver	<input type="checkbox"/> G-Ward Status Offender
<input type="checkbox"/> D-Emanipated Minor	<input type="checkbox"/> K-Murphy		<input type="checkbox"/> H-Ward Juvenile Offender
	<input type="checkbox"/> L-Probate		

Legal Representative: **Relationship:**

Address: **Phone:**

City/State/Zip:

Employment Phone: **Other Information:**

PARENTAL & SCHOOL INFORMATION

Is client under 18: Yes (School & Parental Information required) No (Parental information is optional)

Parent Name: **Relationship:**

San Diego County Mental Health Services
Demographic Form

Address: **Phone:**

City/State/Zip:

Employment Phone: **Other Information:**

School Attending:

School District of Residence:

JUVENILE FORENSICS

REJIS #:

EMERGENCY NOTIFICATION INFORMATION

Name: **Relationship:**

Address: **Home Phone:**

City/State/Zip: **Work Phone:**

Other Information:

CONTACTS

Name (Last, First MI)	Agency/Title/Relationship	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Staff Completing/Accepting the Assessment:

Signature: Printed Name: Corner ID: Date:



Forms-Outpatient Authorization Request (OAR)

This form should be used to request outpatient treatment.
Revised 12.01.18

**COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN
OUTPATIENT AUTHORIZATION REQUEST**

Please check: Initial Request Continuing Request
PLEASE SUBMIT DEMOGRAPHIC FORM W/ INITIAL REQUESTS

To request authorizations, fax or mail to:
Optum Public Sector
Fax: (866) 220-4495,
PO Box 501340
San Diego, CA 92160-1340
Phone: (800)798-2254, option 3 then 3

CONFIDENTIAL **Client Information** **CONFIDENTIAL**

Client Last Name: First: Middle: Gender: M F O Client Ethnicity:

Age: DOB: Living Situation: Homeless Alone I/F B&C SNF
 Other, with whom? Justice System Involvement:
 N/A Yes
If Yes, explain:

Medi-Cal CIN #: Highest Education Level: Current Employment Status:

Current Health Plan: If Child, current IEP: Yes No San Diego Regional Center Client: Yes No
School District:

Current Referral by Child Welfare Services: Yes No: If Yes, PSW name and number:

If Hx of CWS, when and why?

DSM IV/ICD 10 Diagnosis and Other Clinical or Medical Considerations

Primary Diagnosis: ICD 10 Code:

Other Diagnoses (Mental & Physical Health):

Presenting Mental Health Problem, Symptoms, Functional Impairment
Current Symptoms (please list w/ frequency and duration):

How is the client significantly impaired in an important area of life functioning as a result of their symptoms or diagnosis? If client is a child, how is their development at risk of not progressing appropriately due to their symptoms or diagnosis:

Hx of Trauma and/or Abuse? Yes No If Yes, explain:

Substance Use: N/A HX Current Drug(s) of choice:

Describe current substance use impact on functioning:

Current Risk Assessment: Suicidal - N/A Ideation Plan Intent History of harming self
Homicidal - N/A Ideation Plan Intent History of harming others

Client Strengths (i.e., motivated, employed, strong social supports):

Medications (Psychiatric, Medical, & OTC medications)
Name of Medication w/ Dosage or N/A:

Treatment

Proposed Interventions (CBT, DBT, behavioral, strengths-based, groups, etc.):

If Group Therapy, # Participants: Group Topic/Focus:

Treatment plan with measurable/observable goals addressing diagnosis, functional impairments, and risk (include frequencies and duration of treatment goals and separate Individual and Group if facilitating both):

Current treatment provided by others and/or Hx (i.e., Psychiatrist, PCP, NP, CM, TBS, Substance Use Tx, Groups, Peer Support):

How have you coordinated with these providers? If not, please explain:

Progress: N/A (Initial Request) Near completion Improving Stabilizing Regressed due to new stressor Little/no progress
Expected Length of Treatment: If Initial Request, date of Assessment with you:

Referrals made to other community supports and/or aftercare plans for client's recovery:

Client Signature

*****, (print name) participated in the development of this plan and received a copy.

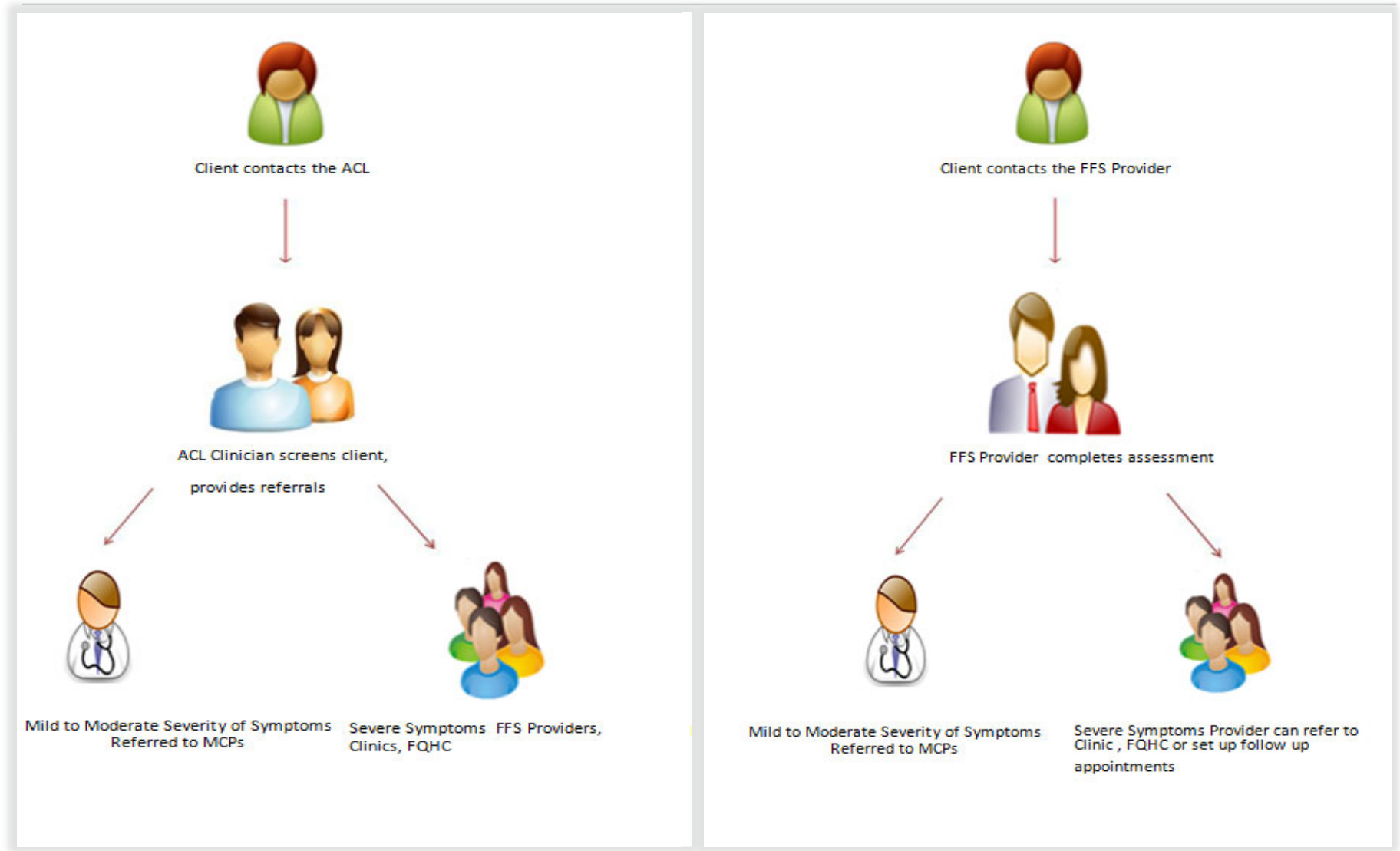
Client Signature: _____ Date: _____
(Signed Client Plan required in Client's Chart within 30 days of commencing treatment; may use separate form than the OAR)

Provider Requested Authorization Units – Please Sign Below
On Begin Date of Sessions, Client is: Adult Child
Interpreter needed for these sessions: No Yes, Language: _____

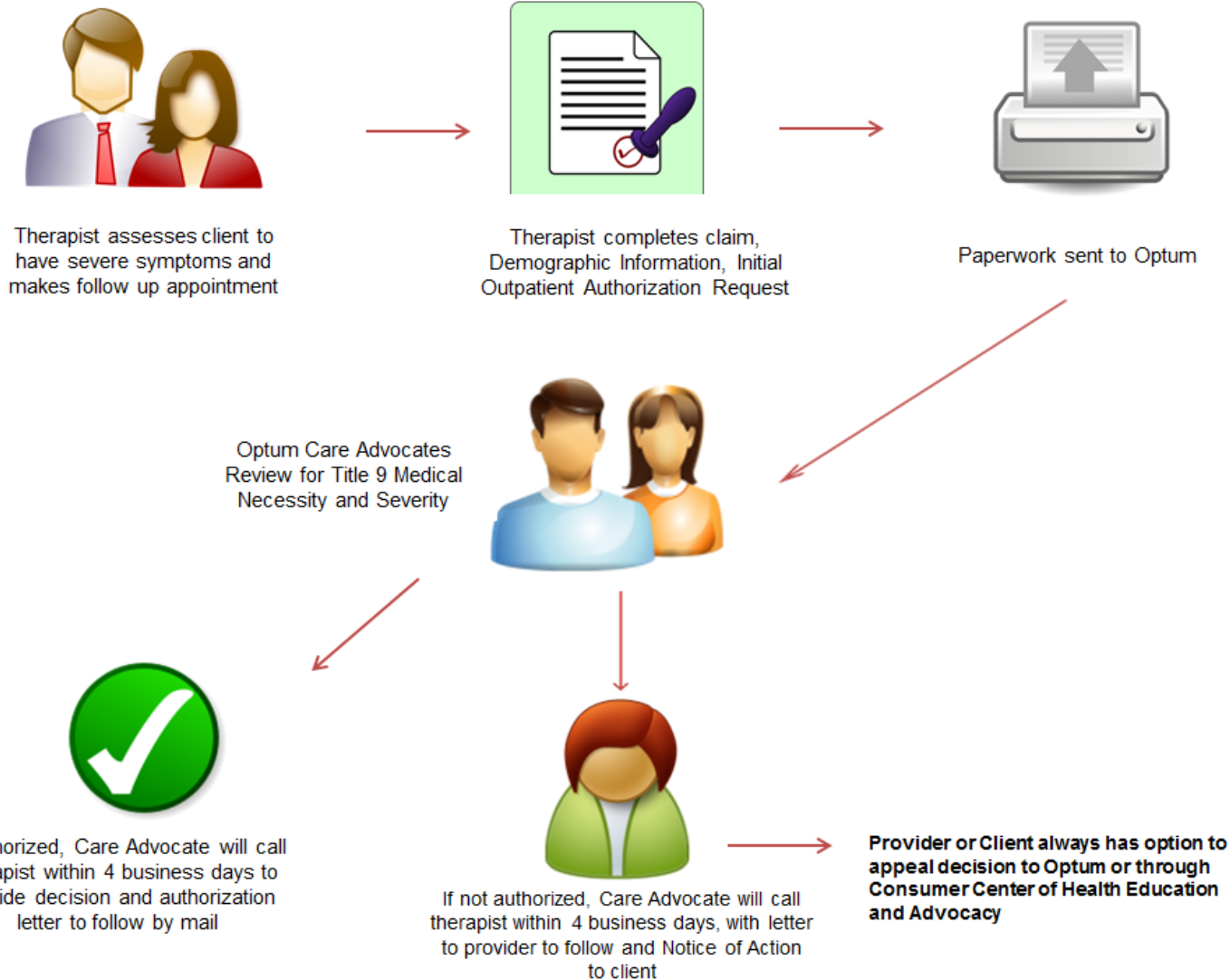
Treatment	Begin Date of Sessions	# of Sessions	Frequency # Sessions per Wk/Mo/Yr	For Optum Care Advocate Sign Approved Service
Psychotherapy (max 12)				
Group Psychotherapy (max 12, specify length of session)				
CFT Meeting (CWS only)/ Team Conference				
Conference Purpose:				
Case Management				
Case Management Purpose:				
Other:				
Other:				
Provider Information				If Modified or Denied, Date of NOA:
Name/Licensure:			Phone:	
Provider Signature:		Date:	Fax:	
If Group Practice, name of Group:				
For Optum Care Advocate If Request Modified or Denied, below sessions were authorized:				
Authorized Treatment	Begin Date of Auth	# of Sessions	Frequency	Optum Signature



The Process-Referrals and Screening

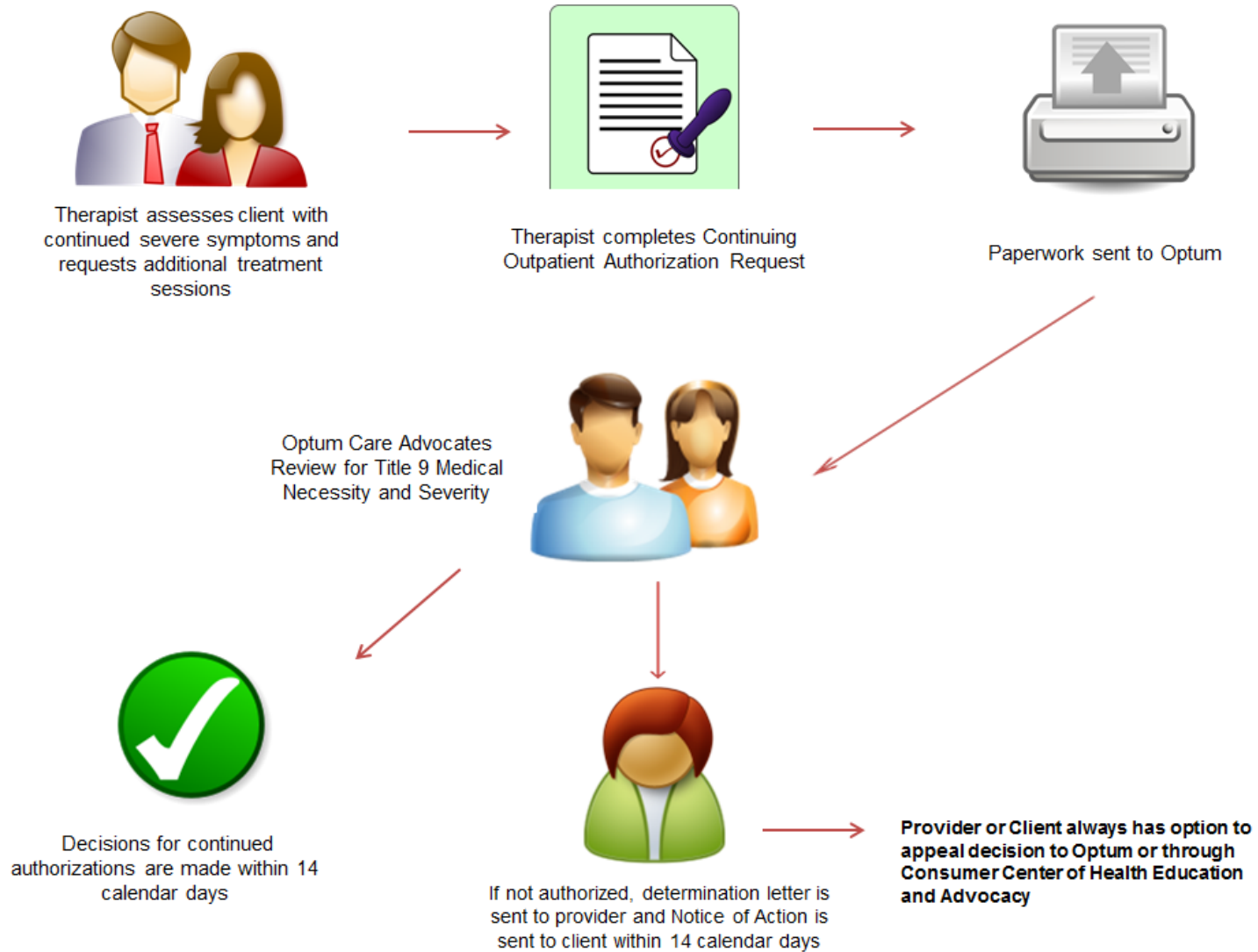


The Process, Obtaining Initial Authorization



*The severity analysis is not applicable to children/adolescents

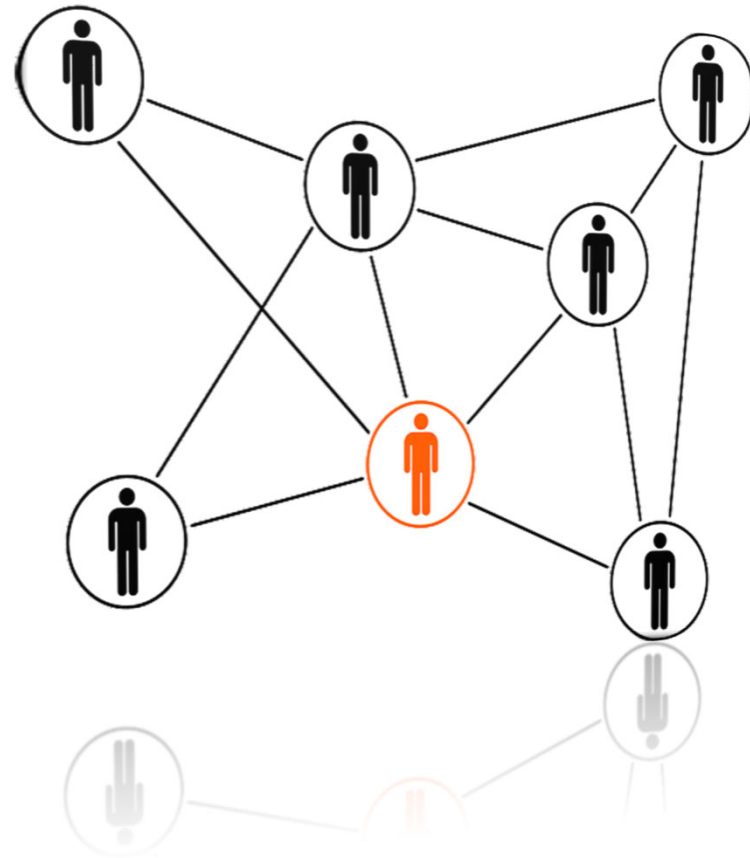
The Process, Obtaining Continuing Authorization



Partnerships

✓ Coordination of Care is Essential

- Managed Care Plans
- Primary Care Physicians
- Psychiatrists
- Case Managers
- TBS workers
- Protective Service Workers
- Probation
- Teachers



Medi-Cal and TERM referrals



UM's role with TERM Treatment Plan Submissions

- ✓ If a TERM client has Medi-Cal, the provider must only submit their TERM required elements
- ✓ A parallel process will occur where TERM clinicians will review for quality and UM will independently review for possible payment using Medi-Cal funds
- ✓ No OAR required for TERM cases; just follow the Treatment Plan due dates
- ✓ If case does not meet CA Title 9 medical necessity- CWS funds are automatically used for Initial Treatment Plans and CWS funds may be available for ongoing cases
- ✓ TERM guidelines will be covered more in depth later in this presentation
- ✓ TERM Medi-Cal authorizations will occur in increments of 12 at one time per week unless otherwise requested by provider


Notice of Adverse Benefit Determination (Denial/NOABD)




State required form for Medicaid funded treatment services.



All denials come from the Medical Director.



An NOABD form will be sent to client. The NOABD explains in detail client rights and appeal options.



A denial letter and a copy of the NOABD will be sent to you explaining the reason for denial. Your letter will explain how you can appeal the decision on the client's behalf.


Appealing a Decision

- ✓ Clients have access to the Consumer Center for Health Education & Advocacy (CCHEA) for support with appeals: (877)734-3258.
- ✓ CCHEA may also be helpful in supporting a client with accessing Medical Managed Care Plan benefits.
- ✓ Jewish Family Services: Inpatient Appeals.
- ✓ State Fair Hearing: decision by judge.
- ✓ Providers can submit an appeal request to Optum, Attention: Quality Improvement Department, in writing within **ninety (90) days** of the date on denial letter.


Wrap up Reminders




We are here to help! Call us! Medi-Cal Provider Line: 800-798-2254, option 3 and then option 3 again for Outpatient.



Non TERM cases, new referrals that are Mild to Moderate may be served by the client's Medi-Cal Managed Care Plan. Adults with severe needs go to the Fee for Service providers, Clinics or FQHCs. The severity analysis is not applicable to children/adolescents.



The role of the provider is to utilize goal-focused treatment targeting an approved diagnosis listed in CA regulation Title 9.



There are many Recovery focused organizations in our County; please refer to all appropriate community supports.



Call Access and Crisis Line 888-724-7240 for additional referrals or resources.

New Provider Orientation

Quality Improvement Department



Agenda



Who We Are



Department Overview



Medi-Cal Fee for Service Outpatient Provider
Reviews



Claim Audits

Quality Improvement Department

Director of Quality Improvement, Provider Services & Behavioral Health Services Team

Michelle Romero, LMFT

Manager

Colleen Bingham, LMFT

Clinicians

Martine Cloutier, LCSW

Joanna Hamilton, LMFT

Sr. Clinical Quality Analyst

Teresa Kappahn, M.S

Certified Coder

Eva Wood, CPC, CPCO

Thanh Khuu, CPC, RHIT

Project Coordinator

Albert Sarinana

Quality Improvement Department

Clinical Quality	Compliance	Appeals
Clinical Quality of Care Committee	Claim audits	Inpatient services
Peer Review Committee	Inpatient provider reviews	Outpatient services
Outpatient provider reviews	Privacy incidents	Long Term Care services
	Serious incident reports	Crisis House
	Ensure adherence to County, State, and Federal regulations	Therapeutic Behavioral Services
		Intensive Home Based Services
		Day Services Request

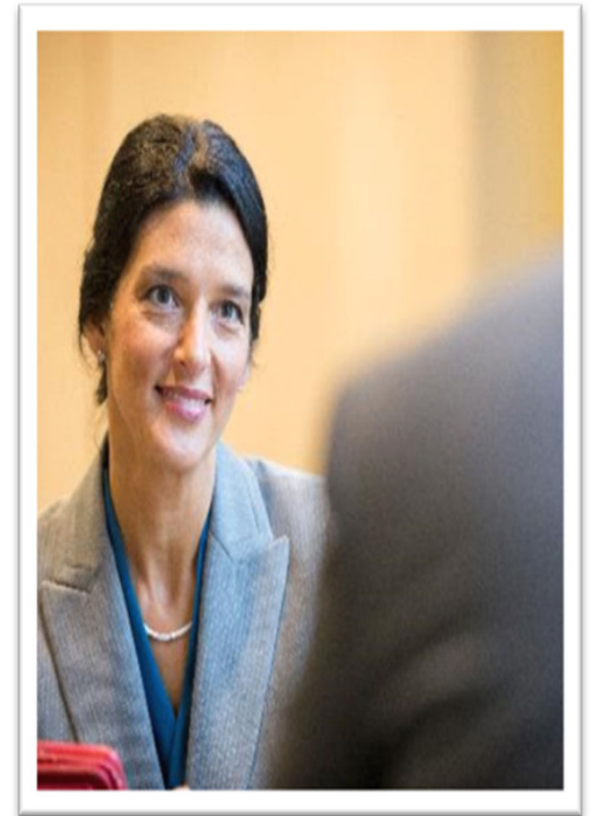
Medi-Cal FFS Outpatient Provider Reviews

The County of San Diego Behavioral Health Services requires review of providers' practice site and documentation of services to determine that County, State, and Federal guidelines and standards are met regarding the quality and effectiveness of clinical services and the accuracy of provider claims.

Monitoring is accomplished through a review of clinical records, billing practices, and an inspection of provider offices

Each provider reviewed once every 3 years

Providers may also be selected for review in response to a complaint or quality of care issue



Site and Treatment Record Reviews

- ✓ Providers will be contacted via email and/or telephone to schedule review
- ✓ Once appointment is scheduled, a confirmation letter will be mailed or emailed with links to the treatment record tool and site review tool
- ✓ After 2 unsuccessful attempts within the month to contact provider, Optum Provider Services may be notified to follow up
- ✓ One week prior to the treatment record review, a list of chart names to be reviewed will be faxed to provider
- ✓ Progress notes will be reviewed for a 6 month period
- ✓ The initial assessment, initial forms, treatment plans and discharge summary are to be included regardless of dates of service
- ✓ Modifications have been made to be able to the treatment record and site review due to Covid-19.

Fee for Service Providers

This page is utilized by Fee For Service MediCal Providers to obtain documentation related to participation on the MediCal panel and continued authorizations for treatment.

- Applications
- Beneficiary Materials
- Claims
- Communications
- Forms
- Manuals
- Quick Reference
- Review - Outpatient
- Review - Inpatient
- Training

Review - Outpatient

Name	Description	Date
DHCS Reasons for Recoupment FY 18-19 (pdf)	For DOS 7/1/18-6/30/19	2019-03-22
Beneficiary Material Order Form (docx)		2019-02-12
DHCS Reasons for Recoupment FY 17-18 (pdf)	For DOS 7/1/17-6/30/18	2017-11-06
Documentation Tip Sheet (pdf)		2016-09-15
Initial Client Checklist (pdf)		2019-02-11
Quick Guide to Provider Orientation (pdf)		2019-02-13
Reasons for Recoupment Quick Guide FY 18-19 (pdf)		2019-02-01
Record Keeping and Treatment Record Requirements (pdf)		2017-08-07
Site Review Tool (pdf)		2018-02-22
Treatment Record Review Tool (pdf)		2017-05-10

After the Review

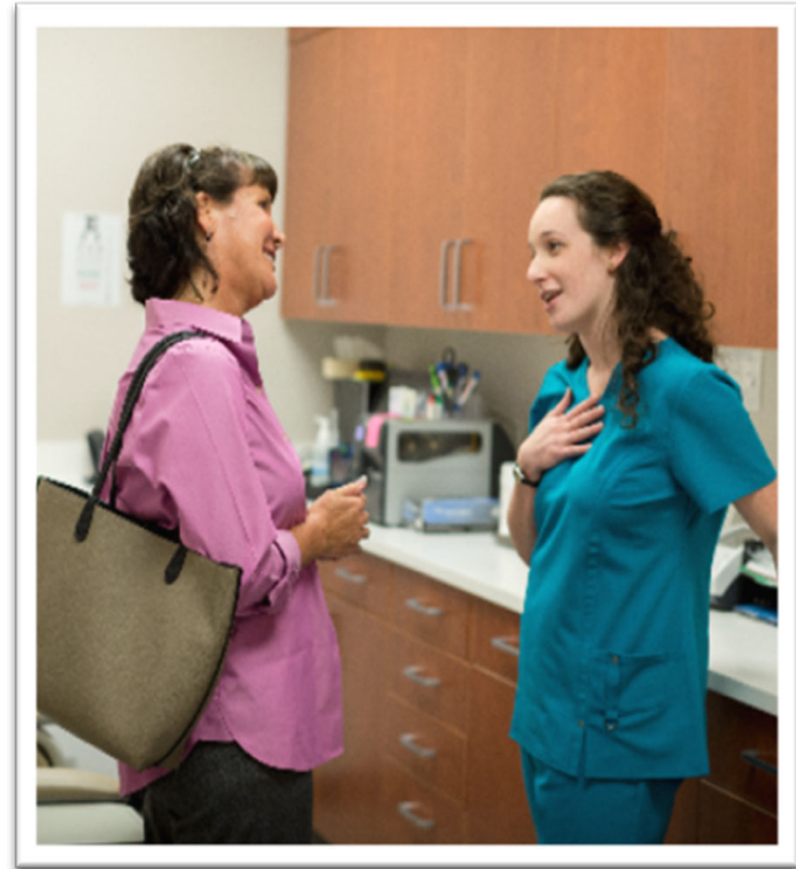
- ✓ QI Clinician completes an official report and sends it to the provider within 30 days
- ✓ A provider must receive a score of 85% to pass
- ✓ Any scores below 85% may be subjected to a Corrective Action Plan and possible re-review
- ✓ If a recoupment occurred a report will be included with the review letter along with appeals process should provider choose to appeal decision

Top Reasons for Recoupment

- No progress note was not found for service claimed
- Progress notes do not meet medical necessity
- Progress note was not signed (or electronic equivalent) by the provider of the service
- Failure to document the expectation the intervention will diminish impairment; prevent deterioration in an important area of life functioning; allow the child to progress developmentally or correct or ameliorate the condition.

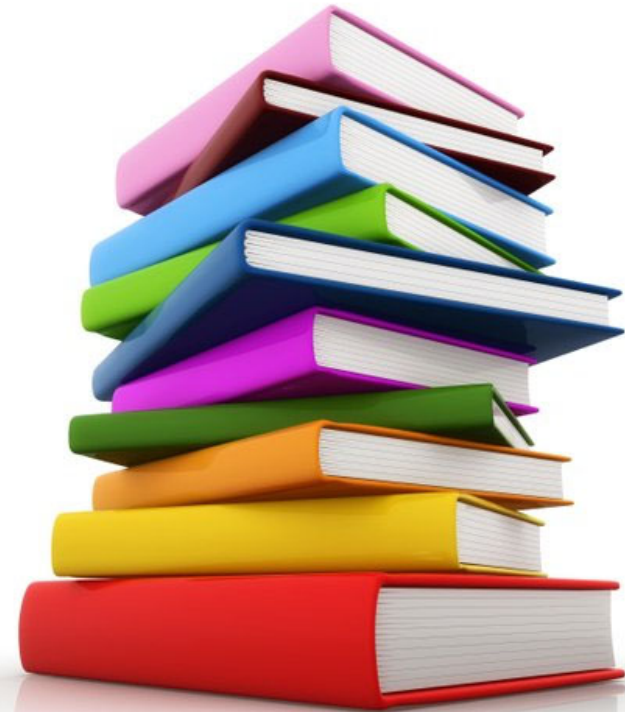
Direct Reviews

- ✓ Significantly high volume
- ✓ Claimable time in one day
- ✓ Unique clients served
- ✓ Up-coding
- ✓ Phantom billing
- ✓ Blanket diagnosis
- ✓ Complaints



Resources for Review

- ✓ Courtesy Reviews
- ✓ Templates
- ✓ Review Tools
- ✓ DHCS Reasons for Recoupment Quick Guide
- ✓ Documentation Tip Sheet
- ✓ Telephonic Support



Questions and Answers?



Thank you for joining us
and becoming part of the Optum Network!