

2018 Administrative Guide

Physician, Health Care Professional, Facility and Ancillary
KanCare Program
Chapter 6: Behavioral Services

Welcome to the UnitedHealthcare Community Plan care provider manual. This complete and up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Operational policy changes and other electronic tools are ready on our website at UHCprovider.com.

Click the following links to access different manuals:

- [UnitedHealthcare Administrative Guide](#) for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual – go to UHCCCommunityPlan.com, click For Health Care Professionals at the top of the screen. Select the desired state.

Easily find information in this manual using the following steps:

1. Select CTRL+F.
2. Type in the key word.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF.

If you have any questions about the information or material in this manual or about any of our policies, please call Provider Services.

We greatly appreciate your participation in our program and the care you offer our members.

Important Information about the use of this manual

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of a conflict between your agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

We amend the manual as policies change.

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United Behavioral Health operating under the brand Optum

Chapter 6: Behavioral Services

6.1 Introduction

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

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

We encourage you to make use of Provider Express, our industry-leading website providerexpress.com where you can get news, access resources and in a secure environment make demographic changes at the time and pace you most prefer. We continuously expand our online functionality to better support your day-to-day operations. Visit us often!

Please take time to familiarize yourself with all aspects of the Network Manual. We've included an easy reference Resource Guide and FAQs to get you started. There is much work to be done. We are interested in your contributions to constructive innovation. Let us hear from you!

Deb Adler
S.V.P. Behavioral Network Services
Optum



Purpose

The Kansas Department for Health and Environment (KDHE) selected UnitedHealthcare of the Midwest, Inc. as one of three contractors to provide managed care services to Kansas Medicaid and CHIP members eligible through KanCare.

United Behavioral Health (UBH) operating under the brand Optum works in close collaboration with UnitedHealthcare to administer the behavioral health benefits for KanCare beneficiaries.

About United Behavioral Health and Optum

United Behavioral Health (UBH) was officially formed on February 2, 1997, through the merger of U.S. Behavioral Health, Inc. (USBH) and United Behavioral Systems, Inc. (UBS). Our company is a wholly owned subsidiary of UnitedHealth Group. We have been operating under the brand Optum since 2012.

We are the nation's largest accredited managed behavioral health care organization, providing services to one in six insured Americans. It is supported by the largest behavioral care provider network in the United States - more than 130,000 practitioners. And we offer the industry's most comprehensive array of innovative and effective behavioral health care programs including integrated behavioral and medical programs, depression management, brain health, employee assistance, work/life management, disability support and pharmacy management programs.

Today, our customers include small businesses, Fortune 100 companies, school districts, health plans, and disability carriers. At the time of this publication, we support 43 million members nationwide.

Optum

Optum is a health services business dedicated to making the health system work better for everyone. We have aligned our businesses and are focused on helping ensure that people receive the right care at the right time from the best practitioners. Optum supports population health management solutions that address the physical, mental and financial needs of organizations and individuals. We provide health information and services to nearly 60 million Americans – educating them about their symptoms, conditions and treatments; helping them to navigate the system, finance their health care needs and stay on track with their health goals.

We serve people throughout the entire health system allowing us to bring a uniquely broad, yet experienced, perspective. We have the ability and scale to help our clients both envision and implement new approaches that drive meaningful, enduring and positive change.

Optum serves people throughout the entire continuum of healthcare, from promoting wellness and prevention, to servicing those that provide care, to delivering and managing prescription solutions, to being an industry-leader in healthcare research and technology.

Mission and Vision

Our mission is to help people live their lives to the fullest. Our vision is to be a constructive and transformational force in the health care system.

Core Values

- Integrity
 - Honor commitments
 - Never compromise ethics
- Compassion
 - Walk in the shoes of the people we serve and those with whom we work
- Relationships
 - Build trust through collaboration
- Innovation
 - Invent the future, learn from the past
- Performance
 - Demonstrate excellence in everything we do

6.2 Resource Guide

Important Notice

Optum provides this manual (Administrative Guide, Chapter 6: Behavioral Services) as a more focused resource for clinicians serving the UnitedHealthcare Community Plan of Kansas membership. This manual does not replace the primary national Optum Behavioral Health Network Manual. Rather, this manual supplements the Optum Behavioral Health Network Manual by focusing on the core service array, roles and responsibilities as well as process and procedures specific to the State of Kansas KanCare program. Many sections of the primary Optum Behavioral Health Network Manual are repeated for convenience and topics or requirements that are specific to the KanCare program are detailed here as well. There a link on the Optum Provider portal to the primary Optum Behavioral Health Network Manual.

Websites

providerexpress.com

Our industry-leading care provider website includes both public and secure pages. Public pages include general updates and useful information. Secure pages are available only to network care providers and require registration. The password-protected “secure Transactions” give you access to member and care provider specific information.

To Register for Access:

Select the “First-time User” link in the upper right hand corner of the home page. Click on “Register” and follow the prompts. For assistance access our Live Chat feature or call (866) 209-9320. The Provider Support Center is available from 7 a.m. to 9 p.m. Central Time, Monday through Friday, excluding holidays.

Secure Transactions:

- Update practice information
 - Add NPI
 - Add Taxonomy Code(s)
 - Update Languages Spoken
 - Update email address
 - Update gender
 - Add Medicaid/Medicare Numbers
 - Update expertise
 - Update ethnicity
 - Request to add or remove Tax ID Number
 - Manage address locations, including practice , remit, credentialing and admitting privileges
 - Update phone and fax numbers
 - Availability status
 - Accessibility-practice hours, wheelchair accessibility, public transportation, etc.

Public Pages:

The home page includes “Quick Links” to our most frequently accessed pages as well as recent news and updates.

- Download standard forms (example: KanCare Agency Roster Update Form)
- Find staff contacts
- Review clinical guidelines
- Locate current and archived issues of Network Notes, the care provider newsletter

liveandworkwell.com

This member website focuses on behavioral health topics and makes it simple for members to:

- Find articles on a variety of wellness and work topics
- Take self-assessments
- Locate community resources
- Identify network clinicians and facilities

Members can explore topics under the Live Well which includes information related to symptoms, diagnoses, tests, treatment, and prevention related to conditions. The BeWell topics are designed to help members manage and take control of life challenges.

Claims and Customer Service

Optum recommends electronic submission of claims for the most efficient claim processing. Additional resources related to claim submission are available and can be found on Provider Express under Administrative Resources.

Claims/Customer Service – Behavioral Health

877-542-9235

Paper Claims - Behavioral Health Claims Mailing Address

United Healthcare
P.O. Box 5270
Kingston, NY 12402

To ensure proper processing of claims, always include your NPI on the claim.

It is also important to promptly contact Network Management if you change your Tax ID number. You may make changes to your practice address online. See secure “Transactions” above.

For Further Assistance

For general information and contractual questions, contact Network Management or your Facility Contract Manager. You can contact us through our National Provider Service Line at 877-614-0484.

6.3 Frequently Asked Questions

Network Requirements

Who can I contact with specific questions or comments?

For general information and contractual questions, contact Network Management or your Facility Contract Manager. You can also contact us through our National Provider Service Line at 877-614-0484.

What is a Payor?

Our Payor definition is the entity or person that has the financial responsibility for funding payment of covered services on behalf of a member who is authorized to access MH/SUD services in accordance with the Agreement.

Do I have to notify anyone if I change my name, address, telephone number, or Tax Identification Number?

Yes. You are required to notify us within 10 calendar days, in writing, of any changes to your practice information. This is especially important for accurate claims processing. We encourage you to make such changes by going to **Provider Express** to update your practice demographics.

As a contracted facility, are we required to notify Optum in the event that we discontinue or change a program or service?

Yes. Contracted facilities are required to provide us with written notification of changes in the services they offer within 10 calendar days.

As a contracted facility, would the addition of programs, services or locations require review of our current contract with Optum?

Yes. Contact your Facility Contract Manager to initiate a review.

Can I be considered a participating clinician at one practice location and non-participating at another?

Yes, always verify your participation through **Provider Express**.

Since our facility or practice group has an Optum contract, does that mean all of our affiliated clinicians are considered participating network clinicians?

No. Generally, only clinicians credentialed with Optum are considered network clinicians. The Optum network status of a facility or group does not guarantee that all clinicians in practice there are network clinicians. In situations where an agency is credentialed by Optum, their affiliated clinicians are not credentialed, but are considered participating under the agency's agreement.

May I bill for Mental Health/Substance Abuse Disorder (MH/SUD) services that another practitioner, intern or assistant provides to Optum members in my office?

No. You can bill only for services which you personally provide. Please follow the Optum Operational Guide for Psychological and Neuropsychological Testing regarding the use of psychometrists. These are available on **Provider Express** under **"Guidelines and Policies."**

If my practice is filling up or if I am going to take a leave of absence from my practice, may I choose to be unavailable for new Optum referrals?

Yes. You may request to be listed in our database as unavailable at one or more of your practice locations for a period of up to six months. You are required to notify Network Management within 10 calendar days of your lack of availability for new referrals. Group practices and facilities/ agencies that wish to be made unavailable should contact Network Management for their state.

Are there procedures to follow if I withdraw from the Optum network?

Yes. The terms and conditions for withdrawal from the network are outlined in your Agreement. For additional details, or to initiate the process, contact Network Management or your Facility Contract Manager. Please also see information about Continuation of Services after Termination in the “Network Requirements” section of this manual.

Benefit Plans, Authorizations and Access to Care

Should I routinely contact Optum regarding eligibility and benefits?

To ensure appropriate authorization guidelines are met always check on member participation prior to rendering services. You can inquire about eligibility and benefits at UHCprovider.com or by calling the Member Services phone number: 877-542-9238. Services and/or conditions not covered under KanCare are not eligible for payment. We comply with regulatory requirements related to coverage election periods and payment grace periods. These requirements can lead to delays in our knowledge of a member’s eligibility status. As a result, the member is the best source for timely information about eligibility, coverage changes and services utilized to-date.

Do all members require prior authorization for outpatient treatment?

No. Members shall be able to access all behavioral health outpatient services (mental health and substance use) without a referral up to a pre-specified initial authorization service limit. Some services do not have a service limit. In addition any service for any woman who is pregnant or has dependent children can be accessed without a referral up to established initial authorization service limits. For services above these limits, Prior Authorization is required and may be obtained by members or care providers.

Can members initiate authorization of benefits for routine outpatient MH/SUD services?

Yes. The authorization for routine outpatient services, when required, is typically obtained through a telephone contact between the member or family member and our Intake staff. However, if a required authorization has not been issued at the time you inquire about eligibility, then you need to request it. You may do this by calling the Clinical Operations site phone number: 877-542-9235.

Are all the services I provide covered under the MH/SUD Authorization?

No. Authorization that is issued to members (when required) covers most common routine outpatient MH/SUD services you provide. Members may self-refer for up to six hours of psychological testing without prior authorization.

Please note that intensive outpatient care and other non-routine outpatient MH/SUD services still require clinician-specific or program-specific authorization of benefits prior to providing those services. To obtain those authorizations, please call the number on the back of the member’s insurance card.

Is there a time limit in which an authorization of routine services is valid?

Yes. The authorization of routine services is valid for the dates specified up to the benefit limit as long as the member's eligibility remains active.

Will I be notified when an authorization expires?

No. Please refer to the effective date on the most recent authorization. The authorization is valid for the dates specified (up to the benefit limit as long as the member's eligibility remains active).

Can I make referrals directly to other Optum network clinicians without prior authorization of benefits?

In some cases, the authorization for routine services is open to any Optum network clinician and allows you to transfer a member to another network clinician for routine outpatient MH/SUD services. Additionally, if you are referring a member to a network clinician for routine medication evaluation and management, prior authorization is not required. However, a prior authorization is still required for services such as, intensive outpatient services and other levels of care.

Treatment Philosophy

Are Optum's Guidelines accessible online?

Yes. Guidelines and Policies are posted under "Quick Links" on the home page of Provider Express. You may also contact Network Management to have a paper copy of these documents mailed to you. Documents include the Level of Care Guidelines, Psychological/Neuropsychological Testing Guidelines, Coverage Determination Guidelines, Best Practice Guidelines and Technology Assessments.

Am I expected to coordinate care with a member's primary care provider or other health care professionals?

Yes. We require network clinicians, both in and out of facilities, to pursue coordination of care with the member's primary provider as well as other treating medical or behavioral health clinicians. A signed release of information to other care providers should be maintained in the clinical record. In the event that a member declines consent to the release of information, his or her refusal should be documented along with the reason for refusal. In either case, the education you provide regarding risks and benefits of coordinated care should be noted.

Privacy Practices

Do HIPAA Regulations allow me to exchange Protected Health Information (PHI) with Optum?

Yes. The HIPAA Privacy Rule permits clinicians and Optum to exchange PHI, with certain protections and limits, for activities involving Treatment, Payment, and Operations (TPO). An individual's authorization for ROI is not required when PHI is being exchanged with a network clinician, facility or other entity for the purposes of Treatment, Payment, or Health Care Operations as enumerated in HIPAA (and consistent with applicable state and other Federal law).

Do I need a National Provider Identifier (NPI) to submit electronic claims?

Yes. HIPAA mandates that all health care providers conducting standard electronic transactions (such as electronic claims submission) must obtain and use a unique identification number known as the National Provider Identifier (NPI). The NPI is required for paper claims as well.

Quality Improvement

Does Optum audit clinicians and facilities?

Optum representatives conduct site visits at clinician offices, agencies such as community mental health centers (CMHCs), facilities, and group provider locations. On-site audits and record requests are routinely completed with CMHCs and facilities. In addition, audits are completed to address specific quality of care issues or in response to member complaints about the quality of the office or facility environment. For additional information, please see the “Quality Management and Improvement” section of this manual.

Compensation and Claims

Can members be billed prior to claims submission?

No. Members are never to be charged in advance of the delivery of services.

Is there one format to be used for diagnosis on claims?

Yes. Submit your claims using the industry-standard ICD-10 code as mapped to DSM-5 defined conditions.

Are there different methods or claim forms I should use when submitting claims to Optum?

Yes. See below.

Electronic Claims: Optum recommends electronic submission of claims for the most efficient claim processing. Network clinicians and group practices can submit MH/SUD claims electronically through one or more designated claim portals. In addition, any clinician, group practice or facility provider can submit claims electronically through an EDI clearinghouse using Payer ID 96385.

Clinician Claim Forms: Paper claims for MH/SUD services should be submitted using the CMS-1500 Claim Form, or its successor form. All paper claims must be typewritten.

Facility Claim Forms: Paper claims should be submitted using the UB-04 billing format, or any successor forms as appropriate.

Is there some easy way for me to determine where to send my claim?

Yes. Claims submitted electronically through the designated claims portal at UHCprovider.com or through an EDI clearing house using Payer ID 96385 are automatically routed to the appropriate claim center.

Do I have to submit my claims within a certain time frame in order for them to be paid?

Yes. All information necessary to process claims must be received by Optum no more than 90 calendar days from the date of service, or as required by state or federal law or specific member benefit plans.

Am I responsible for coordination of benefits?

Yes. You are responsible for determining if other insurance coverage is in effect and for billing the primary insurance carrier first, and notifying Optum of your findings. Optum is required to process claims using industry-wide Coordination of Benefits (COB) standards and in accordance with benefit contracts and applicable state laws.

Can I bill a member when treatment is not authorized, as required, but the member elects to receive services?

No. In the event that you seek prior authorization of benefits for behavioral health services or authorization for continued treatment when required, and Optum does not authorize the requested services, the member may not be billed.

May I submit a claim to Optum for “no-shows”?

No. Billing for no-shows under any circumstances for KanCare members is prohibited.

May I balance bill the member above what Optum pays me?

No. You may not balance bill members for services provided during eligible visits, which means you may not charge members the difference between your billed usual and customary charges and the aggregate amount reimbursed by Optum and member expenses.

Anti - Fraud, Waste and Abuse (FWA)

Am I required to participate in all Anti-Fraud, Waste and Abuse Programs?

Yes. All Fraud, Waste and Abuse investigation activities are a required component of your agreement. This includes, but is not limited to, providing medical records as requested and timely response to inquiries.

Do I have to complete Anti-Fraud, Waste and Abuse or Compliance training?

All care providers and affiliates working on Medicaid programs must provide compliance program training and Fraud, Waste, and Abuse (FWA) training within 90 days of employment and annually thereafter (by the end of the year) to their employees and/or contractors. The training is subject to certain requirements, and may be obtained through any CMS approved source.

What should I do if I suspect FWA?

Anytime there is a suspicion of Fraud, Waste or Abuse, please report it immediately. The faster we know about it, the faster we can intervene. We need your assistance to maximize success.

How do I contact the Optum Program and Network Integrity Department?

Telephone: 877-972-8844

E-Mail: ohbs.pni.tips@optum.com

Mail: P.O. Box 30535, Salt Lake City, UT 84130-0535

Fax: 248-733-6379

General inquiries: ohbs.pni.communications@optum.com

Communications are confidential and may be anonymous.

Where can I find more information about Anti-Fraud, Waste and Abuse?

More information is available on the [Anti-Fraud, Waste and Abuse page](#) on [Provider Express](#).

Appeals

Can I initiate the appeals process if I disagree with Optum's decision not to authorize services I have requested?

Yes. You may initiate the appeals process with Optum. Urgent appeals should be pursued as quickly as possible following a non-coverage (Adverse) determination. For non-urgent appeals, Optum has established a 30 calendar day time frame (plus 3 calendar days if mailed) in which a clinician or member can request the appeal. These time frames apply unless otherwise mandated by applicable law.

Are there different contacts for issues with claims processing or payment?

No. There is one Claims/Customer Service number for KanCare claims: 877-542-9235.

6.4 Glossary of Terms

These definitions are general definitions applied for purposes of this manual. State law, certain practitioner agreements and individual benefit contracts define some of these terms differently. In such cases, the definitions contained in the applicable law or contract will supersede these definitions.

Action

The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure of the health plan to act within established time requirements (provided in 42 CFR 438.408(b)) for service accessibility.

Affiliate

Each and every entity or business concern with which Optum, directly or indirectly, in whole or in part, either: owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Agency

A non-facility based outpatient provider meeting specific criteria. Examples include, Federally Qualified Health Centers (FQHC), Community Mental Health Centers (CMHC), State Licensed Outpatient Clinics, and Community-based Service Agencies. See definitions of these agency types within this glossary.

Agreement

A contract describing the terms and conditions of the contractual relationship between Optum and a clinician or facility under which mental health and/or substance abuse disorder services are provided to members.

Appeal

A request for review of the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure of the health plan to act within established time requirements (provided in 42 CFR 438.408(b)) for service accessibility.

Authorization

The number of inpatient days or non-routine outpatient visits for which benefits have been applied as part of the member benefit plan for payment. Authorizations are not a guarantee of payment. Final determinations will be made based on member eligibility and the terms and conditions of the member's benefit plan at the time the service is delivered.

Balance Billing

The practice of a care provider requesting payment from a member for the difference between the Optum contracted rate and the clinician or facility's usual charge for that service. This practice is not allowed.

Behavioral Health Care

Assessment and treatment of mental health and/or substance use disorders MH/SUD

Care Advocate

An Optum employee who is a licensed clinical professional (e.g., nurse, doctor, psychologist, social worker, or professional counselor) who works with members, health care professionals, physicians, and insurers to maximize benefits available under a member's benefit plan.

Clean Claim

A UB-04 or a CMS-1500 claim form, or its successor, submitted by a facility or clinician for MH/SUD health services rendered to a member which accurately contains all the following information: member's identifying information (name, date of birth, subscriber ID); facility or clinician information (name, address, NPI, tax ID); date(s) and place of service; valid DSM-5 diagnosis or ICD-10 code; procedure narrative; valid CPT-4, HCPCS code, or revenue code; services and supplies provided; facility charges; and such other information or attachments that may be mutually agreed upon by the parties in writing.

Clinician

A licensed professional contracted to deliver behavioral health care services to members (also known as a network clinician).

Community-based Service Agency

Includes peer support group services and drop-in centers (clubhouse model) that have a business license but are not state licensed.

Community Mental Health Center (CMHC)

An entity that meets applicable licensing or certification requirements for CMHCs in the state in which it is located.

Coverage Determination Guidelines

These 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.

Covered Services

Such services will include any that are currently covered in the Kansas Medicaid and CHIP programs.

Credentialing

The process by which a clinician or facility is accepted into the Optum network and by which that association is maintained on a regular basis.

Emergency

Services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

- (1) Placing the patient's health in serious jeopardy;
- (2) Serious impairment to bodily functions; or,
- (3) Serious dysfunction of any bodily organ or part

Emergency - Life Threatening

A situation requiring immediate appointment availability in which there is imminent risk of harm or death to self or others due to a medical or psychiatric condition.

Exclusions

Specific conditions or circumstances listed in the member's benefit plan for which the policy or plan will not provide coverage reimbursement under any circumstances.

Facility

An entity that provides inpatient, residential, or ambulatory services and has contracted to deliver behavioral health care services to members (also known as a network facility).

Facility Contract Manager

An Optum professional dedicated to managing contractual relationships with hospitals and freestanding behavioral health programs and services for the Optum network.

Fair Hearing or State Fair Hearing

A formal meeting where an impartial Hearings Officer, assigned through the Office of Administrative Hearings, listens to all of the facts and then makes a decision based on the law.

Fee Maximum

The maximum amount a participating clinician or facility may be paid for a specific health care service provided to a member under a specific contract. Optum reimburses clinicians based upon licensure rather than degree.

Federally Qualified Health Centers (FQHC)

A federally qualified health center is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-a-Likes. A FQHC Look-A-Like is an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.

FWAE (Fraud, Waste, Abuse, and Error)

Fraud: Intentional misrepresentation or concealing facts to obtain something of value. The complete definition has three primary components:

- Intentional dishonest action or misrepresentation of fact
- Committed by a person or entity
- With knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit

Waste: Inaccurate payments for services, such as unintentional duplicate payments, and can include inappropriate utilization and/or inefficient use of resources.

Abuse: Practices that directly or indirectly result in unnecessary costs to health care benefit programs. This includes any practice that results in the provision of services that:

- Are not medically necessary
- Do not meet professional recognized standards for health care
- Are not fairly priced

Error: Mistakes, inaccuracies or misunderstandings that can usually be identified and fixed quickly.

Group Practice

A group of individually credentialed clinicians who participate in the network under a group contract and share a single tax identification number. The group practice site(s) is the location of practice for at least the majority of each clinician's clinical time. In addition, medical records for all patients treated at the practice site are available to and shared by all clinicians as appropriate.

GT Modifier

Billing modifier used with CPT or HCPCS codes, when indicated, to reflect services were provided in real-time using an interactive audio and video telecommunication system. The modifier is used to indicate Telehealth services.

Health Plan

A health maintenance organization, preferred provider organization, insured plan, self-funded plan, or other entity that covers health care services. This term also is used to refer to a plan of benefits.

HIPAA

The Health Insurance Portability and Accountability Act, by which a set of national standards are set for, among other topics, the protection of certain health care information. The standards address the use and disclosure of an individual's "Protected Health Information"(PHI) by organizations subject to the Privacy Rule ("covered entities"). These standards also include privacy rights for individuals to understand and control how their health information is used. For more information, please visit the Department of Health and Human Services Website.

Independent Review Organization

An independent entity/individual retained by private health plan, state agency or federal agency to review non-coverage determinations (based on medical necessity) that have been appealed by, or on behalf of, a member (also sometimes known as External Review Organizations).

Least Restrictive Level of Care

The Level of Care (LOC) at which the member can be safely and effectively treated while maintaining maximum independence of living.

Level of Care (LOC) Guidelines

Objective, evidence-based admission and continuing stay criteria for MH/SUD services. These guidelines are intended to standardize care advocate decisions regarding the most appropriate and available level of care needed to support a member's path to recovery.

Liveandworkwell.com

An Optum member website which provides resources for wellness information, MH/SUD intervention, network referrals.

Medical Necessity

Generally, the evaluation of health care services to determine if they meet plan criteria for coverage as medically appropriate and necessary in accordance with K.A.R. 30-5-58 (ooo) to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment.

Member

An individual who meets eligibility requirements and participates in the KanCare program through UnitedHealthcare Community Plan of Kansas. Also may be referred to as a plan participant or enrollee.

Member Grievance

An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a care provider or employee, or failure to respect the member's rights.

MH/SUD

Mental Health and/or Substance Use Disorder.

Network Management

Consists of Network Managers and Associates who provide services and information to care providers. In addition, they may act as liaisons with other departments such as Clinical Operations, Account Management and Sales to contract and retain experienced mental health and substance abuse treatment professionals.

Non-Coverage Determination (NCD)

A denial, reduction, or termination of coverage, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on the eligibility of a member or beneficiary to participate in a plan; and a denial resulting from utilization review, the experimental or investigational nature of the service, or the lack of medical necessity or appropriateness of treatment. The term “Adverse Determination” is sometimes used to describe NCDs.

Payor

The entity or person that has the financial responsibility for funding payment of covered services on behalf of a member who is authorized to access MH/SUD services in accordance with the agreement.

Prospective Program

Claim review completed before payment is made that may be denied due to a conflict with a reimbursement policy and/or when more information is needed before a claim can be processed. When more information is needed a request for medical records will be sent to the care provider and/or member as appropriate.

Provider Grievance

A provider grievance is any issue that arises between a care provider and Optum that is not the result of a care provider acting on behalf of a member in the grievance and appeal process and is related to unique administrative functions of Optum.

Provider Express

Website providing resources for clinicians and facilities. General information, manuals, forms and newsletters are available to both clinicians and facilities. Demographic changes can be completed through secure transactions.

Quality Assurance

A formal set of activities to review and affect the quality of services provided. Quality assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient services. Federal and state regulations typically require health plans to have quality assurance programs.

Quality Management and Improvement

A continuous process that identifies opportunities for improvement in health care delivery, tests solutions, and routinely monitors solutions for effectiveness.

Roster Management

For contracted agencies, this is the method by which their clinicians are linked to the agency contract.

To ensure proper maintenance of your independently licensed staff (or state approved non-independent licensed care providers) who will be submitting claims, please submit the KanCare Agency Roster Update Form as staffing changes occur. We do not require a copy of their license or certification. Non-licensed staff are not loaded individually and should not be included; only include the staff who will be submitting claims. The KanCare Agency Roster Update Form can be found on Provider Express, under Quick Links, Forms.

Routine

A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others.

Serious Emotional Disturbance (SED)

The term “serious emotional disturbance” refers to a diagnosed mental health problem that substantially disrupts a child’s ability to function socially, academically, and/or emotionally.

Serious Emotional Disturbance Services provided under the SED are for children between four and 18 years of age who experience serious emotional disturbance and who are at risk of inpatient psychiatric treatment. SED services provide children with special intensive support so they may remain in their homes and communities. Parents and children are actively involved in planning for all services.

An exception may be requested for a child younger than four and older than 18 through the age of 21. The exception must be approved by the Kansas Department for Aging and Disability Services.

Special Health Care Needs (SHCN) Populations

Those members who are considered high risk in accordance with state criteria: 1) adults with severe and persistent mental illness (SPMI); 2) child or adolescent with a serious emotional disturbance (SED); 3) IV drug user with mental illness; 4) pregnant Substance Abuse user with mental illness; 5) dual diagnosis of mental illness and developmental disability/mental retardation (MH/MR); four dual diagnosis of substance abuse and mental illness (MH/SA).

State Licensed Outpatient Clinic (Non CMHC)

An organization that is licensed and or accredited by a state entity to provide mental health and/or substance abuse services.

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. Availability should be within 48 hours or less or as mandated by state law.

6.5 Network Requirements

Clinical Network Development and Maintenance

Optum is responsible for arranging for the provision of a comprehensive spectrum of behavioral health services. In order to fulfill this responsibility, we administer a care provider network including licensed qualified professionals in mental health and substance use disorders. This network represents an array of clinical and cultural specialties and includes facility-based programs that offer a wide variety of services. The diversity of our network allows us to meet the clinical, cultural, linguistic and geographic needs of our members.

Non Discrimination

Optum does not deny or limit the participation of any care provider in the network, and/or otherwise discriminate against any care provider, based solely on any characteristic protected under state or federal discrimination laws.

Furthermore, Optum has never had a policy of terminating any care provider because the care provider or care provider representative: (1) advocated on behalf of a member; (2) filed a complaint against Optum; (3) appealed a decision of Optum; or (4) requested a review of a termination decision or challenged termination decision of Optum. Moreover, consistent with the terms of the settlement agreement entered into in *Holstein v. Magellan Behavioral Health*, Optum has adhered to this practice both before and since the settlement agreement was executed. Optum has not, and will not, terminate any care provider from its network based on any of the four grounds enumerated above. Nothing in the agreement should be read to contradict, or in any way modify, this long-standing policy and practice of Optum.

Clinician Credentialing and Recredentialing

Optum uses the Universal Provider Data Source[®], developed by the Council for Affordable Quality Healthcare (CAQH), to obtain the data needed for credentialing and recredentialing of our network clinicians, and many clinicians who are contracted with us through a group practice, unless otherwise required by law. The CAQH web-based credentialing tool streamlines the credentialing process by enabling you to complete your credentialing application online. This free service for healthcare professionals is available 24 hours a day, 365 days year. The online application allows you to save your work and return later to finish the process. Once completed, CAQH stores the application online and enables you to make updates to your information as needed. By keeping your CAQH information current, future re-credentialing is quick and easy.

Once your application is completed with CAQH, Optum may utilize Aperture, an NCQA certified Credentials Verification Organization (CVO), to review the application packet for completeness and collect any missing or incomplete information.

Clinician Credentialing

Optum credentials clinicians according to rigorous criteria that reflect professional and community standards, as well as applicable laws and regulations. These criteria include, but are not limited to, satisfaction of the following standards:

- Licensure or certification in your state(s) of practice, except as required by applicable state law
- License is in good standing and free from restriction and/or without probationary status
- Board Certification or Board Eligibility (to complete prior to the recredentialing cycle) for psychiatrists
- Current certification through the Federal Drug Enforcement Agency (DEA) for prescribing clinicians in each state in which they practice
- Professional Liability Coverage: a minimum of \$1 million occurrence/\$1 million aggregate for master's-level and doctoral-level clinicians and a minimum of \$1 million/\$3 million for physicians (exceptions to these required insurance amounts maybe made as required by applicable state law)
- Free from any exclusion from government programs

For a more specific list of criteria, please refer to the **Credentialing Plan**.

You will be asked to sign a release of information granting Optum and its agents access to information pertaining to your professional standing. This is required for primary verification and/or review of records from any professional society, hospital, insurance company, present or past employer, or other entity, institution, or organization that may have information pertaining to your professional standing. Obtaining and reviewing this information is necessary to complete the credentialing process. Failure to provide such a release will preclude completion of your credentialing and prevent your participation in the network.

Optum has specific requirements for identified specialty areas. A comprehensive list of specialty areas is available on the KanCare Provider Directory Information Form. If you request recognition of a specialty area, an attestation statement may be required documenting the specific criteria met for the identified specialty. Current competency of a designated specialty may be randomly audited to ensure that network clinicians remain active and up-to-date in their specialty field attestations. The Credentialing Plan addresses the requirements for participation, continued participation (maintaining unrestricted license, cooperating with complaints investigation, etc.), and information regarding disciplinary action up to and including termination of participation in the network. **The Credentialing Plan** is available at **Provider Express**, or you may request that a paper copy be mailed to you by contacting Network Management.

Clinician Re-credentialing

In accordance with our commitment to the highest quality of clinical treatment, we re-credential clinicians every 36 months unless state law or client policies require a different re-credentialing cycle. During recredentialing, we will access your information through your CAQH application if applicable, unless otherwise required by law. In addition, you will be required to provide your current copy of:

- Professional licensure and/or certification
- Federal Drug Enforcement Agency (DEA) certificate (if applicable) for each state in which you practice
- Controlled Dangerous Substances (CDS) certificate (if applicable)
- Professional and general liability insurance
- Curriculum vitae

You may also be asked to:

- Attest to your areas of clinical specialty and appropriate training supporting the identified specialties.
- Sign a release of information granting access to information pertaining to your professional standing. This is required for primary verification and/or review of records from any professional society, hospital, insurance company, present or past employer, or other entity, institution, or organization that does or may have information pertaining to your professional standing. Failure to provide such a release will preclude completion of your re-credentialing and prevent your continued participation in the network.

You are required to provide a copy of all professional documents whenever they renew or change.

Facility/Agency Credentialing and Re-credentialing

Optum follows the guidelines of National Committee for Quality Assurance (NCQA) for credentialing and recredentialing unless otherwise required by law. As part of the credentialing and recredentialing process, facilities and agencies are required to submit documentation supporting their professional and community standing and defining their program offerings. This documentation includes, but is not limited to:

- Current copies of all licenses required by your state for the services you offer
- Current copy of accreditation certificate and/or letter from each accrediting body
- General and professional liability insurance certificates
- W-9 forms
- Disclosure Ownership Form (if applicable)
- Signed malpractice claims statement/history
- Staff roster, including attending physicians
- Daily program schedules
- Program description
- Facility Billing Information Form

Non accredited care providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with your Corrective Action Plan (if deficiencies were cited), OR attach the letter from the government agency stating that the facility is in substantial compliance with most recent survey standards. Facilities who don't meet the requirements above, require an on-site visit before network status may be granted. In the event that your facility/agency is not accredited by an entity recognized by Optum, an on-site audit will be required prior to credentialing and again prior to re-credentialing (see "On-site Audits" in the Quality Improvement section of this manual for more information).

The Credentialing Plan addresses the requirements for participation, continued participation (maintaining unrestricted license, cooperating with complaints investigation, etc.), and information regarding disciplinary action up to and including termination of participation in the network. **The Credentialing Plan** is available at **Provider Express** or you may request that a paper copy be mailed to you by contacting your Facility Contract Manager.

Autism Service Providers

Optum has added a new care provider type to its network, specifically to provide autism services to the children of Kansas with Autism Spectrum Disorders (ASD).

Qualified state-certified autism care providers are eligible to apply for participation for these unique services. Applicants must demonstrate expertise by meeting the requirements of the state certification. All credentialing documents should be submitted to the KanCare Autism Network Manager by fax or email.

Qualified state-certified autism organizations providing ASD treatment services and using a staff model that includes qualified Autism Specialists providing oversight to paraprofessional staff are also eligible to apply for participation in the Kansas Autism Program.

Credentialing and Re-credentialing Rights and Responsibilities

As an applicant to the Optum network, or as a network care provider in the process of re-credentialing, you are entitled to:

- Be informed of your rights
- Be informed of credentialing or re-credentialing status upon request
- Review information submitted to support your credentialing or re-credentialing application, excluding personal or professional references, internal Optum documents, or other information that is peer-review protected or restricted by law
- Make corrections to erroneous information identified by Optum in review of credentialing or recredentialing application

In addition to the above rights, you have the responsibility to submit any corrections to your credentialing or re-credentialing application in writing within 10 business days of your notification by Optum.

Written Notification of Status Changes

You are required to notify Optum in writing within 10 calendar days of any changes to:

- The status of the practice, including changes in practice location, billing address, or telephone or fax number
- Changes in facility, agency, or group ownership
- The status of professional licensure and/or certification such as a revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, debarment from any government program, monitoring or any other adverse action
- The status of professional liability insurance
- Potential legal standing (any malpractice action or notice of licensing board complaint filing)
- The Tax Identification Number (TIN) used for claims filing
- The programs you offer (services you provide must continue to meet our credentialing criteria)

Registered users of **Provider Express**, except facilities and agencies, are strongly encouraged to use the “My Practice Info” function to update this information. Otherwise, clinicians and group practices should submit changes in writing, by fax or mail, to your state- specific Network Management team. Facilities and agencies should submit their changes, in writing, by fax or e-mail, to the Facility Contract Manager or Network Manager for your state. For information on how to contact Network Management, see the Optum Resource Guide section of this manual.

Provider Initiated Unavailable Status

Individual clinicians may request to be made unavailable for new referrals at one or more of your practice locations for up to six months. You are required to notify Network Management within 10 calendar days of your lack of availability for new referrals. You may make this notification through secure “Transactions” on **Provider Express**, or by contacting the Network Manager for your state. You will be sent a letter confirming that your request has been processed.

When you have been on unavailable status for five consecutive months, we will send you a letter reminding you that you will be returned to active status within 30 calendar days. You may contact Network management to request an extension of your unavailable status. Should you decide that you want to return to active status sooner than expected, you may update your status on **Provider Express** or notify Network Management for your state.

Some common reasons for requesting unavailable status are extended illness, vacation or leave plans, and lack of available appointments. Please note that while on unavailable status your agreement remains in effect.

Group practices and facilities/agencies that wish to be made unavailable should contact Network Management for their state.

On-Call and After-Hours Coverage

You must provide or arrange for the provision of assistance to members in emergency situations 24 hours a day, seven days a week. You should inform members about your hours of operation and how to reach you after-hours in case of an emergency. In addition, any after-hours message or answering service must provide instructions to the members regarding what to do in an emergency situation.

When you are not available, coverage for emergencies should be arranged with another participating clinician.

Termination or Restriction of Network Participation

A care provider’s participation with Optum may terminate for a variety of reasons. Both parties have the right to terminate the agreement with Optum, upon written notice, pursuant to the terms of the agreement.

If you need clarification on how to terminate your agreement, you may contact Network Management or your Facility Contract Manager.

In some cases, you may be eligible to request an appeal of an Optum initiated termination or restriction of your participation. If you are eligible for an appeal, Optum will notify you of this in writing within 10 calendar days of the adverse action. The written request for appeal must be received by Optum within 30 calendar days of the date on the letter which notified you of any adverse action decision. Failure to request the appeal within this time frame constitutes a waiver of all rights to appeal and acceptance of the adverse action.

The appeal process includes a formal hearing before at least three clinicians, appointed by Optum. The Appeal Committee members are not indirect economic competition with you, and have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. You may be represented by a person of your choice at the appeal hearing, including legal counsel. At the conclusion of the hearing you have five business days to submit further documentation for consideration. The Appeal Committee’s decision is by a majority vote of the members. The decision of this Committee is final, and may uphold, overturn, or modify the recommendation of Optum. Correspondence regarding the decision is sent to the Clinician or Facility, by First Class

mail, postage prepaid and properly addressed, overnight delivery, facsimile or email, within 30 calendar days of the hearing date if submission of further written statements is waived or within 30 calendar days after the clinician's or facility's submission of any final written statements is due to the Appeals Committee. Receipt shall be deemed delivered and received by a care provider on the 3rd business day after mailing or actual date of delivery if by overnight, facsimile or email.

Continuation of Services after Termination

Network Clinicians, Group Practices and Agencies who withdraw from the Optum network are required to notify Optum, in writing, 90 calendar days prior to the effective date of termination, unless otherwise stated in your agreement or required by state law. With the exception of terminations due to quality-related issues, suspected fraud, waste or abuse or change in license status, clinicians are obligated to continue to provide treatment for all Optum members under their care. The timeline for continued treatment is up to 90 calendar days from the effective date of the contract termination, or as outlined in your agreement or until one of the following conditions is met, whichever is shortest:

- The member is transitioned to another Optum clinician
- The current episode of care has been completed
- The member's Optum benefit is no longer active

Please note that state-specific laws will be followed when they provide for a different post-termination timeframe.

To ensure continuity of care, Optum will notify members affected by the termination of a clinician, group practice or agency at least 30 calendar days prior to the effective date of the termination whenever feasible. Optum will assist these members in selecting a new clinician, group or agency. You are also expected to clearly inform members of your impending non-participation status upon the earlier of member's next appointment or prior to the effective termination date, in compliance with your agreement.

Network facilities that withdraw from the network are required to notify Optum, in writing, 120 calendar days prior to the date of termination unless otherwise stated in your agreement or required by state law. The Care Advocate may continue to issue authorizations for treatment during the termination period at the Optum contracted rate, as provided by your agreement.

To help ensure there is no disruption in a member's care, Optum has established a 120 calendar-day transition period for voluntary terminations. If a facility's participation is terminated due to quality-related issues, fraud or change in license status requiring immediate transfer of a member to another facility, Optum and the facility will coordinate to ensure a safe and effective transition of care.

In some cases, you and the Care Advocate may determine it is in the best interest of a member to extend care beyond these timeframes. Optum will arrange to continue authorization for such care at the Optum contracted rate. You may continue to collect all applicable copayments and deductible amounts. The facility continues under contract at the existing rates through the completion of the episode of care at any level of care provided by the facility. Members may not be balance billed.

6.6 Benefit Plans, Authorizations, and Access to Care

Optum establishes guidelines and requirements for care providers. Where required by law, more stringent standards may be applied. However, if state law permits the application of less stringent standards, the Optum standards specified herein shall still be applied pursuant to the terms of your agreement.

All members shall be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other patients of the care provider. Covered services will be available and accessible to all members.

The Americans with Disabilities Act

Care providers are expected to comply with protections and accommodations as covered by the Americans with Disabilities Act. This includes, but is not limited to, protections against discrimination that limit or prevent access to services based on the presence of the disability and modifications to facilities or equipment that accommodate individuals to gain access to services offered for which they are eligible.

Care Advocates

Care Advocates focus on activities that impact members' stabilization and recovery, and promote active participation in their care. This approach consists of targeted interventions intended to facilitate member services, identify members who may be at risk, and to assist you in the coordination and delivery of care to members. This approach supports a collaborative relationship between you and the Care Advocate. Care Advocate activities include:

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

Care Advocate Availability

The Clinical Operation Site is open for standard business operations Monday through Friday from 8 a.m. to 5 p.m. Central time zone. In addition, Care Advocates are available 24 hours a day, seven days a week, including holidays and weekends, to discuss urgent and emergent situations such as inpatient admissions, clinical benefit determinations and decisions, appeals, or any other questions about the care advocate process.

KanCare Clinical Operations Site Location:

Optum
10895 Grandview Dr, #200
Overland Park, KS 66210
877-542-9235

Affirmative Incentive Statement

Care Advocate decision-making is based only on the appropriateness of care as defined by the **Level of Care Guidelines, Coverage Determination Guidelines, Psychological and Neuropsychological Testing Guidelines**, the member's Benefit Plan, and applicable state and federal laws. The Level of Care Guidelines were developed to produce consistency in decision-making by the Care Advocates and medical staff and to help you reach optimal clinical outcomes. You will find these, along with the **Best Practice Guidelines, Supplemental and Measurable Guidelines**, and the **Coverage Determination Guidelines at Provider Express** or you can receive a paper copy from Network Management.

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

Eligibility Inquiry

The services a member receives are subject to the terms and conditions of the KanCare Benefit Plan with which he or she participates. It is important that you inquire about what services are covered and the member's enrollment status before providing services. This will help to ensure that you see members eligible to access this agreement and the services you provide.

We encourage you to discuss with the member the importance of keeping you informed of changes in coverage or eligibility status. Optum will not always have the eligibility information at exactly the same time as the organization that controls the eligibility decisions. Therefore, the member is often your best source for timely information about eligibility and coverage changes. The agreement states that if an individual was not eligible for coverage for services rendered, those services shall not be eligible for payment by Optum. Members who are no longer eligible to access this agreement under a benefit plan revert to the status of being a private paying patient, and you may bill them directly in accordance with applicable law.

Access to Behavioral Health Services

Members have access to behavioral health services through Optum's state-wide KanCare network of clinicians, groups and facilities for all levels of care. In general, out-of-state services are limited to specific emergency services. Due to the proximity of several cities in neighboring states, there is an exception allowing for members to access routine services from care providers in communities within a 50 mile range of the Kansas border. Care providers may contact the Provider Service Center at 877-542-9235. for information on referring patients for behavioral health services.

Clinical and Benefit Review Process

When a request for services is received, Optum will review member benefit eligibility, gather required clinical information, reference the appropriate criteria set, and determine whether the requested care meets medical necessity criteria. Optum may certify levels of care and treatment services that are specified as available under the specific benefit plan (e.g., acute inpatient, residential, intensive outpatient, or outpatient).

Routine Outpatient Services

Authorization for Mental Health and Substance Use Disorder Benefits

Optum shall permit members to access services without Prior Authorization under the following circumstances for covered services:

Members shall be able to access all behavioral health outpatient services (mental health and substance use) without a referral up to a pre-specified initial authorization service limit. In addition any service for any woman who is pregnant or has dependent children can be accessed without a referral up to the established initial authorization service limits. For services above these limits, prior authorization is required and may be obtained by members or care providers. Care providers must ensure that the prior authorizations are in place before rendering non-emergent services. Care providers should be prepared to provide the following information: the member’s name, address, and identification number, as well as the subscriber’s name and date of birth.

Care providers should discuss member’s treatment plan as well as visits used. Members should request additional services as needed, prior to the pre-specified limits expiring.

Mental Health	
Covered Services	Initial Authorization Limits Renew Annually
Individual Therapy	No limits
Group Therapy	No limits
Family Therapy (in office+home based)	No limits
Psychological Testing	Authorization required for more than six hours of testing per day
Early Childhood Assessment	No authorization requirements.
Case Conference	No authorization requirements.
Attendant Care (Non-waiver)	No authorization requirements
Community Psychiatric Support & Treatment	No authorization requirements
Targeted Case Management	No authorization requirements
Psychological Rehabilitation – Individual	No authorization requirements
Psychological Rehabilitation – Adult Group	
Psychological Rehabilitation – Child Group	
Peer Support	No limits
Crisis	Re-evaluation is required by QMHP every 72 hours

Substance Use Disorders

Care providers must notify Optum by phone 877-542-9235 for Substance Use Disorder services prior to admitting a member to any level of care not specified below.

The KanCare program relies on the American Society of Addiction Medicine (ASAM) as the criteria used to make determinations for all substance use disorder requests.

See the following table for Service Levels and Authorization Limits.

Substance Use Disorders	
Service Level	Initial Authorization Limits
Level 1 – Outpatient Services	60 hours over six months
Level 2 – Intensive Outpatient	45 days over 15 weeks
Level 3.1 – Reintegration Services	30 days
3.3/5 – Residential Intermediate Services	14 days
3.7D – Residential Acute Detox	Pending State Guidelines

Covered SUD Services include:

Service
Level 1 Outpatient
Individual Counseling
Group Counseling
Level 2 Intensive Outpatient Treatment/Partial
Intensive Outpatient
Level 3 Residential/Inpatient Treatment
3.1 Reintegration
3.3 Intermediate
3.5 Intermediate
3.7D Acute Detoxification
Auxiliary Services
Assessment/Referral
Medicaid Case Management
Peer Support
Crisis Intervention

When a member calls seeking referrals, Optum staff will collect demographic information, request coordination of benefits information, explain the services available under the member’s benefit plan, and obtain a brief description of the presenting problem (s). Referrals are based on the clinical , cultural, and geographic needs of the member. The member is responsible for contacting the clinician to schedule an appointment. The member is advised of the number of sessions available under the benefit plan. The member will be given multiple clinician names and numbers from which to choose to schedule an appointment.

When a pre-authorization is required, care providers should ensure member’s coverage through the secure functions available at UHCprovider.com or by calling Optum directly.

This authorization will be valid for the dates specified subject to the member’s continued eligibility and terms of the benefit plan. Optum expects all treatment provided to Optum members be outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. If the member is still in treatment when the authorization expires, you will need to request continued authorization by calling the Clinical Operations site.

MH/SUD Medication Management Services

Eligible prescribers are not required to obtain prior authorization for the initial consult, routine medication management sessions and other routine outpatient services.

Pharmaceutical Management

Pharmacy benefits are managed by OptumRx. The Pharmacy Help Desk number is 888-306-3243. For a copy of the Pharmacy Preferred Drug List or for Prior Authorization contact UHCprovider.com.

Autism Services

Autism services require prior authorization by an Autism Care Advocate. Please be aware that not all membership have coverage for ABA (Applied Behavioral Analysis) services under the program and prior to beginning care, autism care providers must contact us to verify eligibility, review treatment plans and obtain authorization.

ABA/Autism Waiver		
ABA/AU Waiver	Adaptive Behavioral Treatment – First 30 minutes	Authorization required
ABA/AU Waiver	Adaptive behavioral treatment – Each additional 30 minutes	Authorization required
ABA/AU Waiver	Family adaptive behavioral treatment	Authorization required
ABA/AU Waiver	Intensive Individual Supports/services adaptive behavioral treatment by protocol First 30 minutes	Authorization required
ABA/AU Waiver	Intensive Individual Supports/services adaptive behavioral treatment by protocol Each additional 30 minutes	Authorization required
ABA/AU Waiver	Behavior identification assessment, untimed	Authorization required
ABA/AU Waiver	Observational behavioral follow-up assessment for the first 30 mins	Authorization required

ABA/AU Waiver	observational behavioral follow-up assessment — each additional 30 mins)	Authorization required
AU Waiver	Autism Respite Care	168 hours or 672 units per calendar year
AU Waiver	family adjustment counseling	Authorization required
AU Waiver	Autism - Parent Support & Training	30 hours or 120 units per calendar year: individual, group or combo
AU Waiver	Autism - Parent Support & Training (Group)	30 hours or 120 units per calendar year: individual, group or combo

SED Waiver		
SED Waiver	Community-Based Wrap Around Services	Authorization required
SED Waiver	Parent Support and Training – Individual	Authorization required
SED Waiver	Parent Support and Training – Group	Authorization required
SED Waiver	Short Term Respite Care	Authorization required
SED Waiver	Professional Resource Family Care	Authorization required
SED Waiver	Attendant Care – 1915(b) – SED Waiver	Authorization required
SED Waiver	Independent Living/Skills Building	Authorization required

Telehealth

Telehealth seeks to develop a program of assertive outreach and telemedicine programming capabilities where MH/SUD services may be less available.

Consultations, office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided by telecommunication technology. The consulting or expert care provider must bill the procedure code (CPT Codes) using the GT modifier and will be reimbursed at the same rate as a face-to-face service. The originating site, with the member present, should bill with the telemedicine originating site facility code.

Authorization for Inpatient and Sub-acute Services

Optum will maintain the following access standards for screening for institutional care:

- Post-Stabilization: within one hour from initial contact to arrival of care provider in an emergency room
- Emergent: within one hour
- Urgent: 24 hours from referral

Inpatient admissions will be directed only to participating hospitals and attending psychiatrists. All inpatient and sub-acute level of care admissions require pre-authorization by the network care provider or facility. This includes:

- Inpatient Treatment
- Residential Treatment (Substance use and Psychiatry Residential Treatment Program)
- Intensive Outpatient Program Treatment for Substance Use
- Outpatient Electro-Convulsive Treatment
- Methadone Maintenance

Note: Plan exclusions are applied where applicable.

Network care providers are solely responsible for obtaining pre-authorization prior to providing these services, where applicable.

Be prepared to discuss clinical issues related to the member, such as symptom severity, functional impairment and risk factors. A complete copy of the Level of Care Guidelines is available at **Provider Express**. You may also request a paper copy of these guidelines from Network Management.

Services provided to members in an inpatient psychiatric or substance abuse unit are reviewed initially and may be reviewed concurrently by licensed clinicians. These reviews provide information regarding the patient's status and need for continued inpatient care. Optum reserves the right to require a direct conversation with the attending psychiatrist before authorizing benefits for any inpatient stay. For all potential non-coverage determinations based on relevant Optum guidelines, Optum makes a peer reviewer available to you before the decision is made so that you may provide additional information about the case. If you do not contact Optum prior to the expiration of the decision time frame, the peer reviewer will still be available to discuss the basis of a non-coverage determination. If you have received an authorization letter or a non-coverage determination letter and you wish to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, please call the toll-free number in the letter. If benefits are not authorized, Optum will support clinicians or facility staff to maximize benefits that are available.

Emergency Admissions

If an emergency admission for a member requiring immediate treatment and stabilization due to an MH/SUD condition, facilities should stabilize and treat the member as soon as possible. Circumstances that warrant an emergency admission are those in which there is a clear and immediate risk to the safety of the member or another person as a direct result of mental illness or substance use disorder. Facilities should also immediately notify Optum.

A medically necessary admission following stabilization in an emergency room may require authorization prior to the admission. Depending on the member's benefit plan and your facility agreement, charges for ER services may be considered part of the facility inpatient per diem in the event the member is admitted to the facility.

If appropriate, Optum will retrospectively certify coverage of admissions for emergency services provided; however, depending on the specific circumstances of each individual case, Optum reserves the right to deny coverage for all or part of an admission. All requests for retrospective reviews must be received by Optum within 180 calendar days of the date the services were provided to the member, unless state law mandates otherwise.

Psychiatric Residential Treatment Facilities (PRTF)

Psychiatric Residential Treatment Facilities are multidisciplinary/multi-modal treatment programs, provided within a 24 hour secure environment. This treatment environment is psychiatrically supervised and is used when a member cannot be safely maintained in a less restrictive/less intrusive environment. It is potentially available to member's who are between the ages of five and 18 years of age. Authorization is required for PRTF services.

Established level of care guidelines can be found at providerexpress.com.

Retrospective Review Process

A retrospective review occurs only on those rare occasions when an initial request authorization, when required, is made after services have already been delivered but no claim has been filed. Retrospective review requests must be submitted within 180 calendar days following the date(s) of service unless otherwise mandated by state law. For all retrospective reviews, Optum will issue a determination within 30 calendar days of receipt of the request, unless otherwise requested by state law. Any retrospective review request received outside the established time frame will not be processed by Optum.

Psychological/Neuropsychological Testing

All psychological/neuropsychological testing over six hours in duration must be pre-authorized.

Psychological testing is considered after a standard evaluation (including clinical interview, direct observation and collateral input, as indicated) has been completed and one of the following circumstances exists:

- There are significant diagnostic questions remaining that can only be clarified through testing
- There are questions about the appropriate treatment course for a patient, or a patient has not responded to standard treatment with no clear explanation, and testing would have a timely effect on the treatment plan
- There is reason to suspect, based on the initial assessment, the presence of cognitive, intellectual and/or neurological deficits or impairment that may affect functioning or interfere with the patient's ability to participate in or benefit from treatment, and testing will verify the presence or absence of such deficits or dysfunction

Generally, psychological testing purely for educational evaluations, learning disabilities, developmental delays, admission to organizations, or judicial requirements is not covered. Also not covered are tests performed routinely as part of an assessment or tests to determine the extent of potential neurological damage. Requests for neurological assessments are most often channeled through a neurologist for initial evaluation. This service is typically covered under the member's medical benefit plan, and may not be considered a behavioral health benefit. To determine benefit coverage you should pursue a benefits determination in order to coordinate financial responsibilities with the member.

If you have questions regarding coverage for psychological testing, interpretation or report writing you will find **Testing Guidelines and Operational Guidelines** at **Provider Express** under "Guidelines/Policies," then "Psychological/ Neuropsychological Testing Guidelines." You may also contact the appropriate Clinical Operations site at 877-542-9235.

Access to Outpatient MH/SUD

As part of our Quality Management and Improvement Program, and to help ensure all members have access to appropriate treatment as needed, we develop, maintain, and monitor a network with adequate numbers and types of clinicians and outpatient programs. We require that the network adhere to specific access standards, which are outlined in the following table:

Routine Outpatient – MH	Members will be offered an initial appointment within 10 calendar days.
Routine Outpatient – SUD	Assessment within 14 days of initial contact. Treatment services are delivered within 14 days of assessment.
Urgent If not addressed in a timely way could escalate to an emergency situation Life threatening emergencies Imminent risk of harm or death to self or others due to a medical or psychiatric condition Post Inpatient Discharge If you are unable to see the member during this time, refer to another in-network care provider to satisfy this deadline	Referral within 24 hours. Services delivered within 48 hours of initial contact. Referral is immediate. All members must be seen within 72 hours post discharge.
Special Health Care Needs: IV Drug users, identified as having used drugs within the last six months, will need to be seen for treatment	Within 14 calendar days of initial contact.
Special Health Care Needs: identified as pregnant women	Within 24 hours of assessment.
Missed an Appointment The Optum Care Advocate for behavioral services will contact members who have missed a post-discharge appointment to reschedule that appointment	Within 24 hours.

Optum expects members will generally have no more than a 15 minute wait time for their appointment in your office. In addition, any rescheduling of an appointment must occur in a manner that is appropriate for the member’s health care needs and ensures continuity of care consistent with good professional practice.

If you are unable to take a referral, immediately direct the member to the number on the back of his or her insurance card so he or she can obtain a new referral.

Border City Providers

Licensed Mental Health Practitioners can provide services under the border city designation. Border communities must be within 50 miles of the Kansas border. Practitioners must be in the Optum network to provide authorized covered services. Practitioners will need to meet credentialing and contracting guidelines.

Continuation of Services after Termination

Network clinicians, group practices and agencies who wish to withdraw from the Optum network are required to notify Optum, in writing, 90 calendar days prior to the effective date of termination, unless otherwise stated in your agreement or required by state law. With the exception of terminations due to quality-related issues, change in license status, or suspected fraud, waste or abuse, clinicians are obligated to continue to provide treatment for all Optum members under their care for 90 calendar days after the effective date of the contract termination until one of the following conditions is met (whichever is shortest):

- The member is transitioned to another Optum network clinician
- The current episode of care has been completed
- The member's Optum benefit is no longer active

State-specific laws will be followed when they provide for a different post-termination timeframe.

To help ensure continuity of care, Optum will notify members affected by the termination of a clinician, group practice or agency at least 30 calendar days prior to the effective date of the termination whenever feasible. Optum will assist these members in selecting a new clinician, group or agency. You are also expected to clearly inform members of your impending non-participation status upon the earlier of member's next appointment or prior to the effective termination date, in compliance with your agreement.

Network facilities that withdraw from the Optum network are required to notify Optum, in writing, 120 calendar days prior to the effective date of the termination, unless otherwise stated in your agreement or required by state law. The Care Advocate may continue to issue authorizations for treatment during the termination period at the Optum contracted rate as provided by your agreement. To help ensure there is no disruption in a member's care, Optum has established a 120-calendar-day transition period for voluntary terminations. In the event that a facility's participation is terminated due to quality-related issues, fraud or change in license status requiring immediate transfer of a member to another facility, Optum and the facility will coordinate to ensure a safe and effective transition of care.

In some cases, you and the Care Advocate may determine it is in the best interest of the member to extend care beyond these timeframes. Optum will arrange to continue authorization for such care at the Optum contracted rate. You may continue to collect all applicable copayments and deductible amounts. The facility continues under contract at the existing rates through the completion of the episode of care at any level of care provided by the facility. Members may not be balance billed.

6.7 Treatment Philosophy

Introduction

We are committed to creating and maintaining relationships with network care providers. We believe that optimal treatment is attained when delivered in the setting that is both the least restrictive and the one with the greatest potential for a favorable outcome. Based on more than 20 years of experience, we know it is the efforts of our clinical network that give our members the best opportunity to achieve a level of functioning that supports their quest to live healthier lives. As a result, our priority is creating relationships with network care providers that ensure appropriate, time-effective clinical treatment. Through this partnership we look to foster positive outcomes for members receiving behavioral health services.

In accordance with your agreement, you are required to provide services in a manner that is consistent with professional and ethical standards as set forth by national certification and state licensing boards, and applicable law and/or regulation regardless of a member's benefit plan or terms of coverage. Resources are available to you which outline the expectations for Optum network treatment quality.

This manual addresses assessment, treatment and discharge planning, coordination of care, and member rights and responsibilities (see also the "Treatment Record Documentation Requirements" section of this manual). Additional resources in these areas can be found at Provider Express. Select "Clinical Resources", and then click on "Guidelines/Policies", "Patient Education" or "Forms", and then click on find the following guidelines, including but not limited to:

- Level of Care Guidelines
- Psychological/Neuropsychological Testing Guidelines
- Coverage Determination Guidelines
- Best Practice Guidelines
- Supplemental and Measurable Guidelines

Optum participates with NCQA quality of care measures and incorporates these standards into our requirements and guidelines. In addition to **Provider Express**, the newsletter, *Network Notes*, serves as a bi-annual communication for news and policy updates of interest to the network.

Level of Care Guidelines

Our Level of Care Guidelines are intended to promote optimal clinical outcomes and consistency in the authorization of benefits by Care Advocates and medical staff. They are available at **Provider Express** or you may request a paper copy by contacting Network Management. ASAM criteria are used when authorizing services for substance use disorders. They are available at asam.org.

Best Practice Guidelines

We have adopted Best Practice Guidelines from external nationally recognized organizations. The guidelines cover a number of, but not all, diagnostic categories. Included in these guidelines are high-volume diagnostic categories and disorders that have significant evidence of being "high risk". In addition, we have created **Supplemental and Measurable Guidelines** which provide objective and evidence-based measurable components for some conditions. Links to these guidelines may be found at **Provider Express**.

Coverage Determination Guidelines

Our **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. They are available on **Provider Express** or you may request a paper copy by contacting Network Management.

Managing Expectations through Education

We encourage you to educate members about what to expect during treatment. Members benefit from clear explanations about their diagnosis, prognosis, treatment plan, including the projected length and course of treatment, and the potential benefits of medication, if medication is indicated. You can assist members in managing their expectations by explaining that treatment will be focused on their current presenting problems and symptoms. Establishing realistic expectations sets the stage for greater treatment adherence.

We encourage you to discuss all treatment options and the associated risks and benefits, regardless of whether the treatment is covered under the member's benefit plan. Nothing in this manual is intended to interfere with your relationship with members as patients.

Assessment

Thorough clinical assessments are required, and should be included in the clinical record. The biopsychosocial history includes previous medical and behavioral health conditions, interventions, outcomes, and lists current and previous medical and behavioral health care providers. The mental status exam includes an evaluation of suicidal or homicidal risk. A substance use screening should occur for members over the age of 11 years, noting any substances abused and treatment interventions. Other areas to be covered in the assessment are developmental history, education, legal issues, and social support. Cultural and spiritual considerations should be covered. A note should also be made of any community resources accessed by the member. A culmination of these assessment aspects, including negative findings, will yield a solid treatment diagnosis utilizing all current DSM-5 axes.

Treatment Discharge Planning

Effective discharge planning addresses how a member's needs will be met during transition from one level of care to another or to a different treating clinician. This planning begins with the onset of care and should be documented and reviewed over the course of care. Treatment planning will focus on achieving and maintaining a desirable level of functioning after the completion of the current episode of care. Effective treatment and discharge planning is a key indicator of the ongoing health and well-being of a member following acute care. (See also the "Treatment Record Documentation Requirements" section of this manual.)

Care Advocates will work with you to begin the discharge or treatment planning process for members at the time that services are initiated. As appropriate, the discharge or treatment planning process will involve you, a Care Advocate, the member, the member's family and/or representative, the clinician at the next level of care, and/or relevant community resources. Discharge planning involves assessment of the member's needs including current functioning, resources, and barriers to treatment access or compliance.

Discharge instructions should be specific, clearly documented and provided to the member prior to discharge. We expect that a patient's follow-up appointment from an acute inpatient level of care will be scheduled prior to discharge and within 72 hours of the date of discharge. We will work with care providers to ensure that this time frame is met. Care providers must notify us when they are unable to obtain an appointment within the time frame and we will assist with additional referrals.

Throughout the treatment and discharge planning process, it is essential that members be educated regarding the importance of enlisting community support services, communicating treatment recommendations to all treating professionals, and adhering to follow-up care. Members have the right to decline permission to release information to other treating professionals, but should be informed about the potential risks and benefits of this decision and how it affects coordination of care.

Communication with Primary Care Providers and Other Health Care Professionals

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

- It confirms for a primary care provider that his or her patient followed through on a behavioral health referral
- It minimizes potential adverse medication interactions for members who are prescribed psychotropic medication
- It allows for better management of treatment and follow-up for members with coexisting behavioral and medical disorders
- It can reduce the risk of relapse with members in some populations, as with substance use disorders

The following guidelines are intended to facilitate effective communication between you and primary care providers and other health care professionals involved in a member's care:

- During the diagnostic assessment session, request the member's written consent to exchange information with all appropriate treatment professionals
- After the initial assessment, provide other treating professionals with the following information within two weeks:
 - Summary of member's evaluation
 - Diagnosis
 - Treatment plan summary (including any medications prescribed)
 - Primary clinician treating the member
- Update other behavioral health and/or medical clinicians when there is a change in the member's condition or medication(s)
- Update other health care professionals when serious medical conditions warrant closer coordination
- At the completion of treatment, send a copy of the discharge summary to the other treating professionals
- Attempt to obtain all relevant clinical information that other treating professionals may have pertaining to the patient's mental health or substance use problems

Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum, as well as accrediting organizations, expect you to make a "good faith" effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the member.

Member Rights and Responsibilities

You will find a copy of our Member Rights and Responsibilities at the end of this manual. You may request a paper copy by contacting Network Management. These rights and responsibilities are in keeping with industry standards. All members benefit from reviewing these standards in the treatment setting. We request that you display the Patient Rights and Responsibilities in your waiting room, or have some other means of documenting that these standards have been communicated to Optum members.

The Clinical Technology Assessment Committee (CTAC)

The CTAC meets quarterly to review current medical and scientific literature. An Optum Medical Director chairs this multidisciplinary committee that includes at least one external clinician on a standing basis. In addition, this committee consults on an as-needed basis with professionals who are actively working with relevant technology and/or clinical issue(s) that may be affected by the technology under review. This Committee examines the use of new technologies and new applications of existing technologies for the assessment and treatment of behavioral health conditions. The Committee also reviews existing technologies when questions arise as to their application. The Committee recommends as "best practices" those treatments for which there

is published scientific evidence of efficacy and safety. This evidence must consist of controlled studies of adequate sample size, published in established peer-reviewed journals. State and federal regulations are reviewed to determine whether any regulations are in place that may support or have proven the use of a technology.

If you have a technology you would like to have reviewed by this committee, please contact the Clinical Operations site with which you most often work. Make your request to the Medical Director for that region and he or she will notify the committee chair of your interest.

Services of Interpreters

It is typically your responsibility to arrange for the services of interpreters, when indicated, for members under your care. Interpreter services can be arranged by contacting the Optum Clinical Operations through UnitedHealthcare Community Plan of Kansas at 877-542-9238. These services are free of charge.

6.8 Treatment Record Documentation Requirements

Introduction

Based on your agreement, you are required to maintain high quality medical, financial and administrative records (including appointment or scheduling books) related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community, and conform to all applicable laws and regulations including, but not limited to, state licensing and/or national certification board standards.

To perform required utilization management and quality improvement activities, Optum may request access to such records, including, but not limited to, claims records and treatment record documentation. You are permitted under HIPAA treatment, payment or healthcare operations to provide requested records as contractually required. In accordance with HIPAA and the definition of treatment, payment or healthcare operations, you must provide such records to the member or his/her personal representative upon request. Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to Optum and its payors, customers, clinicians, and facilities.

Optum may review your records during a scheduled on-site audit or may ask you to submit copies of the records to Optum for review. An on-site audit and/or treatment record review may occur for a number of reasons, including, but not limited to:

- Reviews of facilities without national accreditation such as The Joint Commission, CARF or other agency approved by Optum
- Audits of high-volume clinicians
- Routine random audits
- Audits related to claims coding or billing issues
- Audits concerning quality of care issues identified by Optum or brought to Optum's attention by members, family members or their representatives
- Audits of clinicians with a home office
- Audits related to a member complaint regarding the physical environment of an office or facility

The audits may focus on the physical environment (including safety issues), policies and procedures, and/or thoroughness and quality of documentation within treatments records. Optum has established a passing performance goal of 85% for both the treatment record review and on-site audit. On-site audit or treatment record review scores under 85% will require a written Corrective Action Plan (CAP). Scores under 80% require submission of a written CAP and a re-audit within six months of the implementation of the CAP.

Treatment Record - Content Standards

- Optum expects that all non-electronic treatment records are written legibly in blue or black ink, and at a minimum include:
 - The member’s name or identification number on each page of the record
 - The member’s address; employer or school; home and work telephone numbers, including emergency contacts; marital or legal status; appropriate consent forms; and guardianship information
- Treatment record entries include the date and start and stop time of service, CPT code billed, notation of session attendees, the responsible clinician’s name, professional degree, license, and relevant identification number
- Treatment records should be made contemporaneously with treatment description and include the date of entry; if records are not contemporaneously made with treatment, then the date of service should be noted along with date of entry
- Clear and uniform modifications; any error is to be lined through so that it can still be read, then dated and initialed by the person making the change
- Clear documentation of medication allergies, adverse reactions and relevant medical conditions; if the member has no known allergies, history of adverse reactions or relevant medical conditions, this should be prominently noted
- Clear and uniform medication tracking that provides a thorough picture of all medications taken by the patient from the onset of care through discharge includes the following:
 - Standing, P.R.N. and STAT orders for all prescription and over-the-counter medications
 - The date medications are prescribed along with the dosage and frequency
 - Informed member consent for medication, including the member’s understanding of the potential benefits, risks, side effects, and alternatives of the medications
 - Changes in medication and/or dosage should be clearly documented along with the clinical rationale for the changes
 - Discharge summaries should specify all medications and dosages at the time of discharge
- A clear summary of presenting problems, the results of mental status exam(s), relevant psychological and social conditions affecting the member’s medical and psychiatric status, and the source of such information
- Prominent documentation (assessment and reassessment) of special status situations, when present, including but not limited to imminent risk of harm, suicidal or homicidal ideation, self-injurious behaviors, or elopement potential. It is also important to document the absence of such conditions
- A medical and psychiatric history including previous treatment dates, clinician or facility identification, therapeutic interventions and responses, sources of clinical data, and relevant family information
- For children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic)
- For members 12 years of age and older, documentation includes past and present use of cigarettes or alcohol, as well as illicit, prescribed or over-the-counter medications

- Documentation of a DSM-5 diagnosis consistent with the presenting problem(s), history, mental status examination, and other assessment data
- Treatment plan documentation needs to include the following elements:
 - Specific symptoms and problems related to the Axis I diagnosis of the treatment episode
 - Critical problems that will be the focus of this episode of care are prioritized
 - Relates the recommended level of care to the level of impairment
 - Member (and, when indicated, family) involvement in treatment planning
 - Treatment goals must be specific, behavioral, measurable, and realistic
 - Treatment goals must include a time frame for goal attainment
 - Progress or lack of progress towards treatment goals
 - Rationale for the estimated length of the treatment episode
- Progress notes include:
 - Member strengths and limitations in achieving treatment plan goals and objectives
 - Treatment interventions that are consistent with those goals and objectives
 - Dates of follow up visits
 - Documentation of missed appointments
- Documentation of on-going discharge planning (beginning at the initiation of treatment) includes the following elements:
 - Criteria for discharge
 - Identification of barriers to completion of treatment and interventions to address those barriers
 - Identification of support systems
- A discharge summary is completed at the end of the treatment episode that includes the following elements:
 - Reason for treatment episode
 - Summary of the treatment goals that were achieved
 - Specific follow up activities/aftercare plan
- Documentation of coordination of care activities between the treating clinician or facility and other behavioral health or medical clinicians, facilities, or consultants. If the member refuses to allow coordination of care to occur, this refusal and the reason for the refusal must be documented. Coordination of care should occur:
 - At the initiation of treatment
 - Throughout treatment as clinically indicated
 - At the time of transfer to another treating clinician, facility, or program
 - At the conclusion of treatment
- Documentation of referrals to other clinicians, services, community resources, and/or wellness and prevention programs
- When care involves more than one family member, separate treatment records must be maintained
- Billing records should reflect the member who was treated and the modality of care

Guidelines for Storing Member Records

The following are additional guidelines for completing and maintaining treatment records for members.

- Practice sites and facilities must have an organized system of filing information in treatment records.
- Treatment records must be stored in a secure area and the site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable laws and regulations, including HIPAA.
- The site must have a process in place to ensure that records are available to qualified professionals if the treating clinician is absent.
- Treatment records are required to be maintained for a minimum period of seven years from the date of service, or in accordance with applicable state or federal laws or regulations, whichever is longer. Termination of the agreement has no bearing on this requirement.
- Financial records concerning covered services rendered are required to be maintained from the date of service for ten years, or the period required by applicable state or federal law, whichever is longer. Termination of the agreement has no bearing on this requirement.

Member Access to Medical/Mental Health Records

A member, upon written request and with proper identification, may access his/her records in the possession of Optum. Before a member is granted access to his/her records, the record will first be reviewed to ensure it contains only information about the member. Confidential information about other family members in the record will be redacted.

6.9 Privacy Practices

Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law enacted to ensure privacy and security of a consumer's Protected Health Information (PHI). PHI is basically defined as individually identifiable health information that is transmitted or maintained in any form or medium. A few examples of PHI include an individual's name, social security number or consumer identification number, address, and date of birth.

All aspects of our operations are compliant with the required HIPAA privacy practices as well as other applicable state and federal laws. Below are some of the highlights of these practices.

Uses and Disclosures of PHI

We have established policies relating to requests for and disclosure of PHI in accordance with HIPAA and other applicable federal and state laws. These policies ensure that only the minimum amount of information necessary is disclosed to accomplish the purpose of the disclosure or request.

Release of Information

It is our policy to release information only to the individual, or to other parties designated in writing by the individual, unless otherwise required or allowed by law. For each party that the individual designates permission to access their PHI, he or she must sign and date a Release of Information specifying what information may be disclosed, to whom, and during what period of time. This policy is not applicable to PHI being exchanged with a network clinician, facility or other entity designated by HIPAA for the purposes of Treatment, Payment, or Health Care Operations.¹

Identification and Authentication

We require anyone requesting access to PHI be appropriately identified and authenticated. Members and personal representatives, for example, are required to provide the member identification number or subscriber number and the member's or subscriber's date of birth. You or your administrative staff are identified and authenticated in a number of ways and may be asked for your federal tax identification number or physical address as part of this verification process.

¹ "Treatment, Payment, or Health Care Operations" as defined by HIPAA include: 1) Treatment – Coordination or management of health care and related services; 2) Payment purposes – The activities of a health plan to obtain premiums or fulfill responsibility for coverage and provision of benefits under the health plan; and 3) Health Care Operations – The activities of a health plan such as quality review, business management, customer service, and claims processing.

Internal Protection of Verbal, Written and Electronic PHI

Optum works with Optum's Information Risk Management team to ensure that all physical and logical safeguards are in place to protect against the unauthorized use, disclosure, modification, and destruction of PHI across all media (e.g., paper records and electronic files). All employees of Optum receive training and are familiar with the HIPAA privacy practices relevant to their job duties and responsibilities.

Disclosure to Plan Sponsors or Employers

Summary health information may be released to a plan sponsor² without the authorization of the affected individual. This information may be used for the purpose of obtaining premium bids or modifying, amending, or terminating the group health plan. It may also be used for providing access to employees of an employer or Plan Sponsor to carry out administrative duties of a health plan related to treatment, payment or health care operations.

Members receive privacy notices outlining the uses and disclosures of their PHI and their rights, as well as the legal duties of their health plan to ensure protection of their PHI under HIPAA. This Privacy Notice is posted on our member website, liveandworkwell.com and **Provider Express** under "**Privacy & HIPAA**", or is available in paper copy by contacting Network Management.

National Provider Identifier

The purpose of a National Provider Identifier (NPI) is to improve the efficiency and effectiveness of the electronic transmission of health information. The implementation of this provision in 2007 is in compliance with HIPAA. We require the billing clinician to include NPI information on all electronic claims. In addition to all electronically submitted claims, some states mandate that the NPI be used on all claims (whether paper or electronic submission is used). For more information about obtaining an NPI, you may contact the **Center for Medicare and Medicaid**. For additional information about claims processing, visit **Provider Express** > Home page > Admin Resources > NPI resources.

6.10 Quality Improvement

Participation in the UnitedHealthcare Quality Improvement Program

We are committed to the highest quality of care provided in a manner consistent with the dignity and rights of members and to meeting or exceeding customer expectations. Our Quality Improvement (QI) Program monitors: accessibility; quality of care; appropriateness, effectiveness and timeliness of treatment; and member satisfaction. The QI Program is comprehensive and incorporates the review and evaluation of all aspects of the managed behavioral health care delivery systems. If you have any feedback regarding QI projects and processes, please contact Network Management.

UnitedHealthcare has a Quality Management Committee (QMC), chaired by the CEO or designee of the CEO, which meets quarterly at a minimum and has oversight responsibility for issues affecting health services delivery. It is the decision-making body ultimately responsible for the implementation, coordination and integration of all quality improvement activities for the health plan. The QMC is composed of UnitedHealthcare management staff and reports its recommendations and actions to the UnitedHealthcare Board of Directors. The QMC has three standing sub-committees:

- **Provider Advisory Subcommittee** reviews and recommends action on topics concerning credentialing and recredentialing of care providers and facilities, peer review activities, and performance of all participating care providers. Participating care providers give UnitedHealthcare advice and expert counseling medical policy, quality management, and quality improvement. A Medical Director chairs the Provider Affairs Subcommittee.
- **Health Care Quality and Utilization Management Subcommittee** reviews statistics on utilization, provides feedback on Utilization Management and Case Management policies and procedures, and makes recommendations on clinical standards and protocols for medical and psychiatric care.
- **Service Quality Improvement Subcommittee** reviews timely tracking, trending and resolution of member administrative complaints and grievances. This subcommittee oversees member and care provider intervention for quality improvement activities as needed.

Cooperation with quality improvement activities

All participating physicians and care providers must cooperate with all quality improvement activities. These include, but are not limited to, the following:

- Timely provision of medical records upon request by us or our contracted business associates;
- Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans;
- Participation in quality audits, including site visits and medical record standards reviews, and annual Health Care Effectiveness Data and Information Set (HEDIS®) record review;
- If we request medical records, provision of copies of such records free of charge (or as indicated in your agreement with us) during site visits or by email, secure email, or secure fax.

Sentinel Events

Sentinel events are defined as a serious, unexpected occurrence involving a member that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services, which has, or may have, deleterious effects on the member, including death or serious disability, that occurs during the course of a member receiving behavioral health treatment. If you are aware of a sentinel event involving a member, you must notify Optum Care Advocacy within one business day of the occurrence by calling the number on the back of the member's ID card.

We have established processes and procedures to investigate and address sentinel events. This includes a centralized Sentinel Event Committee, chaired by medical directors within Optum, and incorporates appropriate representation from the various behavioral health disciplines. You are required to cooperate with sentinel event investigations.

Member Satisfaction Surveys

On at least an annual basis, we conduct a member satisfaction survey of a representative sample of members receiving outpatient and inpatient behavioral health services within the Optum network. The results of the survey are reviewed. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Clinician Satisfaction Surveys

We regularly conduct a satisfaction survey of a representative sample of clinicians delivering behavioral health services to members. This survey obtains data on clinician satisfaction with Optum services including care advocacy, network services and claims administration.

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

Practice Guidelines

Optum has adopted clinical guidelines from nationally recognized behavioral health organizations and groups. We also have Supplemental and Measurable Guidelines based on existing nationally recognized guidelines, additional literature review and clinician input. The development of these Supplemental and Measurable Guidelines is driven by quality initiatives aimed at improving clinical outcomes for Members. The adopted **Best Practice Guidelines** and the **Supplemental and Measurable Guidelines** are available through **Provider Express**. On the home page left sidebar “QuickLinks” menu, select “Guidelines/Policies”. Your feedback is encouraged on all guidelines and any suggestions on new guidelines to be considered for adoption are welcome. If you would like a paper copy of these guidelines please contact Network Management.

Complaint Investigation and Resolution

You are required to cooperate with Optum in the complaint investigation and resolution process. If Optum requests written records for the purpose of investigating a member complaint, you must submit these to Optum within 14 business days, or sooner as requested. Complaints filed by members should not interfere with the professional relationship between you and the member. QI staff, in conjunction with Network Management staff, monitors complaints filed against all clinicians and facilities, and solicits information from them in order to properly address member complaints. In general, resolution of most complaints is communicated to the member when the complaint is received from, or on behalf of, the member. QOC complaints do not generally include notification of resolution except as required by state law.

Optum requires the development and implementation of appropriate Corrective Action Plans (CAP) for legitimate problems discovered in the course of investigating complaints. Such action may include, but is not limited to, having Optum:

- Require you to submit and adhere to a CAP
- Monitor you for a specified period, followed by a determination about whether substandard performance or noncompliance with Optum requirements is continuing
- Require you to use peer consultation for specific types of care
- Require you to obtain specific additional training or continuing education
- Limit your scope of practice in treating members
- Hold referrals of any members to your care by changing your availability status to “unavailable” and/or reassigning members to the care of another participating clinician or facility
- Terminate your participation status with Optum

Cooperation with an unavailable status associated with complaint, quality-of-care or sentinel event investigations may include:

- Informing members of unavailable status at the time of an initial request for services, and identifying other network clinicians or facilities to provide services or referring the member to Optum for additional referrals
- Informing current members of status and their option to transfer to another network clinician or facility
- Assisting with stable transfers to another network clinician or facility at the member's request

Audits of Sites and Records

On-site and record-only audits may occur with any contracted care provider. Both types of audits involve reviewing a sampling of treatment records. The on-site audit also involves a review of policies and procedures, including policies related to hiring and supervision of staff, discussion of services that are offered and a tour of the facility or office site.

Optum representatives conduct site visits at clinician offices, agencies such as community mental health centers (CMHCs), facilities and group provider locations. On-site audits are routinely completed with clinicians who have a clinical office in their home or who offer services in the homes of members, and CMHCs and facilities that do not meet the accreditation criteria listed below. In addition, audits are completed to address specific quality of care issues or in response to member complaints about the quality of the office or facility environment.

Facilities and CMHCs that hold national accreditation through organizations such as the Joint Commission, CARF, COA, HFAP, CHAP, AOA, ACHC, DNV, CAH, DNV TJC, and/or AAAHC; or who can provide a copy of their most recent Kansas government agency survey (may not be older than 36 months) or a letter from the Kansas government agency stating that the facility is in substantial compliance with the most recent survey standards will receive credit for meeting those standards of care for the identified accredited services or programs without additional review prior to the initial credentialing process. KanCare facilities and CMHCs that do not meet these criteria will be required to participate in an on-site audit prior to credentialing and a recredentialing audit prior to their specified recredentialing timeframe. Any facility or CMHC, regardless of their accreditation status, maybe subject to an on-site audit for any member complaints or suspected quality of care concerns brought to the attention of Optum.

During on-site and record-only audits for all types of care providers, chart documentation is reviewed, including (but not limited to) the assessment, diagnosis, treatment plan, progress notes, coordination of care activities, and discharge planning. This process also verifies that services were provided to members. You are expected to maintain adequate medical records on all members and document in the record all services that are provided. Prior to the audit, you will be notified of the specific types of charts that will be reviewed. Failure to adequately document services that are rendered and/or dates of services may lead to a request for a Corrective Action Plan (CAP). Please see the "Treatment Record Documentation Requirements" section of this manual for more information.

The audit tools are based on NCQA, the Joint Commission and Optum standards. These forms are used during audits and are available at Provider Express for reference.

Member Education

We offer a variety of Health and Wellness Tip sheets for members. These are educational materials, written in common, everyday language. Topics include, but are not limited to general therapy issues, self-help, mood and anxiety disorders, and substance use disorders and address child, adult and elderly populations. You are encouraged to distribute these to members as appropriate.

Health and Wellness Tips are available at liveandworkwell.com or you can request paper copies by contacting Network Management.

6.11 Compensation and Claims Processing

Compensation

The network rate for eligible outpatient visits is reimbursed to you at the lesser of (1) your customary charge, less any applicable copayments, coinsurance and deductibles due from the member, or (2) the Optum fee maximum, less any applicable copayments, coinsurance and deductibles due from the member.

The contracted rate for facilities is referenced in the Payment Appendix of the facility agreement and defines rates applicable to inpatient and/or outpatient care through that facility. When the contracted rates include care provider fees, the facility is responsible for payment of all treating care providers and for notifying the care providers that payment will be made by the facility and not Optum.

Financial records concerning covered services rendered are required to be maintained from the date of service for the greater of 10 years, or the period required by applicable state or federal law, whichever is longer. Any termination of the agreement has no bearing on this legal obligation.

Balance Billing For Covered Services is Prohibited

Under the terms of the agreement, you may not balance bill members for covered services provided during eligible visits, which means you may not charge members the difference between your billed usual and customary charges and the aggregate amount reimbursed by Optum and member expenses.

Billing for Non-Covered Services and “No Shows”

If you seek prior authorization of benefits for behavioral health services or authorization for continued treatment, and Optum does not authorize the requested services, the member may not be billed.

Optum does not pay for sessions a member fails to attend. You may not bill Optum for such sessions or services. A member who misses a scheduled appointment may not be billed. Members are never to be charged a deposit or advance payment for a potential missed appointment.

Claims Submission

Unless otherwise directed by Optum, a care provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, (its equivalent or successor) whichever is appropriate, with applicable coding including, but not limited to, ICD-10 diagnosis code (s) CPT, revenue and HCPCS coding.

The care provider shall include in a claim the member number, customary charges for the MHSA services rendered to a member during a single instance of service, the care provider’s federal tax I.D. number and/or other identifiers requested by Optum.

In addition, you are responsible for billing of all members in accordance with the nationally recognized CMS Correct Coding Initiative (CCI) standards. Please visit the **CMS website** for additional information on CCI billing standards.

Although claims are reimbursed based on the network fee schedule or facility contracted rate, your claims should be billed with your usual and customary charges indicated on the claim. For information about fast and efficient electronic claims submission, please see **Provider Express “Improve the speed of payment— Tips for Claims Filing.”**

Claim Entry through a Designated Claims Portal: Care providers will be able to submit claims electronically through one or more designated secure, HIPAA-complaint portals. UHCprovider.com will be one of those options. As further information is available Optum will inform the Provider Network and provide any needed training or assistance.

EDI/Electronic Claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a payor (Optum). You may choose any clearinghouse vendor to submit claims through this route. Because Optum has multiple claims payment systems, it is important for you to know where to send claims. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. For Optum claims use Payer ID 96385. Additional information regarding EDI, is available on Provider Express “Claims Tips”.

Clinician Claim Forms: Paper claims can be submitted using the CMS-1500 claim form. Paper claims must be mailed to UnitedHealthcare. The claims should include all itemized information such as diagnosis code (ICD-10 code as listed in DSM-5), length of session, member and subscriber names, member and subscriber dates of birth, member identification number, dates of service, type and duration of service, name of clinician (i.e., individual who actually provided the service), credentials, tax ID and NPI numbers. Clinician’s may file claims through an EDI vendor.

Facility Claim Forms: Paper claims should be submitted using the UB-04 billing format. Paper claims must be mailed to UnitedHealthcare. Claims should include all itemized information such as diagnosis code (ICD-10 code as listed in DSM-5), member name, member date of birth, member identification number, dates of service, procedure (CPT-4) and/or revenue codes, name of facility and federal tax ID number of the facility, the NPI, and billed charges for the services rendered. After receipt of all of the above information, participating facilities are reimbursed according to the appropriate rates asset forth in the facility’s agreement. Facilities may file claims through an EDI vendor.

Anti - Fraud, Waste and Abuse (FWA): Optum has an Anti-Fraud, Waste and Abuse Program in place. You agree to remain in compliance with Optum’s FWA Program. Please review the Anti-Fraud, Waste and Abuse section of this manual.

Customer Service Claims Help

Optum has a dedicated customer service department with staff available five days a week during regular business hours to assist our network with questions related to general information, eligibility verification or the status of a claim payment. The main Optum/ KanCare customer service phone number is 877-542-9235.

Coordination of Benefits (COB)

Some members are eligible for coverage of allowable expenses under one or more additional health benefit plans. In these circumstances, payment for allowable expenses shall be coordinated with the other plan(s). It is your responsibility to inquire and collect information concerning all applicable health plans available to a member and communicate such information to Optum.

If Optum is a secondary plan, you will be paid up to the Optum contracted rate. You may not bill members for the difference between your billed usual and customary charge and the amount paid by the primary plan(s) and Optum.

NOTE: UnitedHealthcare follows KMAP TPL policy. All KMAP TPL billing requirements still apply.
Please refer to KMAP General TPL Payment Provider manual. Clarification to this care provider manual will be added at a later date.

Processing and Payment of Claims

All information necessary to process claims must be received by Optum no more than 90 calendar days from the date of service, or as allowed by state or federal law or specific member benefit plans. Claims received after this time period may be rejected for payment at the discretion of Optum and/or the payor. You may not bill the member for claim submissions that fall outside these established timelines. Any corrections or additions to a claim should be made within 90 days of receipt of the initial claim.

Claims should be submitted as directed by Optum. We strongly recommend that you keep copies of all claims for your own records. You permit Optum, on behalf of the payor, to bill and process forms for third-party claims or for third-party payors, and execute any documents reasonably required or appropriate for this purpose. In the event of insolvency of the member's employer or Optum, your sole redress is against the assets of Optum or the applicable payor, not the member. You must agree to continue to provide services to members through the period for which premiums have been paid. Any termination of the agreement has no bearing on this requirement.

Claims that contain all of the required information and match the authorization, if applicable, will be processed and paid or processed and denied within 30 calendar days after receipt. This may exclude claims that require Coordination of Benefits (COB) determinations. Benefits are payable provided coverage is in force at the time expenses are incurred, and are subject to all limitations, provisions and exclusions of the plan. You will be paid for covered services by Optum and will not under any circumstances seek payment through Optum for plans for which Optum is not the payor or administrator.

Optum may make corrective adjustments to any previous payments for services and may audit claims submissions and payments to ensure compliance with applicable policies, standards, procedures, including without limitation, the manual, the credentialing plan, the agreement, and state and federal law. Optum may obtain reimbursement for over payments directly or by offsetting against future payments due as allowed by law.

The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable state or federal laws.

Claims for Autism and SED Programs

Submit paper claims using the CMS-1500 claim form. You must mail paper claims to UnitedHealthcare Community Plan. The claims should include all itemized information such as diagnosis code (ICD-10 code as listed in DSM-5), length of session, member and subscriber names, member and subscriber dates of birth, member identification number, dates of service, type and duration of service, name of clinician (i.e., individual who actually provided the service), credentials, tax ID and NPI numbers (must be listed in box 24J) . Clinicians may file claims through an EDI vendor.

6.12 Anti-Fraud, Waste and Abuse

Optum believes that care providers are an integral part of our program integrity work. Protecting clients, providers and stakeholders through the prevention, early detection, investigation and ultimate resolution of potential Fraud, Waste and Abuse (FWA) issues is a fundamental component of quality care and sound clinical practice. We are pleased to work in consultation with care providers to find solutions that address potential FWA without adding unnecessary burdens to your office.

Federal law requires:

...the establishment of “Special Investigations Units” or their equivalents and the “Effective System for Routine Monitoring, Auditing and Identification of . . . Risks” and to “carry out appropriate corrective action” (Centers for Medicare and Medicaid Services (CMS) requirement).

At Optum, our “Special Investigations Unit” is called the Program and Network Integrity (PNI) department. This group of professionals is committed to a balanced approach to potential FWA including open and clear communication with the care provider community.

The PNI department is committed to appropriate corrective action on a continuum commensurate with the questionable activity. Actions include addressing simple mistakes and the need for education to fraudulent activity and referral to law enforcement. There is also a requirement to recover payments – it is critical that dollars not appropriately directed get recovered while education and other appropriate action is under way.

Optum is committed to:

- A comprehensive view of how PNI interacts with you
- Building and sustaining trust in care provider communities regarding FWA initiatives and activities
- Transparency into our activities
- Ensuring reliability and timeliness in our practice and methodology
- Overall education and awareness for the Network
- Soliciting critical feedback from the network and professional associations in developing long-term strategies for identifying and avoiding potential FWA

In summary, Optum is committed to addressing and correcting questionable activity and known offenses, recovering inappropriately paid funds, improving overall anti-Fraud, Waste and Abuse (FWA) ability and partnering with both the network and state and federal agencies to educate, pursue and prosecute violators to the fullest extent of the law.

Program Introduction

The FWA Program incorporates multiple components leveraging technology, expertise and collaboration in a proactive way. Program components include, but are not limited to the following: education and awareness, prevention, detection, investigation, system enhancement and capability, corrective action and recovery and resolution. The PNI team consists of clinicians, investigators, prospective intervention specialists, data analytics staff, certified coders and executive leadership.

Potential fraud, waste and/or abuse practices include, but are not limited to, the following:

Fraud	Waste	Abuse
Intentional misrepresentation to gain a benefit	Any unnecessary consumption of health care resources	Unsound business practice that can include inappropriate utilization and/or inefficient use of resources.
Example: Knowingly billing for a service(s) that were never performed.	Example: Billing for services 5X per week when 1X per week would have been medically appropriate. Please note that medical necessity is not something monitored or managed by the SIU.	Example: Billing for a 90792 (diagnostic evaluation) when individual therapy was performed.

The identification process includes, but is not limited to, examining claims to identify outlier claims billing patterns.

If potential fraud, waste and/or abuse is identified, appropriate corrective actions are implemented using a range of tools from education of care providers to full recoupment of improperly paid funds. Possible interventions may include, but are not limited to:

- Outreach meetings and/or written correspondence to care providers
- Records review and/or site audit
- Individual case peer-to-peer reviews, and
- Referral for further investigation

Care providers are contractually required to cooperate in this process and participate in any activities related to the identification and correction of potential fraud, waste, and abuse. Once an intervention has occurred, we continue to monitor to ensure that care providers adhere to all requirements for payment.

Code of Conduct and Conflict of Interest Policy Awareness

All care providers and affiliates working on Medicaid programs – including contracted care providers – must provide a copy of our Code of Conduct to employees and contractors.

You can obtain and review our **Code of Conduct**, at unitedhealthgroup.com > About > Ethics & Integrity, and provide this to your employees and contractors.

Education, Awareness & Compliance Training

All care providers and affiliates working on Medicaid programs must provide compliance program training and Anti-Fraud, Waste, and Abuse (FWA) training within 90 days of employment and annually thereafter (by the end of the year) to their employees and/or contractors. The training is subject to certain requirements, and may be obtained through sources outside your organization.

All care providers and affiliates meeting the FWA certification requirements through enrollment in the fee-for-service Medicare program are deemed by CMS rules to have met the training and education requirements. It is our responsibility to ensure that your organization is provided with appropriate training for your employees and applicable subcontractors. To facilitate that, we are providing training attestation materials on the **Forms page on Provider Express**. Home page > Admin Resources > Fraud, Waste & Abuse.

In compliance with federal regulations, you are required to administer the compliance and FWA training materials to your employees and/or contractors. If your organization has already completed a compliance and FWA training program— either on your own or through a Medicare plan – that meets CMS requirements, we will accept documentation of that training. You must maintain records of the training (e.g., sign-in sheets, materials, etc.) in compliance with CMS requirements. Documentation of the training may be requested at any time for verification that training was completed.

Prevention, Detection and Prospective Process

Among the ways we address prevention are education, use of rigorous credentialing standards, and proper contracting.

Optum has a prospective program that leverages technology to search through real-time claims data to alert us to anything unusual in that data in order to make a determination to pay or to investigate further. The FWA look back period or period of claims reviewed is normally determined by state and federal regulation.

Retrospective Investigations and Corrective Action Plan (CAP)

When potential fraud, waste and abuse is reported or detected we conduct an investigation to determine potential corrective action. A sample of retrospective FWA investigation actions may include, but is not limited to:

- Contacting care providers to obtain and review medical and billing records
- Reviewing care providers' disciplinary activity, civil or criminal litigation, and financial records
- Educating care providers on errors in their billing, and
- Negotiating with care providers regarding a corrective action plan and settlement of overpayment

Following investigation, timely payment is made or, in the event that a claim denial is issued, the denial notification includes the care provider's standard appeal rights.

Findings of billing inconsistent with our policies by in-network care providers may result in such actions as:

- Clarification of proper procedure
- A Corrective Action Plan (CAP)
- A change in network availability status, or
- May result in termination of a care provider's agreement

In the case of retrospective review, Optum and our payors reserve the right to pursue up to full recoupment of funds paid. The Credentialing Committee may recommend termination. If the care provider is notified in writing and provided with information about appeal rights, if applicable, and in compliance with state and federal laws. A care provider's voluntary termination from the network does not suspend or stop fraud, waste and/or abuse investigations or reviews, which may still be required by law.

Regulatory Reporting

Optum works closely with state and federal agencies in combating fraud, waste and abuse and periodically refers suspected and/or confirmed cases of fraud, waste and abuse to these agencies as required by regulation and contract.

Cooperation with State and Federal Agencies

Optum is committed to working with and cooperating fully with state and federal agencies in battling FWA. Optum will work diligently to fulfill all requests for investigative assistance, subpoenas and/or other investigative information requests. This includes but is not limited to providing information pursuant to civil and/or criminal proceedings as well as providing expert opinion or fact testimony at depositions and trials.

Optum will participate with and contribute to information sharing sessions, working groups, task forces and communication efforts to enhance the overall national anti-FWA effort. Optum will retain all records pursuant to these activities, and may be required to produce those records upon request in accordance with applicable laws and regulations.

As warranted, care providers will be reported to their respective State Department of Insurance, licensing board(s), and any other regulatory agencies based on the outcome of the investigation and as required by state and federal laws. Throughout this process, we adhere to state law, ERISA guidelines, and confidentiality standards.

Code of Conduct and Conflict of Interest Policy Awareness

All care providers and affiliates working on Medicare Advantage, Part D or Medicaid programs – including contracted care providers – must provide a copy of our Code of Conduct to employees and contractors.

You can obtain and review our Code of Conduct, at unitedhealthgroup.com > About > Ethics & Integrity, and provide this to your employees and contractors.

Exclusion/Sanction/Debarment Checks

As part of the Code of Federal Regulations (45 C.F.R. Part 76), all governmental entities receiving funding from the federal government must participate in a government wide system for non-procurement debarment and suspension. A person or entity who is debarred or suspended shall be excluded from federal financial and non-financial assistance and benefits under federal programs and activities. Debarment or suspension of a participant in a program by one agency shall have government wide effect. The Kansas Department for Aging and Disability Services (KDADS) is authorized to impose debarment. Before any person or entity enters into an agreement, grant or contract with Optum or KDADS, the System for Award Management” (SAM) (located at the website sam.gov/portal/public/SAM) shall be researched for potential debarred persons or entities.

All care providers and affiliates must review federal exclusion lists (HHS-OIG and GSA) at the time of hire/contracting with their current employee s/contractors, health care professionals, or vendors that work on Medicare Advantage, Part D or Medicaid programs to ensure that none are excluded from participating in Federal health care programs. For more information or access to the publicly accessible excluded party online databases, please see the following links:

- Health and Human Services – Office of the Inspector General (HHS-OIG) List of Excluded Individuals / Entities: oig.hhs.gov/exclusions/index.asp
- System for Award Management” (SAM) (located at the website sam.gov/portal/public/SAM)

What You Need to Do: Review applicable exclusion/sanction/debarment lists to ensure that none of your employees or contractors are excluded from participation in federal health care programs.

We have guidelines to address suspected fraud, waste and/or abuse by care providers. In accordance with your agreement, you are required to cooperate with the review process to include any requests for medical records.

When medical records are requested, you will receive a letter outlining specific information required which may include, but is not limited to:

- Counseling session start and stop times
- Medication prescription monitoring (if applicable)
- Modalities and frequencies of treatment furnished
- Results of clinical tests (if applicable), and
- Any summary of the following; diagnosis, functional status, treatment plan/goals, prognosis and progress to date

6.13 Appeals and Grievances

Introduction

A non-coverage determination, for the purposes of this section, is a decision by Optum to deny, in whole or in part, a request for authorization of treatment or of a request for payment. A non-coverage determination may be subject to the appeals process described in the Appeals Process section.

Care advocate decision-making is based on the appropriateness of care as defined by the Level of Care Guidelines, the Psychological and Neuropsychological Testing Guidelines, and the Coverage Determination Guidelines as well as the existence of coverage for the requested service in the member's plan.

The **Level of Care Guidelines**, the **Psychological Neuropsychological Testing Guidelines** and the **Coverage Determination Guidelines** are available at Provider Express. To request a paper copy of these guidelines, please contact Network Management. All treatment certified by Optum must be outcome-driven, clinically necessary, rational, evidence-based, and provided in the least restrictive environment possible.

Optum offers no financial rewards or other incentives for care providers, utilization reviewers or other individuals to reduce behavioral health services, limit the length of stay, withhold or deny benefit coverage.

Appeals Process

The appeals process is available to members, or their authorized representative, which may be their treating clinician at any level of care, in the event of a non-coverage determination. If Optum issues a denial, in whole or in part, then such determination will be subject to the applicable reconsideration or appeals process. The procedures for the appeals process, including any applicable state and/or federal requirements for the filing and handling of an appeal, will be disclosed in the notice of the non-coverage determination sent to you and the member.

Additional information on the provider grievance and appeal process and time-lines for submission of provider grievance and appeals can be found in Chapter 15 of the Provider Administrative Guides located at UHCCommunityPlan.com.

Additional information on the member grievance and appeal processes and time-lines for submission of member grievance and appeals can be found in Chapter 05 of the Provider Administrative Guides located at UHCCommunityPlan.com.

6.14 Manual Updates and Governing Law

Manual Updates

This manual may be updated periodically as procedures are modified and enhanced. Care providers will be notified a minimum of 30 calendar days prior to any material change to the manual unless otherwise required by regulatory or accreditation bodies. The current version of the manual is always available at Provider Express. You can view the manual online or download a complete copy from your computer. If you do not have internet access or printing capabilities, you may request a paper copy by contacting Network Management.

Governing Law and Contract

This KanCare Network Manual shall be governed by, and construed in accordance with, applicable federal, state and local laws as applicable for the KanCare membership. To the extent that the provisions of this Network Manual conflict with the terms and conditions outlined in your Provider Participation Agreement to include the corresponding KanCare Medicaid and CHIP Downstream Appendix, the subject matter shall first be read together to the extent possible; otherwise and to the extent permitted by, in accordance with, and subject to applicable law, statutes or regulations, the agreement shall govern.

6.15 Member Rights and Responsibilities

In the course of care, a member has both rights and responsibilities.

Member Rights

Optum believes and supports the proposition that every member has the right to:

- Be treated with respect and recognition of his or her dignity and right to personal privacy
- Confidentiality of information
- Receive care that is considerate and respectful of his or her personal values and belief system
- Reasonable access to care in a timely manner, regardless of race, religion, gender, sexual orientation, ethnicity, age, disability or communication needs
- Receive information about Optum and its services, practitioners and care providers, clinical guidelines, quality improvement program, member rights and responsibilities and any other rules or guidelines utilized to make coverage and payment decisions
- Be informed of rules and regulations concerning his or her own conduct
- Be informed, along with his or her family, of his or her Optum rights in a language they understand
- Participate with his or her practitioners or care providers in an informed way in making decisions about his or her health care
- A candid discussion with his or her treating professionals about appropriate or medically necessary treatment options and alternatives for his or her condition regardless of cost or benefit coverage
- Participate in treatment planning, if over the age of 12, and/or to have family members participate in treatment planning
- Designate a surrogate decision maker if he or she is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care

- Consent to or refuse treatment and to be informed of potential consequences that may be associated with choosing not to comply with recommended treatment
- Receive information regarding medications, (e.g., what they are, how to use them and possible side effects)
- Receive reasonable continuity of care, including information about continuing health care requirements following discharge from an inpatient facility
- Individualized treatment, including:
 - Adequate and humane services regardless of the source(s) of financial support
 - Provision of services within the least restrictive environment possible
 - An individualized treatment plan that is periodically reviewed and updated
 - An adequate number of competent, qualified and experienced professional clinical staff to supervise and carry out the treatment plan
- Participate in the consideration of ethical issues that may arise in the provision of care and services, including:
 - Resolving conflicts including those related to proposed or provided treatment
 - Developing an Advance Directive to include the decision to withdraw or withhold resuscitative or other life prolonging or sustaining services
 - Participating in investigational studies or clinical trials, and the member's right to refuse to participate in such research projects
- Voice complaints or appeals about his or her care provider or decisions made by Optum which could include treatment authorization, claims payment, or benefit interpretation issues without risk of subsequent discrimination
- Make recommendations regarding Optum's rights and responsibilities policies
- Be informed of the reason for any utilization management non-coverage determination, including the specific utilization review criteria or benefits provision used in the determination
- Have utilization management decisions based on appropriateness of care; Optum does not reward care providers or other individuals conducting utilization review for issuing non-coverage determinations for coverage or service
- Protection from unauthorized or inappropriate use of Personal Health Information (PHI) in all settings
- Receive a copy of the Optum Privacy Notice including information regarding Optum privacy practices.
- Request to obtain and inspect a copy of his or her PHI, to amend or restrict the use of his or her PHI and to receive an accounting of non-routine disclosures of the member's PHI
- Request confidential communications of PHI be sent to an alternate address or by an alternate means
- Voice complaints regarding use or disclosure of PHI
- Be informed that routine consent is given upon enrollment in the plan for Optum to use PHI as needed for Optum operations, such as: treatment, coordination of care, measurement and survey data collection, utilization review, billing and fraud detection
- Request a second opinion from a contracted professional within the Optum KanCare network at no cost to the member.
- Be free from any form of restraint and seclusion used for coercion, discipline, convenience or retaliation.

Member Responsibilities

In addition to the rights listed above, every member has the responsibility to:

- Learn and understand his or her rights.
- Know his or her plan benefits and abide by plan policies and procedures.
- Understand his or her health problems and participate in developing with his or her treating practitioner or care provider mutually agreed upon treatment goals to the degree possible.
- Follow plans and instructions for care that they have agreed upon with his or her treating care provider.
- Review information regarding covered services, exclusions, limitations, and policies and procedures as stated in member materials and his or her Certificate of Coverage.
- Pay any required deductibles, copayments and/or coinsurance at the time services are rendered.
- Provide to his or her treating care provider(s), to the extent possible, information necessary in order to receive appropriate care.

