QUICK GUIDE TO PROVIDER ORIENTATION

EVERYTHING YOU NEED TO KNOW IN 30 MINUTES OR LESS

TABLE OF CONTENTS

- Provider Services
- First Session Reminders
- Medical Necessity
- Utilization Management
- Claims
- Quality Improvement
- CPT Codes
- Contact Information

PROVIDER SERVICES

Assists with any issues related to credentialing, re-credentialing, contracting, provider relations and complaints

Contractual agreements include:

- Notifying Optum Public Sector Provider Services within 10 business days of changes to the status of your practice and demographics (i.e. name, address, areas of specialty, etc.)
- Attestations: Updating wait time for new clients 2x/per year, accuracy of information, completion of documentation training and 4 hours of cultural competency training annually
- Abiding by regulations as highlighted in the Fee For Service Provider Manual

Contact Provider Services to:

- Open or close your practice to new referrals
- Terminate your contract

FIRST SESSION REMINDERS

Prior to your first session, ensure the client's Medi-Cal eligibility

YOUR INTAKE MUST INCLUDE:

- Informed Consent
- Consent for Psychotropic Medication (as applicable)
- State Guide to Mental Health Services
- Limits of Confidentiality
- Notice of Privacy Practices
- See Quality Improvement section for complete list of intake requirements (initial client checklist available here)

DURING THE INTAKE:

- Assess for medical necessity (must be moderate to severe)
- If mild to moderate, refer to Managed Care Plan (MCP)

AFTER THE INTAKE:

- Submit the claim form to the Claims Department
- Submit the following to Utilization Management:
  - Demographic Form
  - Outpatient Authorization Request-Psychotherapy or Outpatient Authorization Request Form -Psychiatry

To assess for medical necessity...

MEDICAL NECESSITY EXAMPLES

MEETS CRITERIA WHEN:

- Acute risk for harm to self or others
- Psychosis
- Cognitive impairment
- Impulsive/aggressive
- Seriously incapacitated in daily activities
- Multiple mental health hospitalizations
- On conservatorship
- Chronic mental health conditions

REFER TO MCP WHEN:

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

For more information on determining medical necessity, CLICK HERE

Once you have determined your client meets medical necessity, submit your authorization request form to Utilization Management...

UTILIZATION MANAGEMENT

Dedicated outpatient team consisting of LCSWs, LMFTs and RNs to assist you in:

- Determining medical necessity
- Authorizing outpatient treatment
- Answer any questions you may have about Outpatient Authorization Request forms

OUTPATIENT AUTHORIZATION REQUEST FORM TIPS

- Complete all required sections of the form. The majority of the items on the Psychotherapy OAR and Psychiatry OAR are **required** to properly ensure the client is meeting Title 9 Medical Necessity. Incomplete forms will be returned

- Include current symptoms, clinical presentation and functional impairment

- The Begin Date for Sessions is the date you will start your sessions after the assessment (or the date you believe you will run out of sessions if requesting continued authorization)

- Client signature is needed on the form if you intend to use it as your client/treatment plan. The County of San Diego requires client signatures on client/treatment plans within 30 days of the initial assessment
    - If client refuses to sign OAR, document in a progress note that client agrees to treatment plan goals

OUTPATIENT AUTHORIZATION REQUEST FORM TIPS

(continued)

- The frequency of sessions must be specific. “ As needed” cannot be added to the authorization system. Please use “ 1x per week” , “2x per month”, etc.
- You can submit claims for Team Conference and Case Management, but you must be sure to include frequency of these services on the OAR
- SUBMIT ALL OARS WITH A COMPLETED DEMOGRAPHIC FORM
- Continuing treatment sessions are pre-authorized. Retroactive requests will be honored only within 30 days, so be timely!
- You will be notified whether your request has been authorized within 5 business days

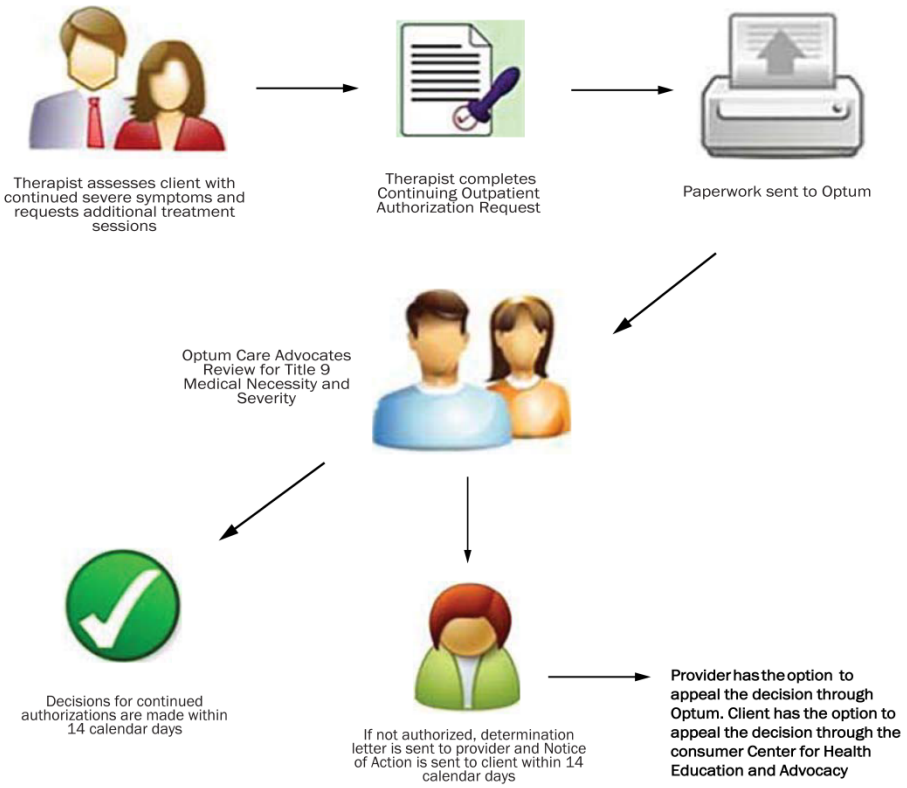
Remember, you can request an interpreter if needed, at no cost to you…

REQUESTING AN INTERPRETER

- Complete the Interpreter Services Authorization Form
- Follow the instructions and fill out ALL highlighted areas
- Do NOT sign the document. Optum is the entity approving the service
- Must be submitted via fax AT LEAST 2 business days prior to the appointment, or as soon as appointment is set
- Incomplete forms will be returned and will cause delays in processing

NEED MORE THAN 12 SESSIONS?

Repeat the process…



WHAT IF MY REQUEST WAS DENIED?

- Either you or the client can appeal the denied authorization request
- A Notice of Adverse Benefit Determination (NOABD) is sent to the client. The second page of the client NOABD explains in detail the clients rights and appeal options.
- Clients have access to the Consumer Center for Health Education & Advocacy (CCHEA) for support with appeals: (877)734-3258.
- A determination letter and a copy of the NOABD are sent to you explaining the reason for the denied authorization request. Your letter will explain how you can appeal the decision.
- Providers can submit an appeal request to the Optum Quality Improvement Department, in writing, within ninety (90) days on the determination letter.

Your sessions are now authorized, let's get you paid...

CLAIMS: WHAT YOU NEED TO DO TO GET PAID

TIPS:

- Verify your client's Medi-Cal eligibility monthly
- Ensure your client has been authorized for treatment by Utilization Management
- Complete and mail a CMS1500 form to file your claim
- Ensure the primary diagnosis on the claim form is a Title 9 Diagnosis
- Claim form must be submitted to Optum 60 calendar days from date of service

OOPS! *Was your claim denied due to an error?*

- Fax in a corrected claim form, indicating the form is a corrected claim in BOX 19
- Submit within 60 days of the Explanation of Benefits (EOB) but no later than 4 months from date of service

Now that you are up and running…

QUALITY IMPROVEMENT

Oversees:

- Clinical quality for all providers on the network
- Appeals for:
  - Authorization request denials
  - Recoupments due to treatment record reviews
- Serious Incident Reports
- Fee-for-Service re-credentialing site and treatment record reviews
- Fee-for--Service inpatient professional service reviews

FFS OUTPATIENT REVIEWS

- Each fee-for-service provider is reviewed once during each credentialing period as a requirement for re-credentialing
  - Reviews may also occur in response to a quality of care concern or at the request of the County of San Diego

- Types of reviews:
  - Site Review only: occurs when you have not had enough billable services to mandate a treatment record review
  - Treatment Record Review only: occurs when you do not see clients from a personal office space
  - Site and Treatment Record Review: occurs when you have had at least 5 paid services within the past year, at your personal office space

- This is what we look for:
  - Site Requirements
    - Don't have all the materials? Print them from our website or fill out this form
  - Treatment Record Requirements

TIPS AND TRICKS FOR A SUCCESSFUL REVIEW

REQUIREMENTS INCLUDE, BUT ARE NOT LIMITED TO:

- Client signature on informed consent
- Documentation of client participation with treatment plan (i.e. client signature on OAR, client signature on separate treatment plan or documented in progress note within 30 days of initial assessment)
- Progress note is present for each billed date of service
- The date on the progress note MUST match the date of service on the claim form
- Provider signature on each progress note
- “Signature on file” is not acceptable to meet the requirement of the client signature for treatment plan

CONSIDER USING THESE TEMPLATES:

- Assessment
- Therapy Progress Note
- Psychiatry Progress Note
- Discharge Summary

Recoupment Reasons Quick Guide

CPT CODES

Per your contracting agreement, you are responsible for knowing which CPT codes are available to you. Click below for a complete list of approved FFS CPT Codes:

- LMFT, LCSW, LPCC
- Ph.D, Psy.D
- PNP
- MD, DO

Be aware, CPT codes and documentation requirements thereof will be assessed during your treatment record review. Overbilling or failure to meet documentation requirements for the code billed can lead to recoupment

CONTACTS

Provider Line: 800-798-2254

- **Provider Services:**
  Option 7
  sdu_providerserviceshelp@optum.com
- **Utilization Management :**
  Option 3, then #3
- **Claims:**
  Option 2
- **Quality Improvement :**
  sdqi@optum.com

To verify a client's Medi-Cal eligibility:

- LMFT/LPCC: 800-798-2254 option 2
- MD/PNP/LCSW/Psy.D/Ph.D: 800-541-5555 or go to www.medi-cal.ca.gov

Fax Interpreter Request Form to: 866-220-4495

Fax Outpatient Authorization Requests to: 866-220-4495

Send Claims to:

Optum
PO Box 601340
San Diego, CA 92160-1340

Fax corrected claims to: 619-641-6975