



Optum Idaho

Clinical Model 2.1 “One Year In”

August 2016



Introduction of Optum staff

- Presenters

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Agenda

- Introductions
- Our Commitment
- Changes brought about by Clinical Model 2.1
 - Utilization Management
 - Service Categories
 - Removal of PECFAS/CAFAS requirement
- Service Trends
- Review of Medical Necessity
- Questions and Answers



Our Commitment to Idaho

With our shared goal of better outcomes for members, Optum's commitment to Idaho is to transform the behavioral health outpatient system of care.

Our approach is founded on a recovery and resiliency model that includes reliance on medical necessity guidelines offering the right care with the right intensity at the right time and in the right place.

Progress with the transition of Idaho's care provision is dependent upon communication between each of the groups involved in outpatient care, including members, providers, stakeholders and Optum.



Clinical 2.1 Changes

- Moved two more Category 3 services to Category 4, with relaxed prior authorization requirements
 - Case Management
 - Peer Support
- A one time extension on pre-service reviews if requested by the member, provider or insufficient clinical information is provided
- Use of a new Service Request Form that replaced the old UM Template did not significantly improve process or experience with preauthorization.
- Removed the requirement for a PECFAS/CAFAS on a service request
- Revised Level of Care Guidelines improved clarity with:
 - Case Management
 - CBRS
 - Peer Support Services
 - OP Psychotherapy Extended Sessions



Clinical Model 2.1: Current Service Categories 1-3

- Category 1: No authorization required
 - Assessments
 - Medication Management
- Category 2: Open authorization required
 - Individual Therapy
 - Group Therapy
- Category 3: Provider specific authorization required
 - Psychological and Neuropsychological Testing
 - Community Based Rehabilitation Services (CBRS)
 - Skills Training and Development, per 15 minutes; Partial Care



Clinical Model 2.1: Category 4

Case Management

Behavioral Health, Substance Abuse

Peer Support Services (PSS)

Family Support Services (FSS)

Crisis Services (H2011)

Crisis services should be used at the time of the crisis

Authorization for crisis services is completed on a retrospective basis (after the crisis)

Treatment Plan: the following services may bill using H0032

Peer Support Services, Case Management, CBRS

Extended Office Visits

May be used for EMDR

BH Assessment (H0031, no longer includes PECFAS/CAFAS)



Category 4 Thresholds (Per Member)

Crisis Management Services

- Threshold is currently **10 hours per calendar year**
- Additional services must be authorized
 - Post delivery of services for authorization process
 - Address denial via dispute process

Case Management

- Threshold will be **60 hours per calendar year**
- Additional services must be authorized
 - Prior authorization process
 - Address denial via dispute process

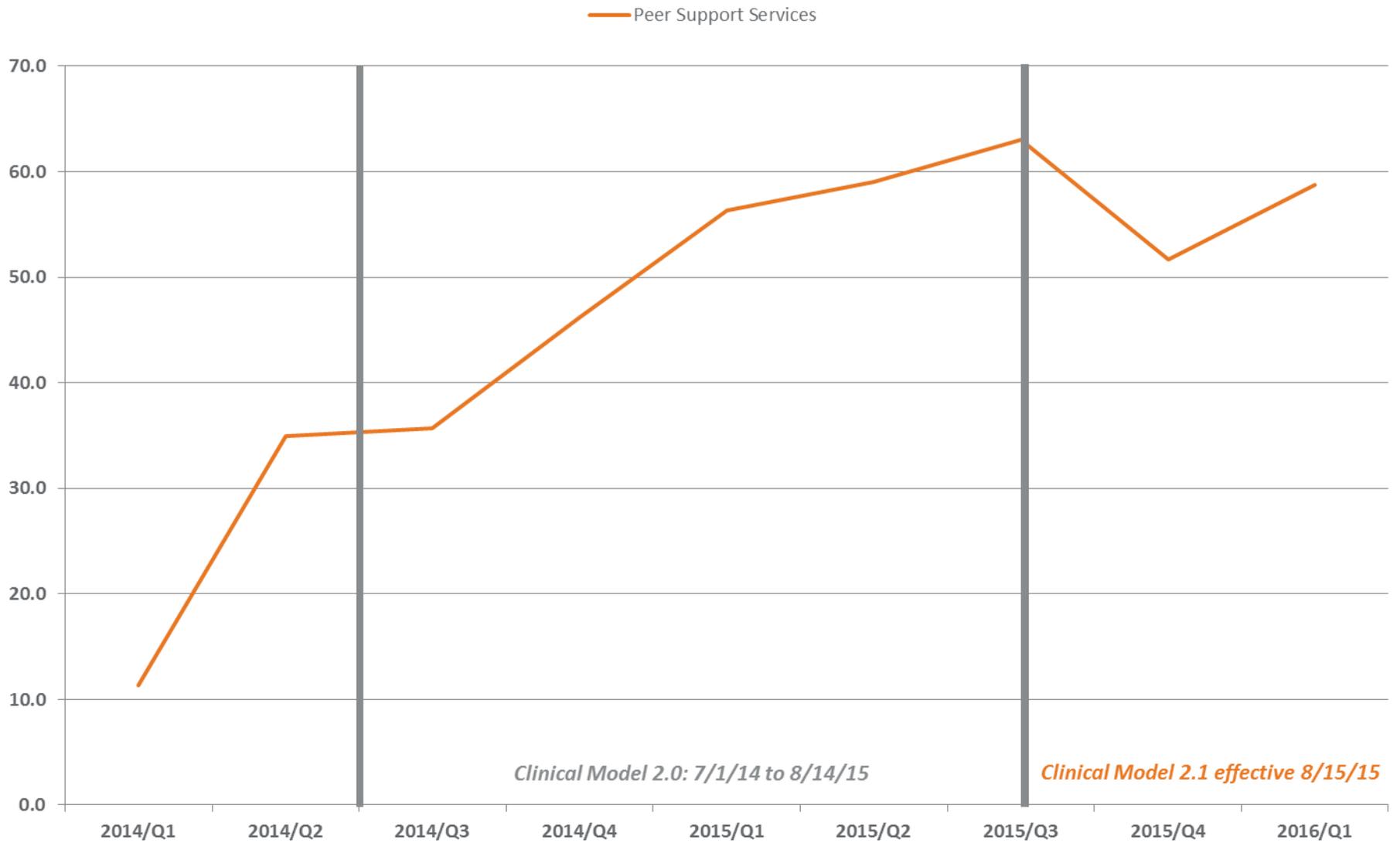
Family Support Services

- Threshold is **2 hours per week for 6 months**
- Additional services must be authorized
 - Prior authorization process
 - Address denial via dispute process

Peer Support Services

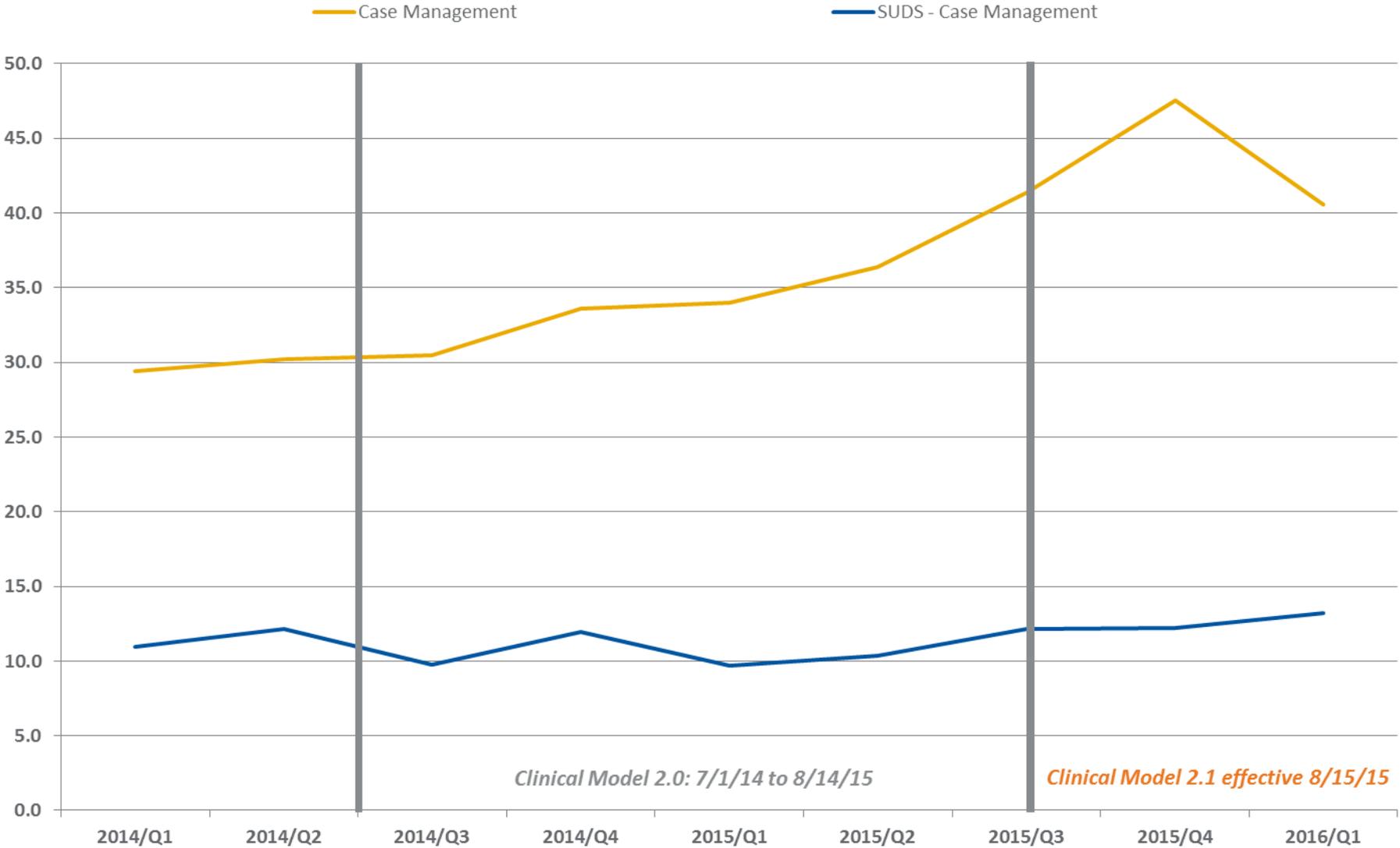
- Threshold will be **2 hours per week for 12 months (a full calendar year)**
- Additional services must be authorized
 - Prior authorization process
 - Address denial via dispute process

Peer Support Utilization: Avg Units per Member



Based on paid claim data by date the service was provided.

Case Management Utilization: Avg Units per Member

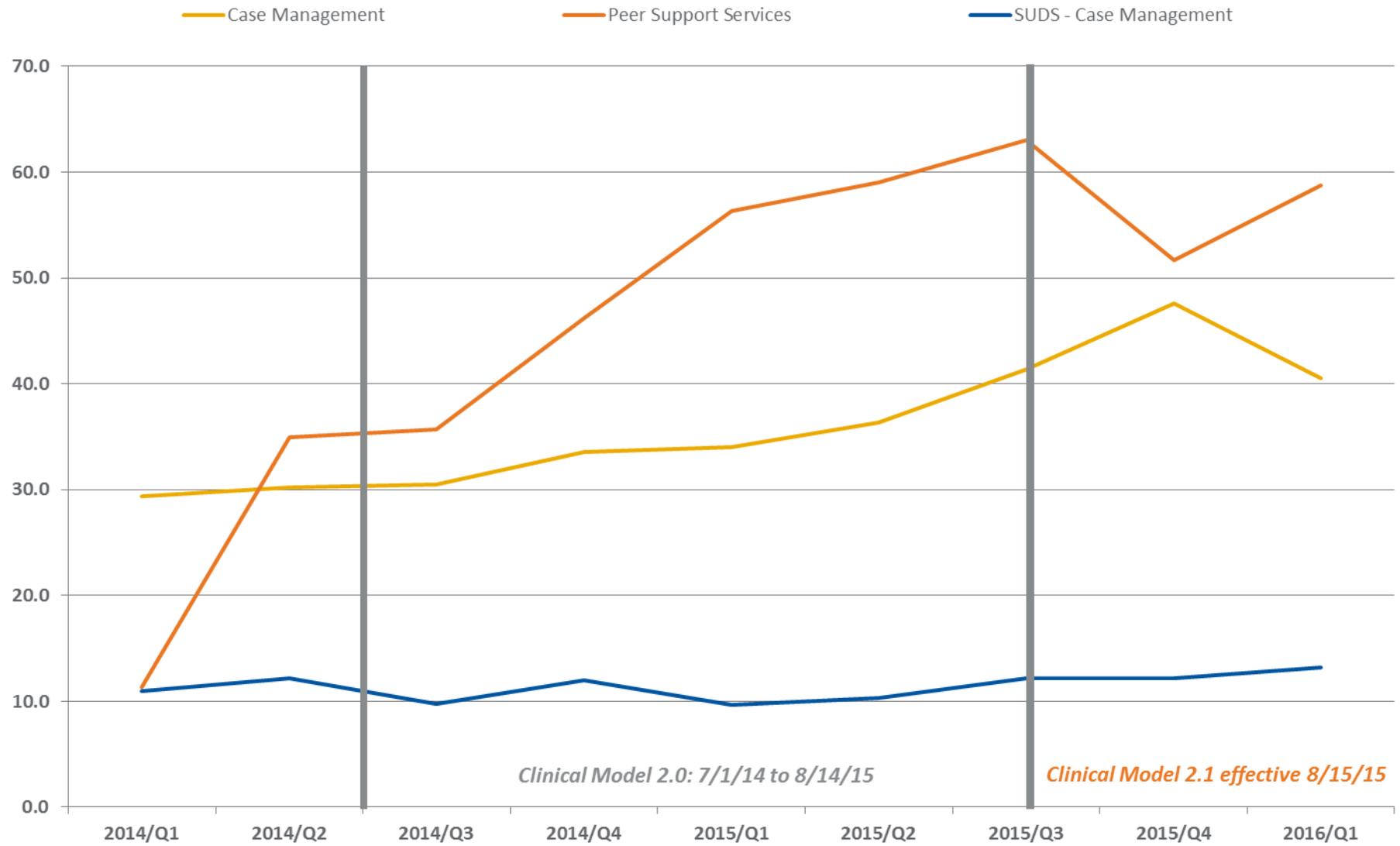


Clinical Model 2.0: 7/1/14 to 8/14/15

Clinical Model 2.1 effective 8/15/15

Based on paid claim data by date the service was provided.

Case Management and Peer Support Utilization: Avg Units per Member



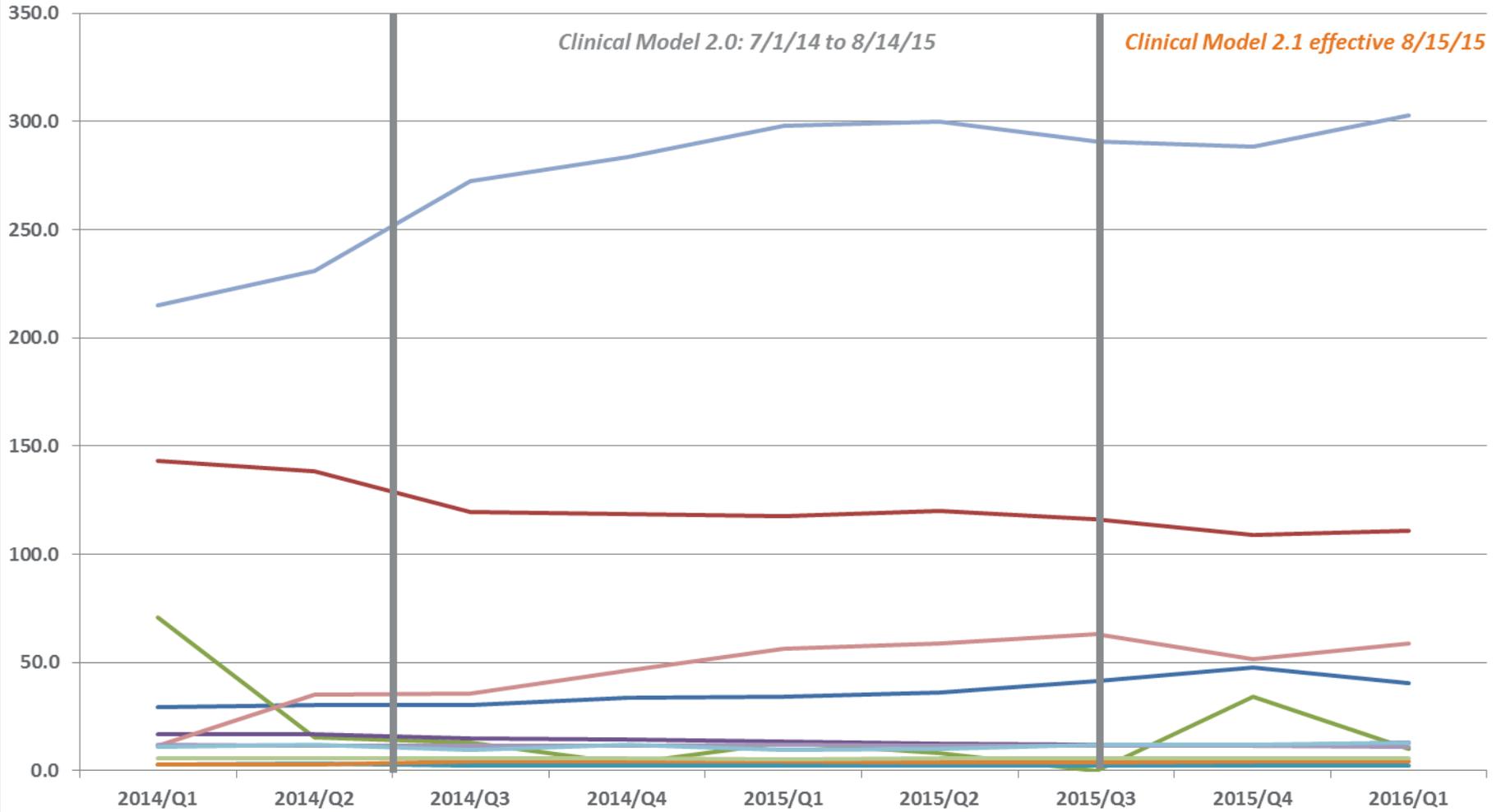
Clinical Model 2.0: 7/1/14 to 8/14/15

Clinical Model 2.1 effective 8/15/15

Based on paid claim data by date the service was provided.

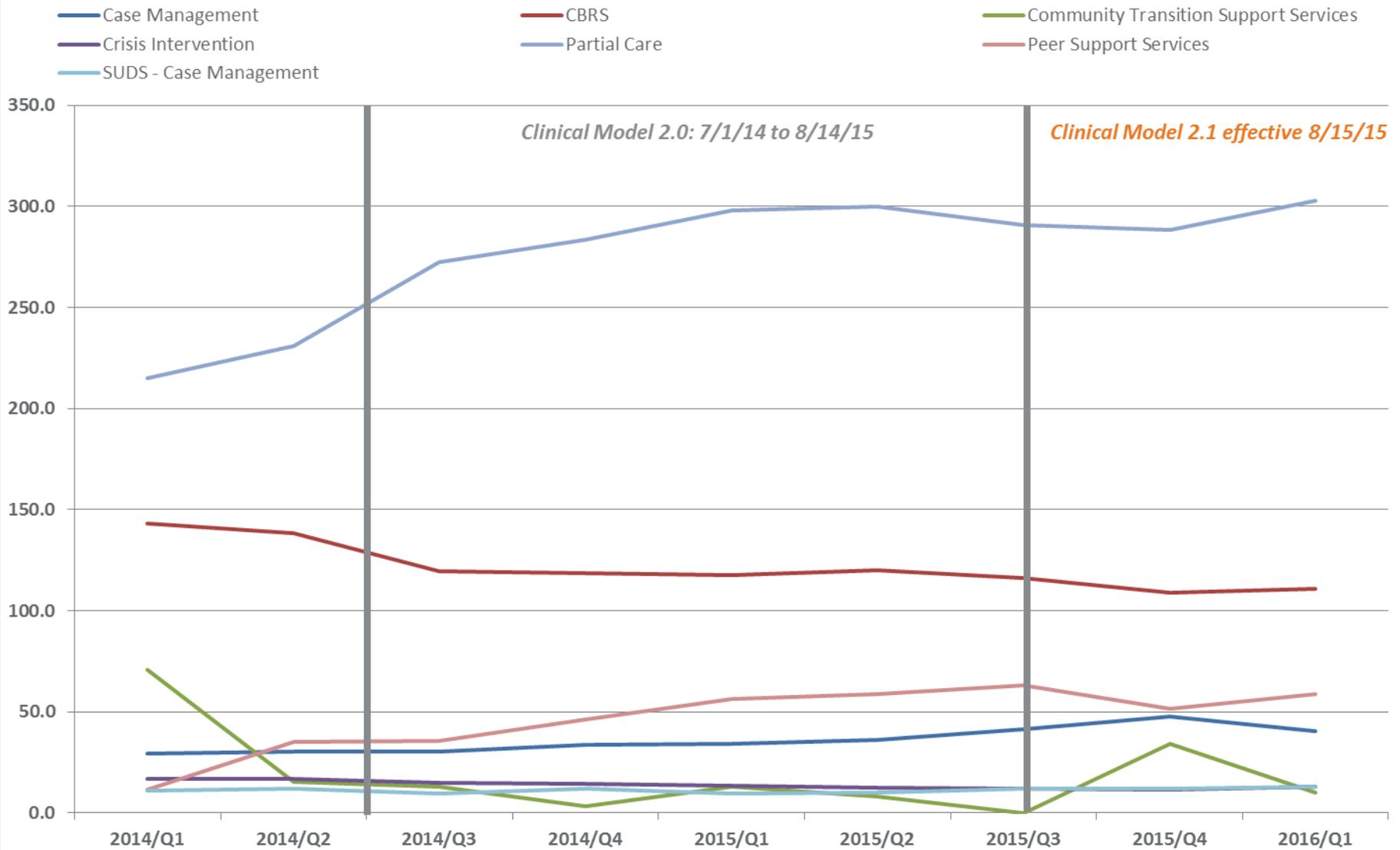
Category 3 and 4 Service Utilization: Avg Units per Member

- Case Management
- Crisis Intervention
- Partial Care
- SUDS - Assessment
- CBRS
- Extended Office Visits
- Peer Support Services
- SUDS - Case Management
- Community Transition Support Services
- MH Assessment/Tx Plan Development
- Psych or Neuropsych Testing



Based on paid claim data by date the service was provided.

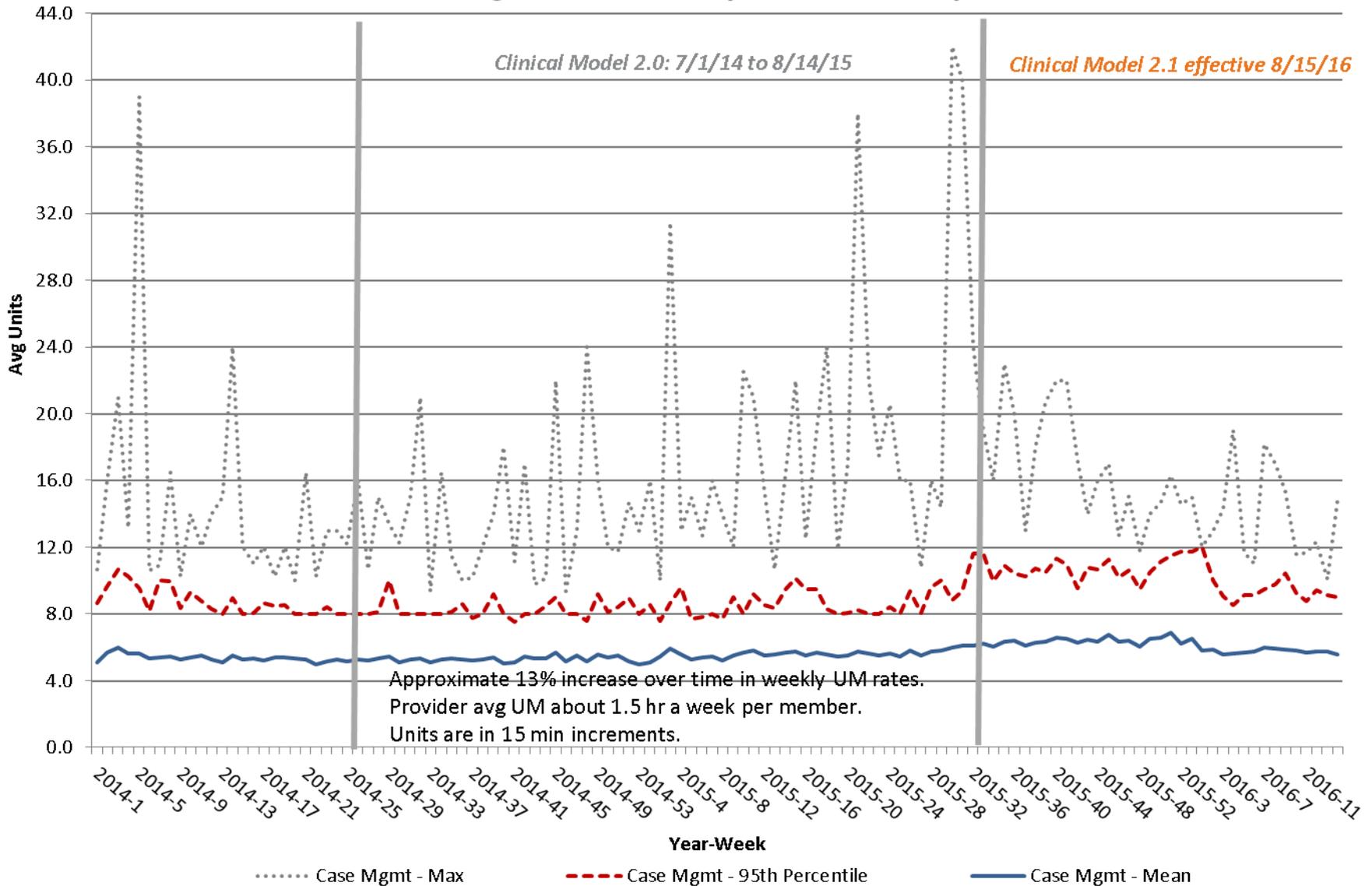
Category 3 and 4 Service Utilization: Avg Units per Member



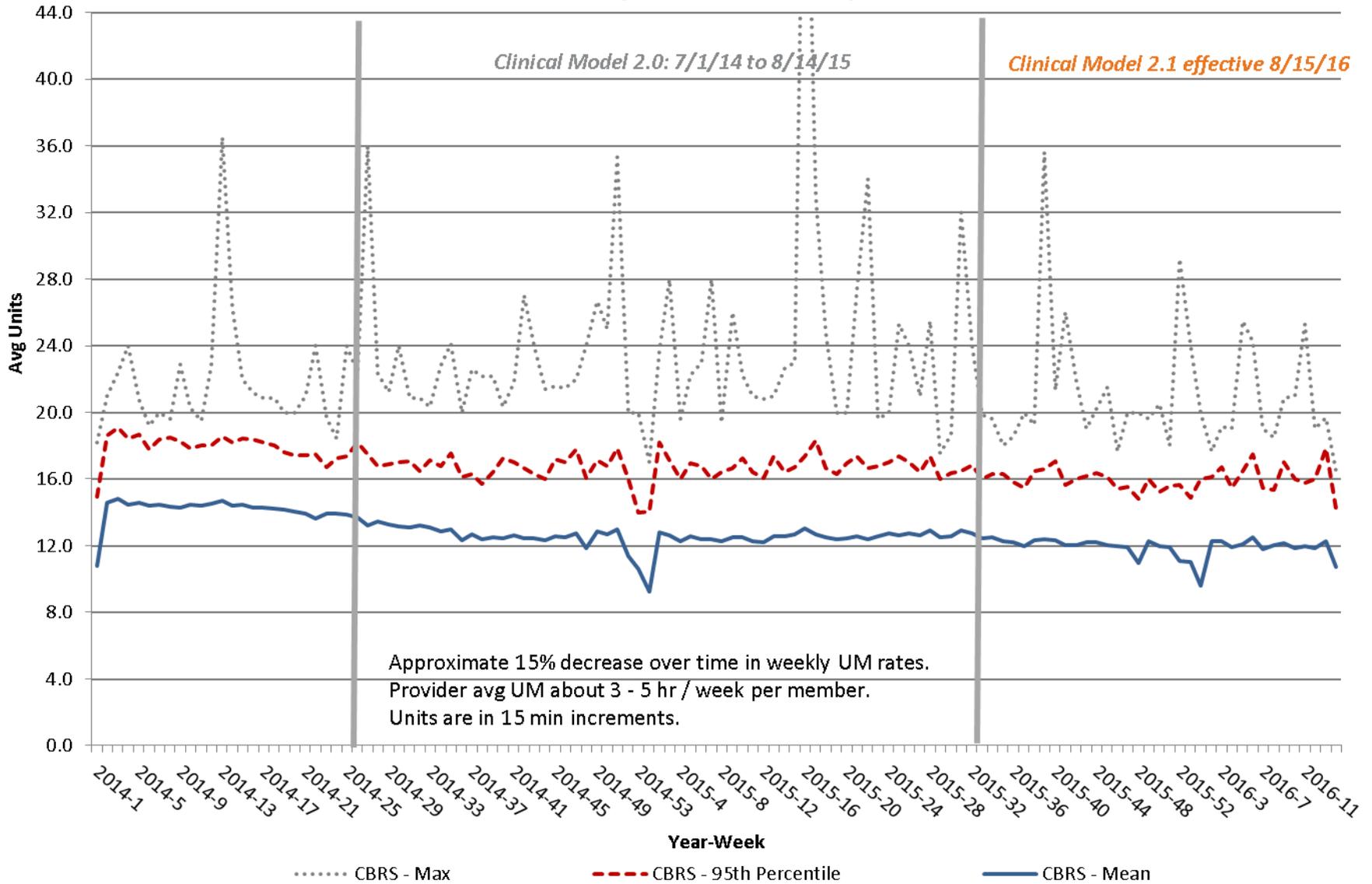
Based on paid claim data by date the service was provided.

Provider Utilization Rates

Case Management - Units per Member by Week

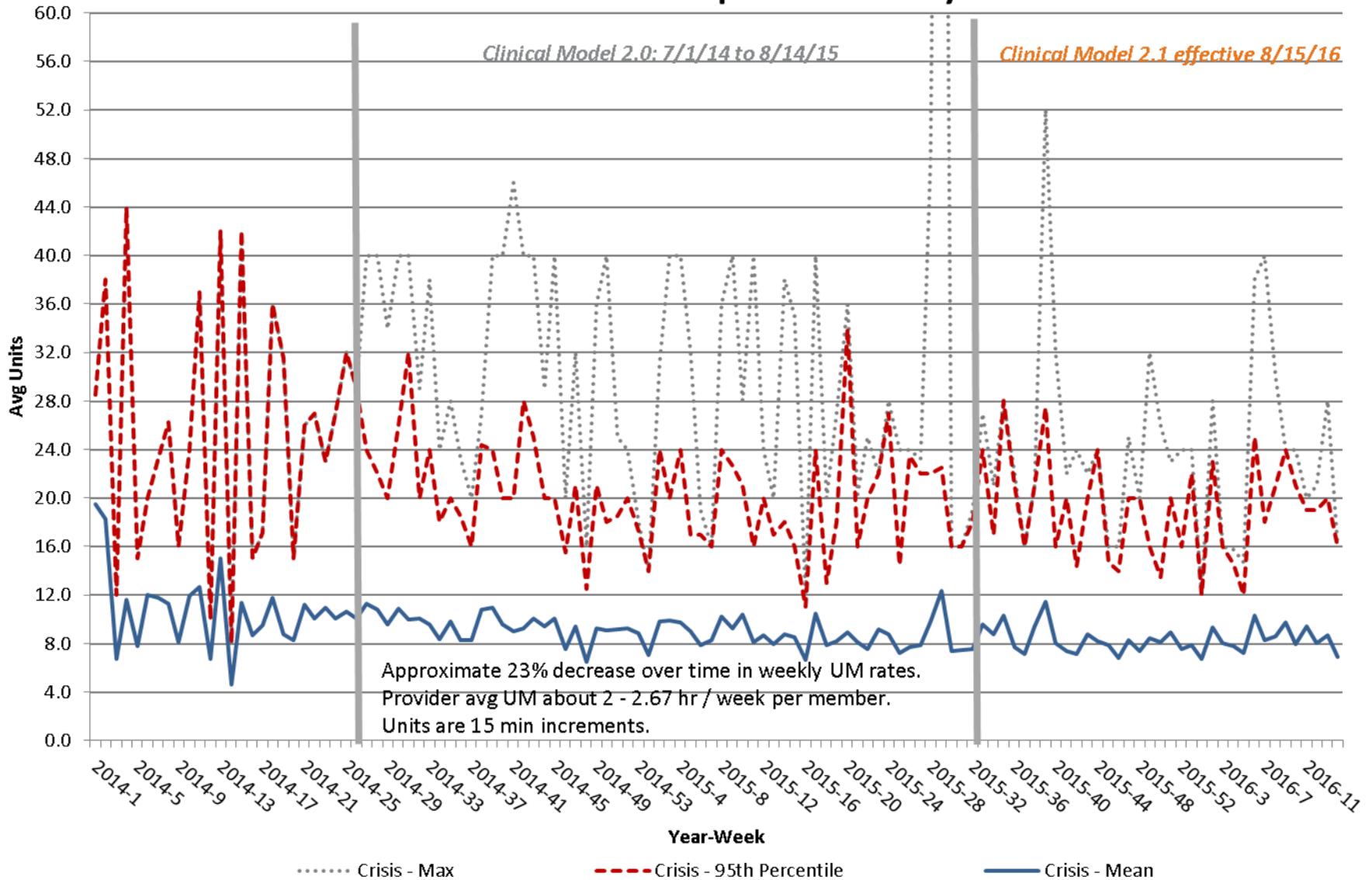


Provider Utilization Rates CBRS - Units per Member by Week



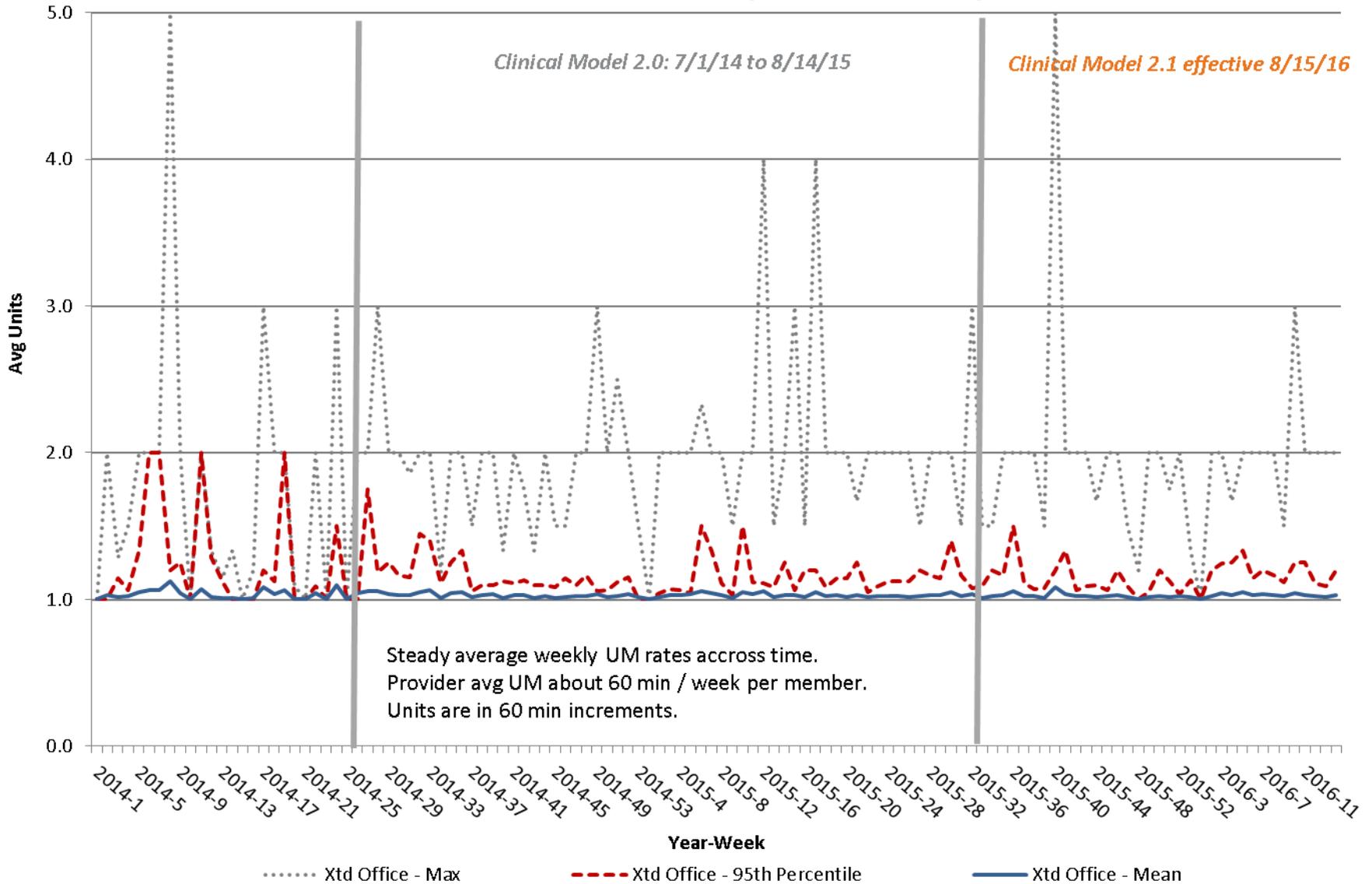
Provider Utilization Rates

Crisis Intervention - Units per Member by Week



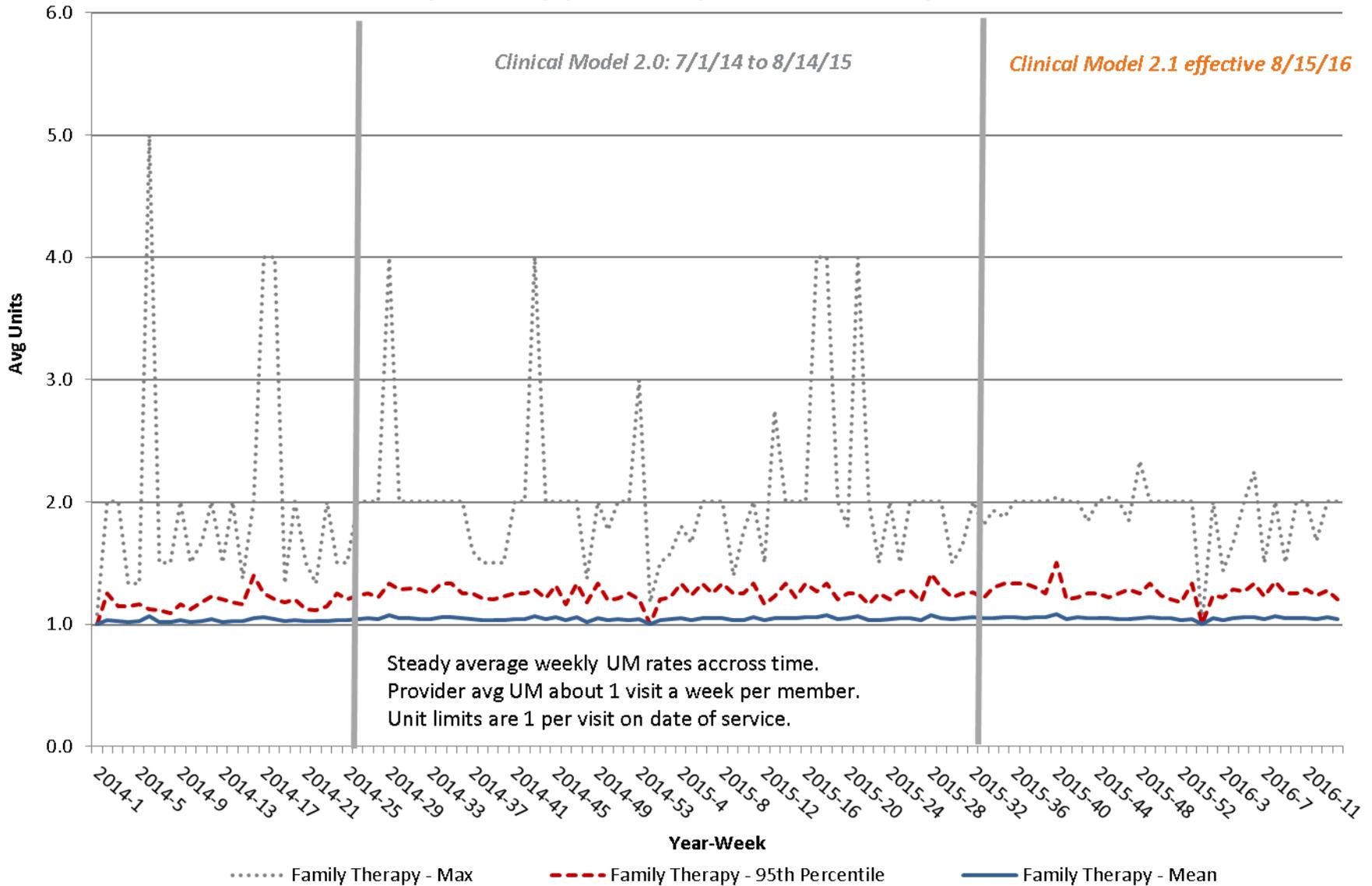
Provider Utilization Rates

Extended Office Visits- Units per Member by Week



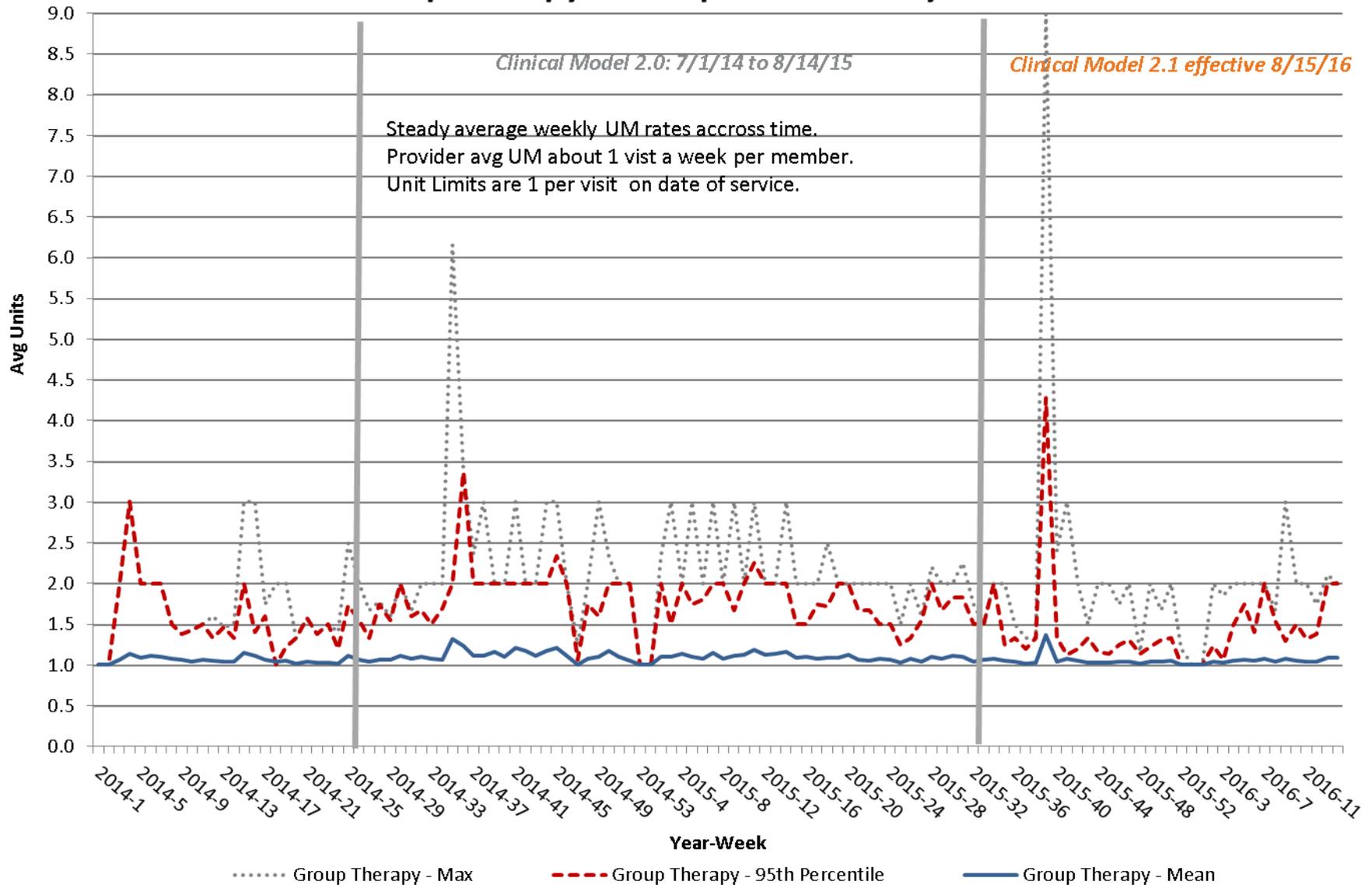
Provider Utilization Rates

Family Therapy - Units per Member by Week



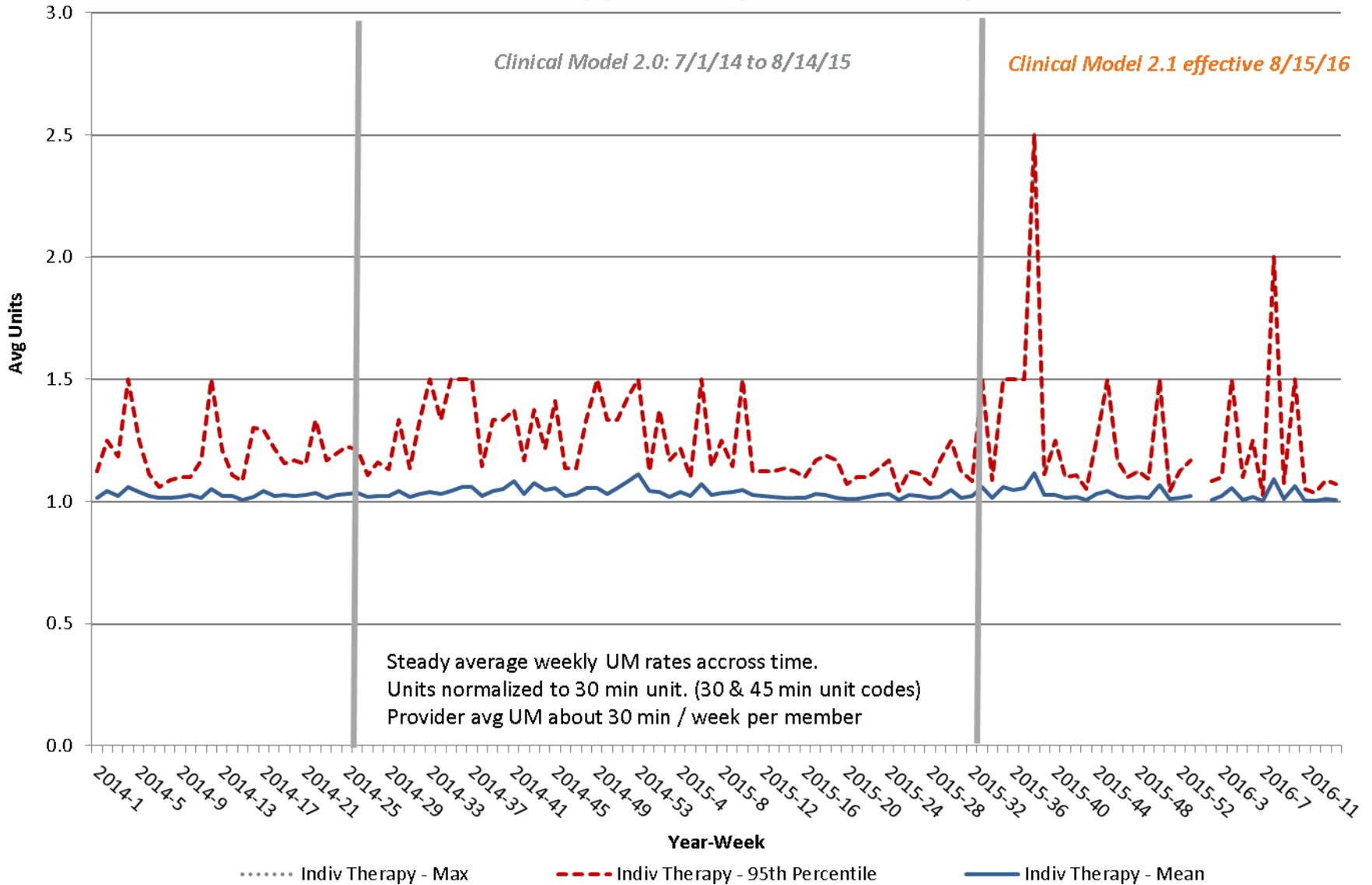
Provider Utilization Rates

Group Therapy - Units per Member by Week



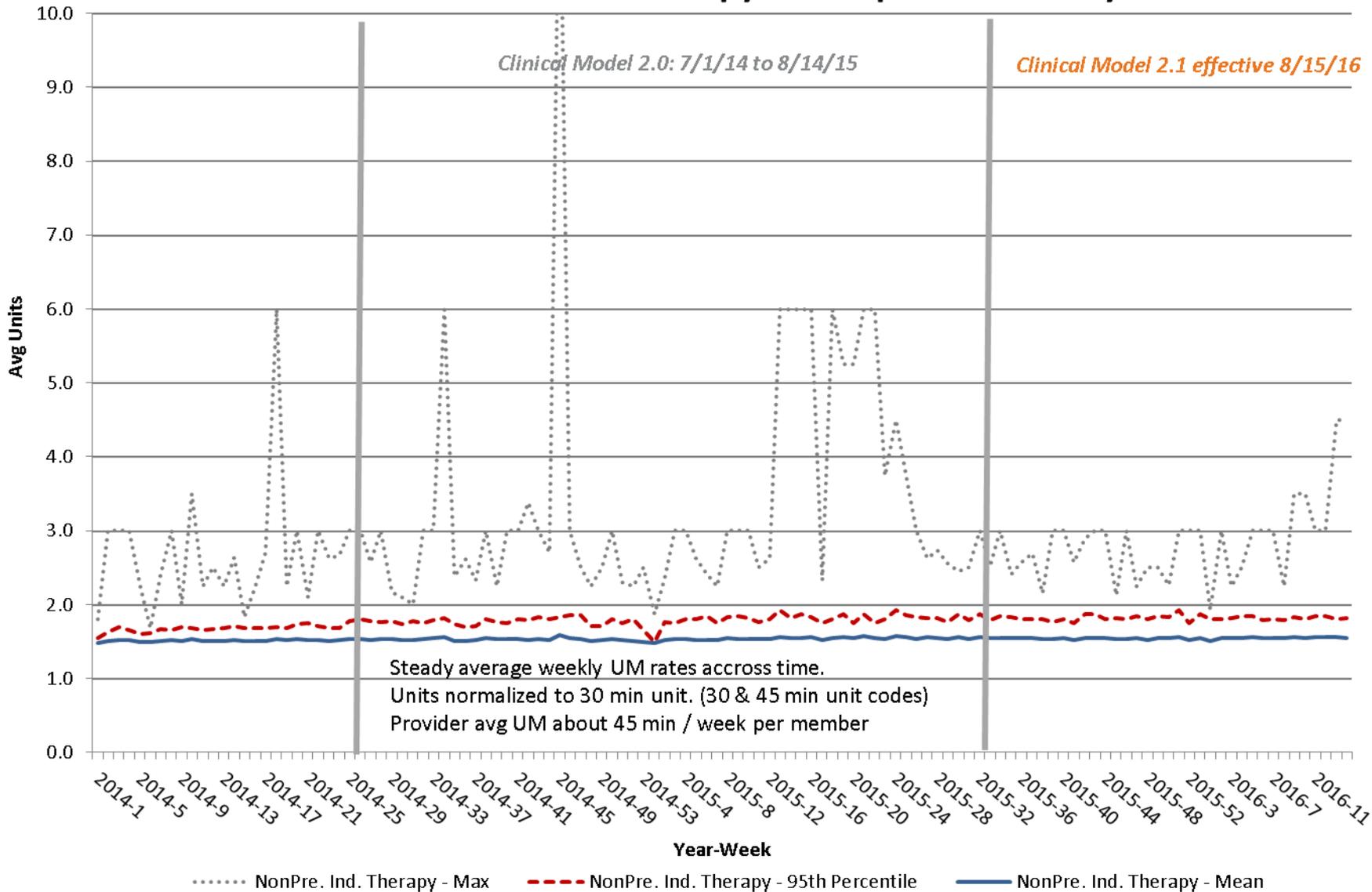
Provider Utilization Rates

Individual Therapy - Units per Member by Week



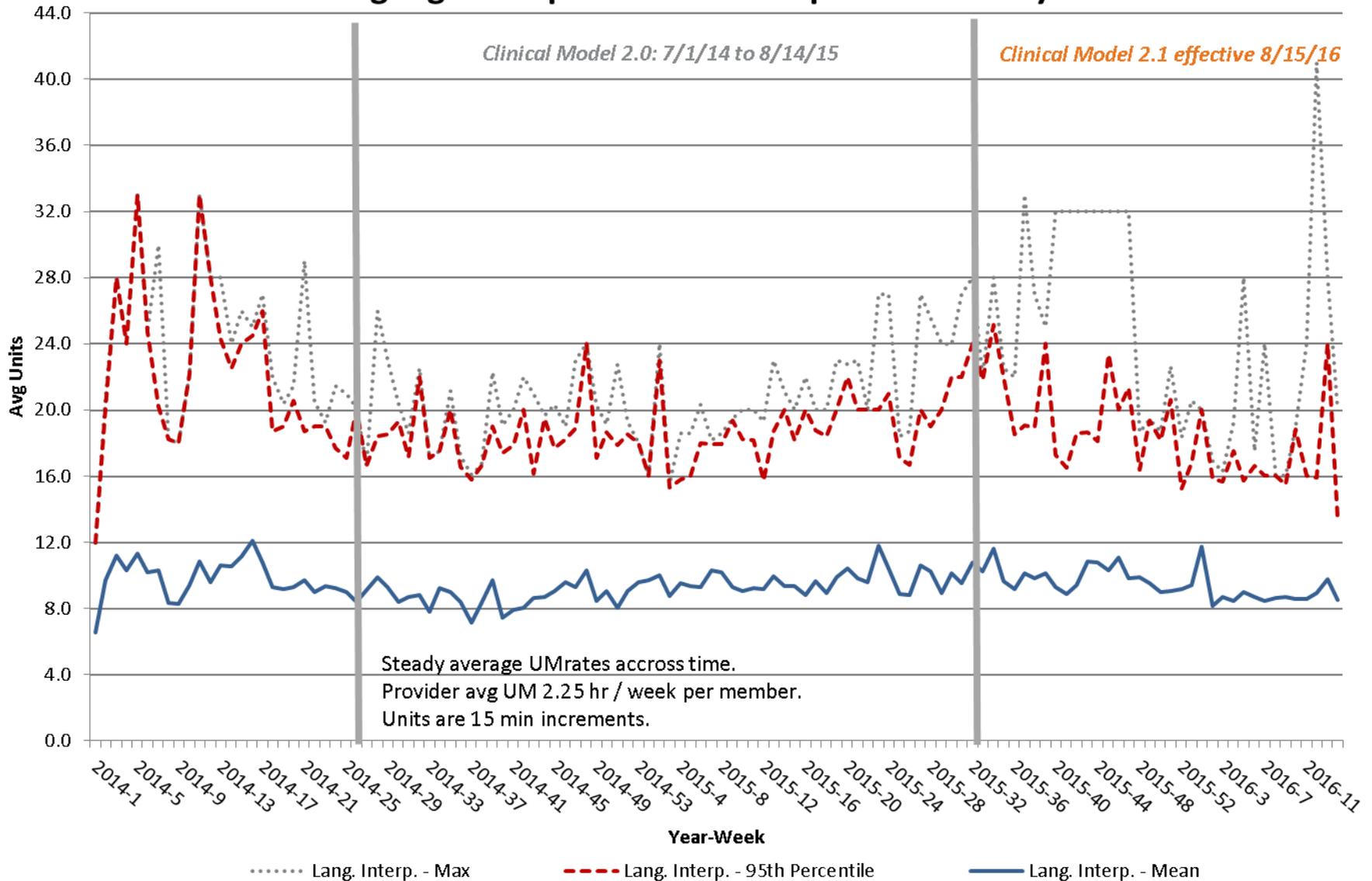
Provider Utilization Rates

Non-Prescriber Individual Therapy - Units per Member by Week



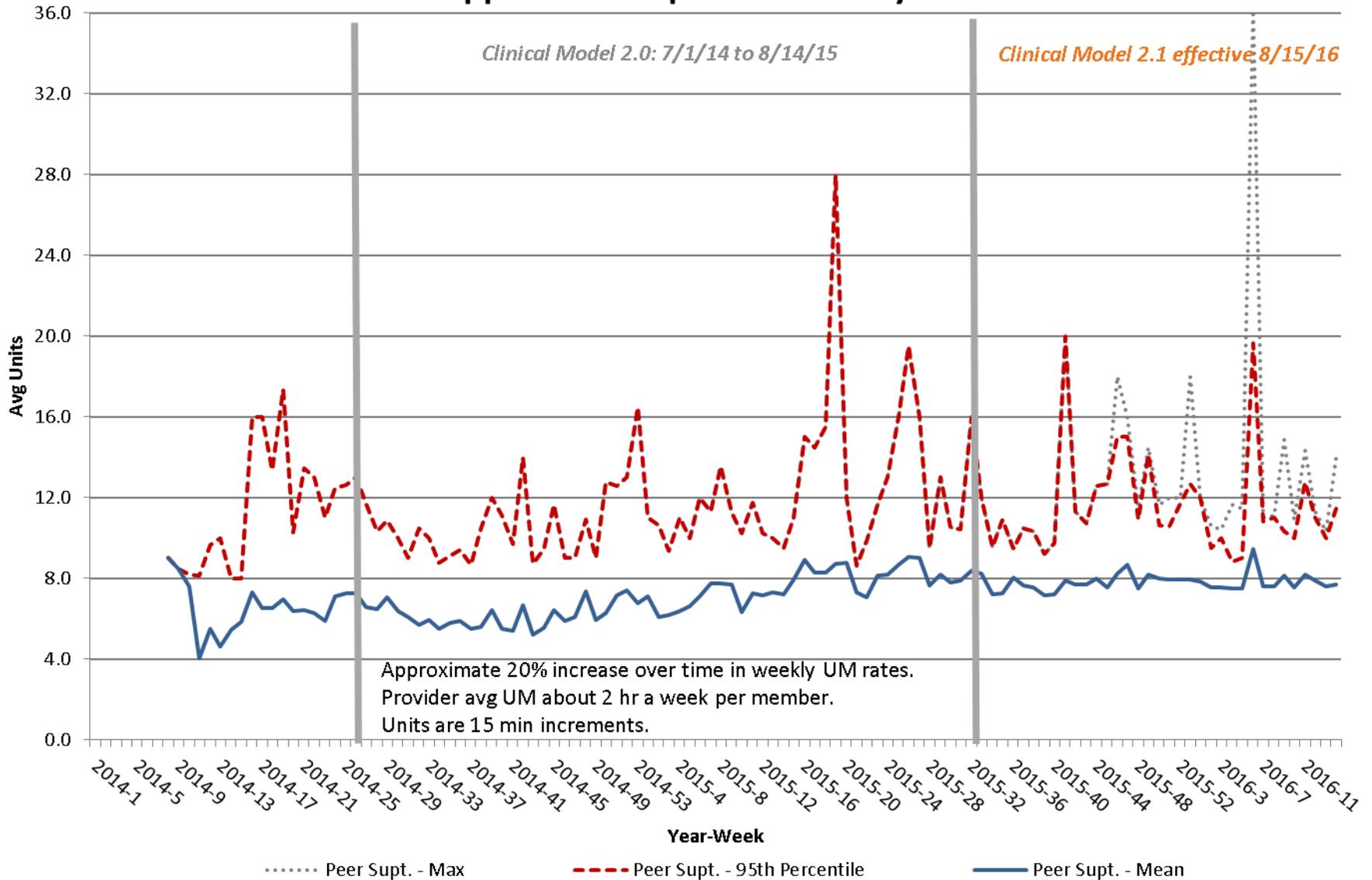
Provider Utilization Rates

Language Interpretation - Units per Member by Week



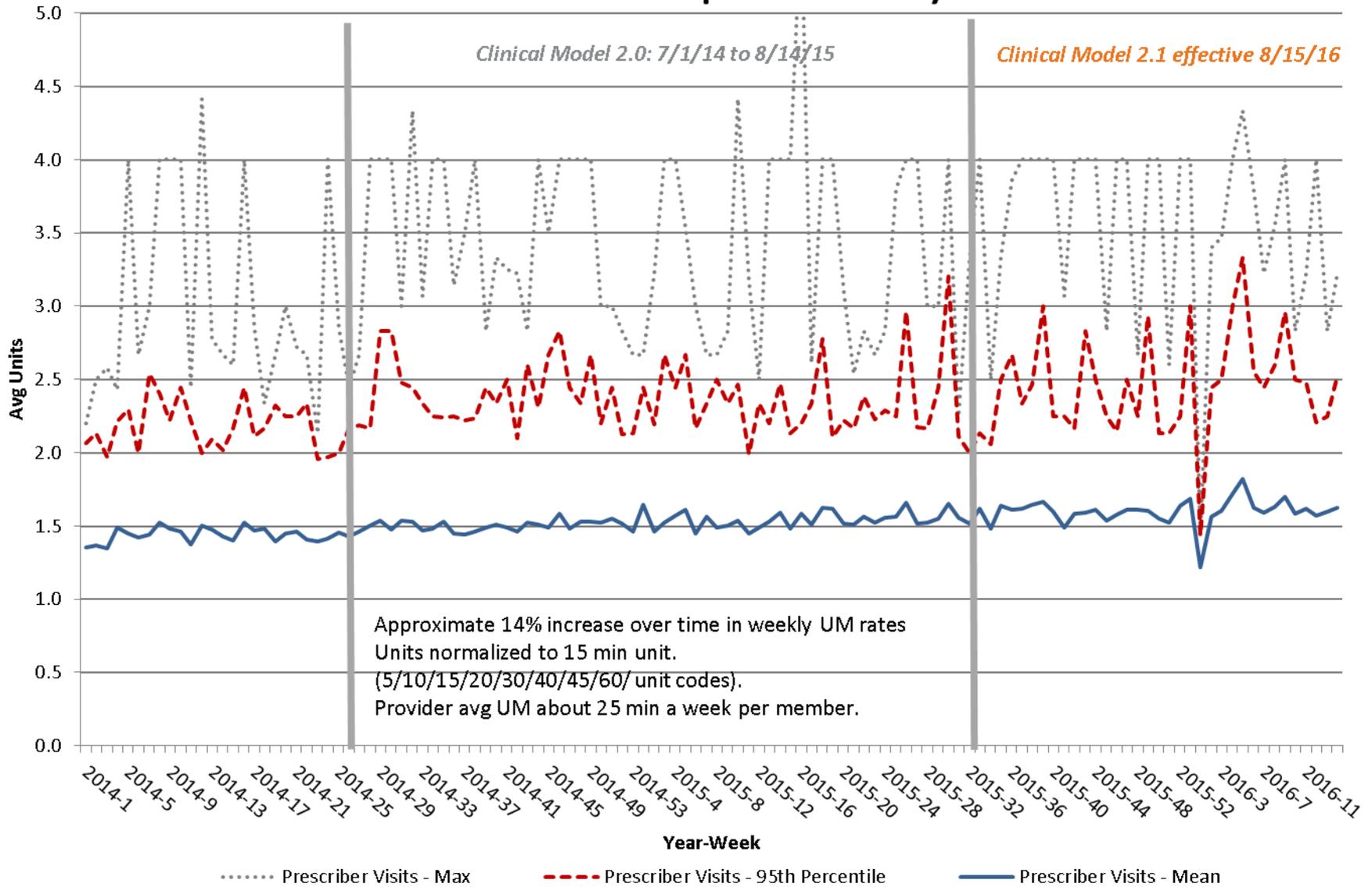
Provider Utilization Rates

Peer Support - Units per Member by Week



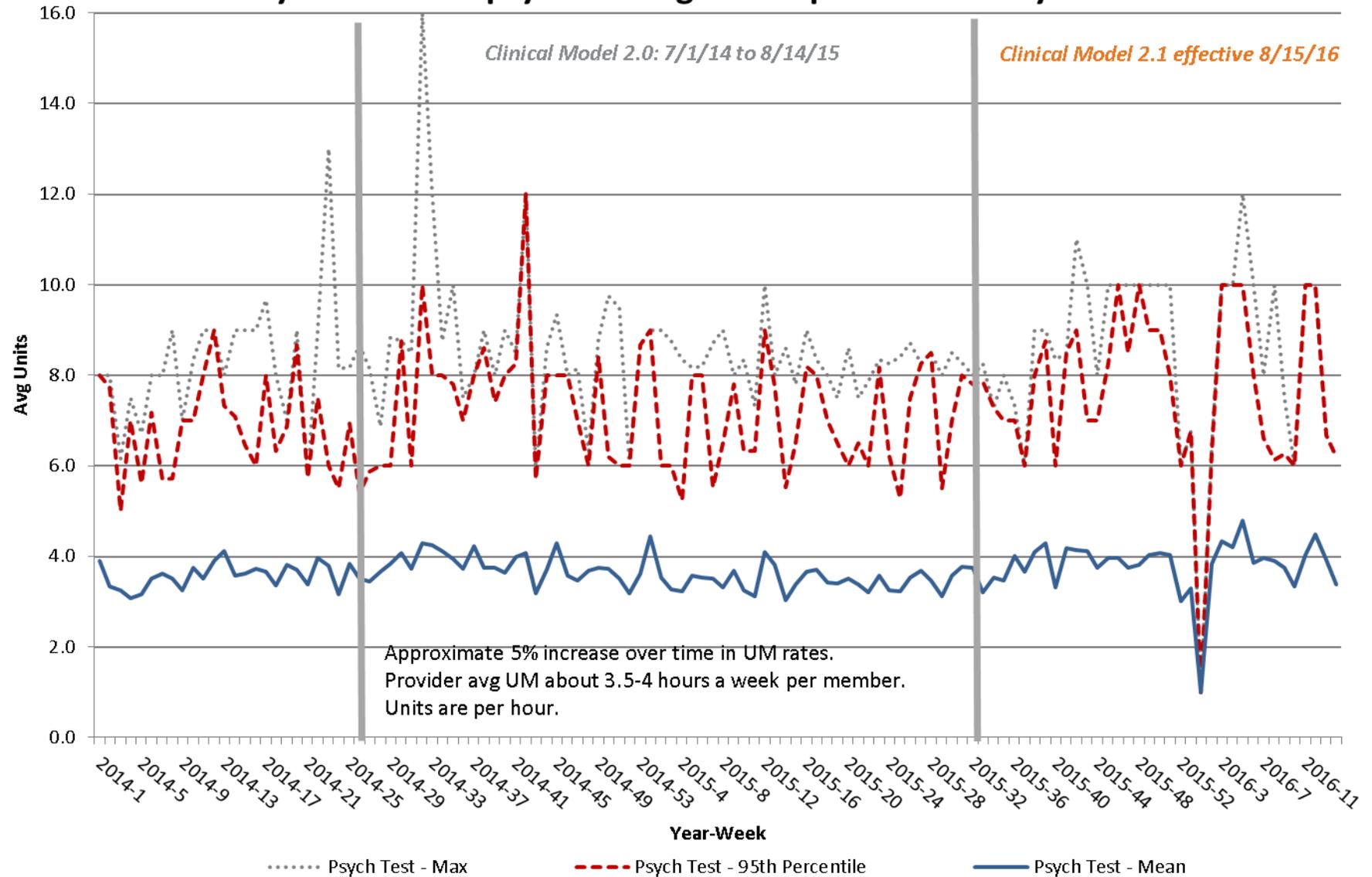
Provider Utilization Rates

Prescriber Visits - Units per Member by Week



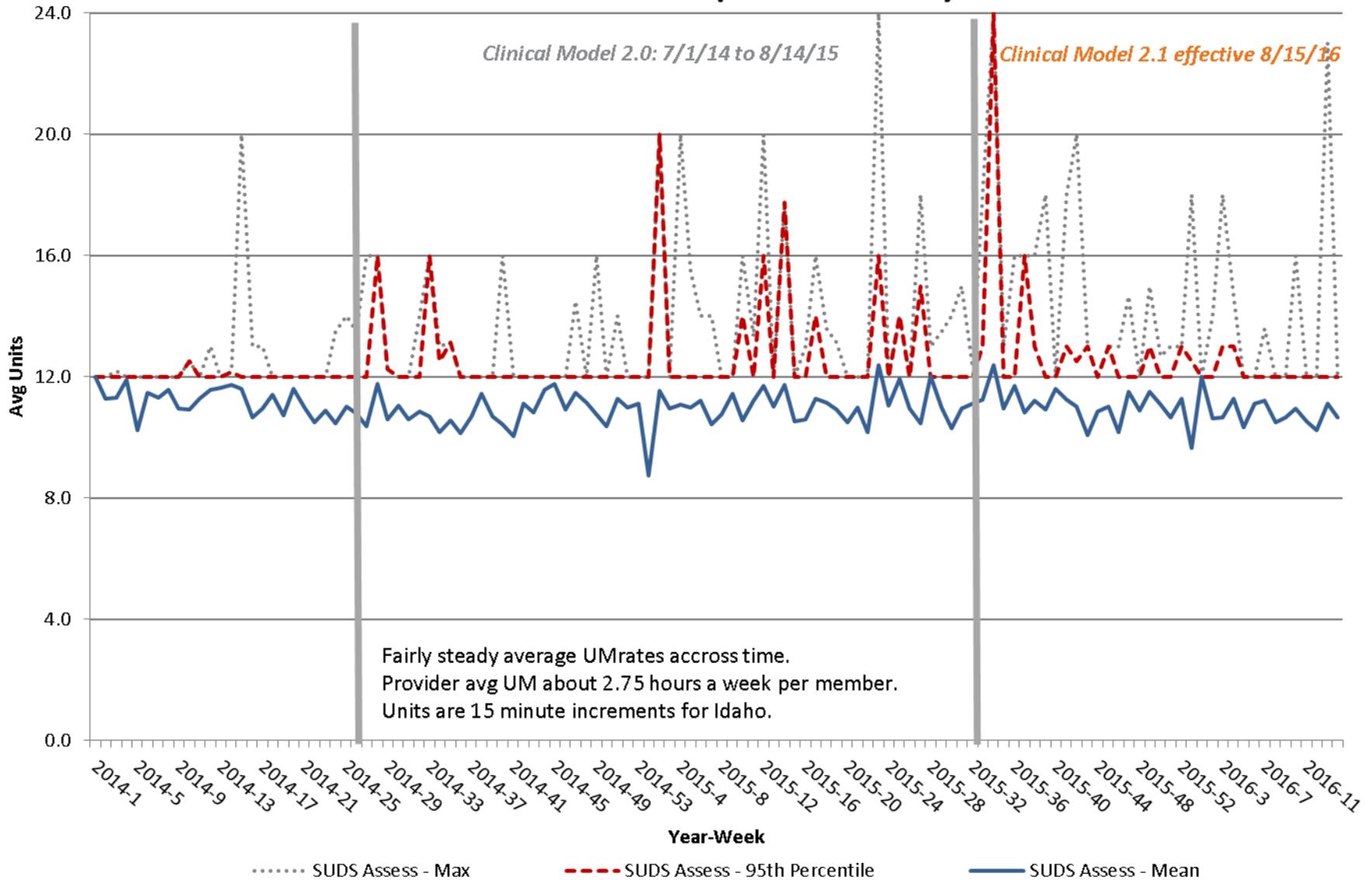
Provider Utilization Rates

Psych- or Neuropsych-Testing - Units per Member by Week



Provider Utilization Rates

SUDS Assessment - Units per Member by Week



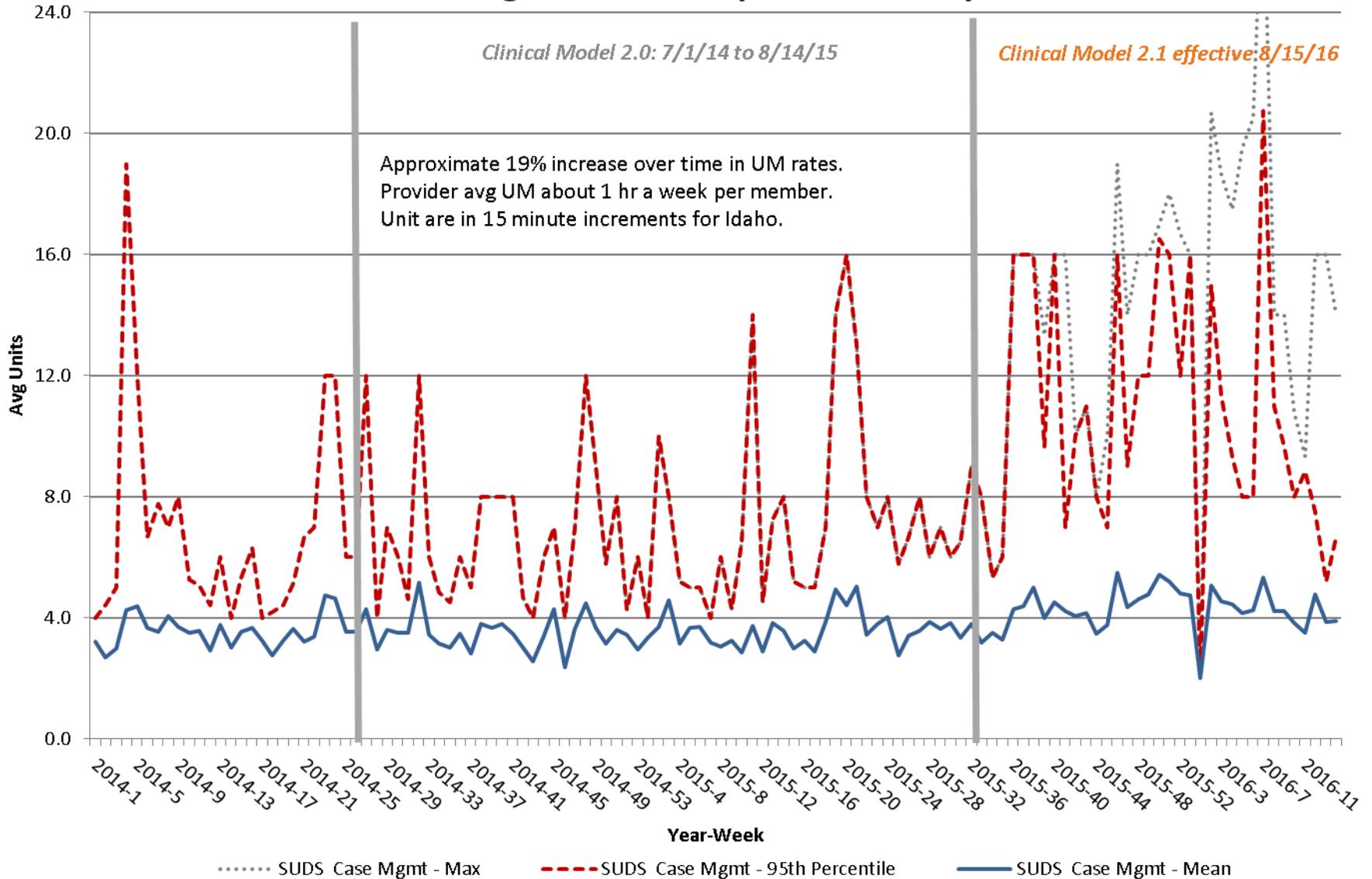
Provider Utilization Rates

SUDS Case Management - Units per Member by Week

Clinical Model 2.0: 7/1/14 to 8/14/15

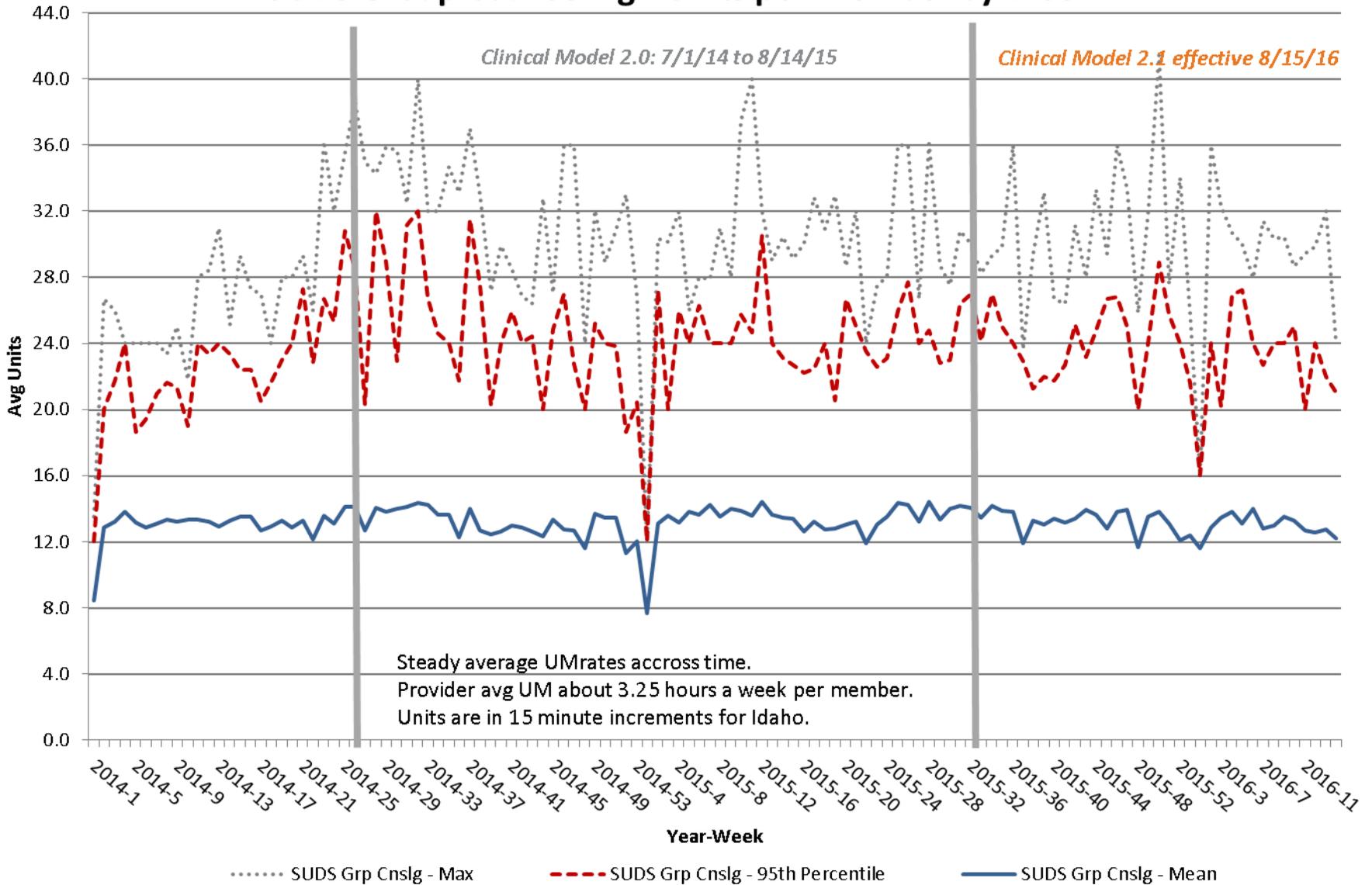
Clinical Model 2.1 effective 8/15/16

Approximate 19% increase over time in UM rates.
 Provider avg UM about 1 hr a week per member.
 Unit are in 15 minute increments for Idaho.



Provider Utilization Rates

SUDS Group Counseling - Units per Member by Week





What is medical necessity

The State of Idaho's regulatory definition of medical necessity:

A service is medically necessary if:

- It is reasonably calculated to prevent, diagnose, or treat conditions in the member that endanger life, cause pain, or cause functionally significant deformity or malfunction; and
- There is no equally effective course of treatment available or suitable for the member requesting the service which is more conservative or substantially less costly
- Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality

Location of definition: IDAPA 16.03.09.011.16:

<http://adminrules.idaho.gov/rules/current/16/0309.pdf>



What is medical necessity (continued)

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

- Medically necessary services for eligible Medicaid participants under the age of twenty-one (21) are healthcare, diagnostic services, treatment, and other measures described in **Section 1905(a) of the Social Security Act (SSA)** necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan
- Services must be considered safe, effective, and meet acceptable standards of medical practice

Location of definition: IDAPA 16.03.09.880:

<http://adminrules.idaho.gov/rules/2014/16/0309.pdf>



What is medical necessity (continued)

The Optum Idaho Provider Manual defines medical necessity on page 16:

- Generally, the evaluation of health care services is to determine whether the services meet plan criteria for coverage: are medically appropriate and necessary 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. The Level of Care Guidelines and Best Practice Guidelines that are used by Optum Idaho Care Managers in the determination of medical necessity are available on optumidaho.com.

Location of manual:

https://m1.optumidaho.com/c/document_library/get_file?uuid=852658a4-9743-4700-a850-7ef7cd19ebb2&groupId=110293



Best Practice Guidelines

Links to the Best Practice Guidelines are located on the Optum website, Provider Express. These guidelines should be reviewed by all providers **prior** to rendering services to Optum Idaho members.

- The recommended guidelines for adults are developed and maintained by the American Psychiatric Association (APA)
- The recommended guidelines for children and adolescents are developed and maintained by the American Academy of Child and Adolescent Psychiatry (AACAP)
- Guidelines are always accessible at <https://www.providerexpress.com/html/guidelines/preferredPracticeGuidelines/index.html>



Level of Care Guidelines

Optum Idaho Level of Care Guidelines are reviewed and approved by both Optum and the Idaho Department of Health and Welfare (IDHW)

- These guidelines are always accessible at <https://m1.optumidaho.com/web/optumidaho/providers> Provider tab > Guidelines and Policies > Level of Care Guidelines



Moving Toward Success

We believe that by relying on lessons learned and provider feedback to improve the clinical model we can work together to create a system that works better for everyone including providers and the individuals and families we jointly serve.

Together we can offer the right care, at the right time and at the right place.

Questions?



Thank you for attending!