



Optum National Network Manual
Addendum
for
AllWays Health Partners

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Introduction

United Behavioral Health (UBH) operating under the brand Optum administers mental health and substance use disorder benefits for AllWays Health Partners in Massachusetts. Generally, the [Optum National Network Manual](#) applies to all types of business managed by Optum. There are some sections that may differ based on specific benefit plans. This addendum highlights areas in which AllWays Health Partners procedures, in order to meet regulatory requirements, supersede procedures set forth in the Optum National Network Manual. Those requirements which apply only for MassHealth/ACO members have been clearly identified throughout this addendum.

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 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. The Optum National Network Manual is located on Provider Express. From the home page, select Clinical Resources > Guidelines/Policies & Manuals > Manuals > National Network Manual. We continuously expand our online functionality to better support your day-to-day operations. Visit us often.

Governing Law

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual conflict with the terms and conditions outlined in your Agreement, 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.

Authorization Information

Services Requiring Authorization:

- Acute Inpatient Hospitalization
- Partial Hospitalization
- Intensive Outpatient
- Applied Behavioral Analysis (ABA) Services for Members with Autism Spectrum Disorder
- Substance Use Disorder (SUD) Residential Rehabilitation Services: Optum complies with all requirements outlined in [Session Laws, Acts \(2014\), Chapter 258](#).
 - SUD Residential Rehabilitation Services Level 3.1: no authorization is required for the first ninety (90) days
 - SUD Residential Rehabilitation Services, all other Levels: no authorization is required for the first fourteen (14) days

Providers can obtain authorization for the above services by calling the number on the back of the member's identification card. Contracted providers may also request authorization for the services listed above online through Provider Express.

For the services listed below, authorization must be requested by calling the number on the back of the member's identification card (online authorization requests are not available):

- Electroconvulsive Treatment
- Transcranial Magnetic Stimulation

Services that Do Not Require an Authorization

- Standard Office Visit for Therapy or Medication Management
- Outpatient Opioid Treatment
- Extended Outpatient Treatment
- Psychological Testing Under Five Hours
- Most Children's Behavioral Health Initiative (CBHI) Services

Important Reminder: Services for Partners HealthCare Plan members seeing a contracted provider will not require authorization.

Timelines for Authorization Decisions:

- Authorization requests made while a member is in the emergency room are processed within 30 minutes of the request.

- Non-urgent authorization requests are processed within 24 hours.
- On-going review frequency is determined based on an individual's need and medical necessity criteria.

Consent for Treatment, Minors

In certain situations, according to state law, a minor is able to consent for treatment. Examples may include:

- Treatment for Drug Abuse: minors who are 12 or older who have been found to be drug dependent by at least two doctors may consent to substance abuse treatment (except for methadone maintenance therapy).
- Mental Health treatment: minors who are 16 or older may consent to admission at a mental health treatment facility.

Coordination of Care and Transition of Care

Coordination of Care Between Behavioral Health Providers and Primary Care Physicians or Other Health Professionals:

We expect behavioral health providers to coordinate care with the member's primary care physician as well as other treating medical or behavioral health providers. A signed release of information should be maintained in the clinical record.

In the event 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, education you provide regarding benefits and risks of coordinated care should be noted.

Coordination Between Behavioral Health Providers and State Agencies:

Behavioral health providers are expected to coordinate care with any relevant state agencies that are working with a member or member's family. This includes, but is not limited to the Department of Children and Families (DCF), Department of Youth Services (DYS), Department of Mental Health (DMH), Department of Transitional Assistance (DTA) and local education authorities.

Protocols for Transitioning Members from One Behavioral Health Provider to Another:

If a member transfers from one behavioral health provider to another, the transferring provider must obtain a release of information from the member and send a case summary, including the reason for the transition to the new provider.

MassHealth/ACO Covered Services

My Care Family (MassHealth/ACO line of business) offers care and coverage through MassHealth by Greater Lawrence Family Health Center, Lawrence General Hospital, and AllWays Health Partners. My Care Family is a patient-focused Accountable Care Partnership Plan designed to coordinate care, improve quality and ensure patients get the care and help they need to meet their health goals.

The following behavioral health and substance use disorder services are covered for MassHealth/ACO members:

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth	ACO MassHealth Family Assistance	CarePlus
Inpatient Mental Health	X	X	X
Inpatient Substance Use Disorder Services (Level 4)	X	X	X
Observation/Holding Beds	X	X	X
Administratively Necessary Day (AND) Services	X	X	X
Community Crisis Stabilization	X	X	X
Community Based Acute Treatment (CBAT) for Children and Adolescents	X	X	
Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	X	X	X
Clinical Support Services for Substance Use Disorders (Level 3.5)	X	X	X
Transitional Care Unit (TCU)	X	X	
Residential Rehabilitation Services (Level 3.1)	X	X	X
Community Support Program (CSP)	X	X	X
Partial Hospitalization (PHP)	X	X	X
Psychiatric Day Treatment	X	X	X
Structured Outpatient Addiction Program (SOAP)	X	X	X
Intensive Outpatient Program (IOP)	X	X	X
Recovery Coaching	X	X	
Recovery Support Navigators	X	X	X
Family Consultation	X	X	X

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth	ACO MassHealth Family Assistance	CarePlus
Case Consultation	X	X	X
Diagnostic Evaluation	X	X	X
Dialectical Behavioral Therapy	X	X	X
Psychiatric Consultation on an Inpatient Medical Unit	X	X	X
Medication Visit (Office)	X	X	X
Couple/Family Treatment	X	X	X
Group Treatment	X	X	X
Individual Treatment	X	X	X
Inpatient-Outpatient Bridge Visit	X	X	X
Assessment for Safe and Appropriate Placement (ASAP)	X	X	
Collateral Contact	X	X	
Opioid Treatment Services	X	X	X
Ambulatory Detoxification	X	X	X
Psychological Testing	X	X	X
Special Education Psychological Testing	X	X	
Applied Behavioral Analysis for Members Under 21 Years of Age (ABA Services)	X	X	
Family Support and Training	X		
Intensive Care Coordination	X		
In-Home Behavioral Services	X		
In-Home Therapy Services	X	X	
Therapeutic Mentoring Services	X		
Emergency Services Program (ESP) Encounter	X	X	X
Youth Mobile Crisis Intervention	X	X	
Electroconvulsive Therapy (ECT)	X	X	X
Specialing – therapeutic services provided to a member in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual’s safety.	X	X	X

Children's Behavioral Health Initiative (CBHI) Services for MassHealth/ACO Members

The Children's Behavioral Health Initiative is an interagency undertaking whose mission is to strengthen, expand and integrate behavioral health services for children and adolescents. These services are mental health and substance use disorder services provided to youth up to age 21 in a community based setting such as home, school or the community. Most of these services do not require a prior authorization:

- Family Support and Training (no authorization required)
- Therapeutic Mentoring (no authorization required)
- Intensive Care Coordination (ICC) (no authorization required)
- In-Home Behavioral Services (no authorization required)
 - Behavior Management Therapy
 - Behavior Management Monitoring
- In-Home Therapy Services (no authorization required)
- Youth Mobile Crisis Intervention (no authorization required)

CBHI services that do not require an authorization will be managed using our outpatient management strategy, Algorithms for Effective Reporting and Treatment (ALERT). Member claims data and service combinations are reviewed to identify services that occur at a frequency and/or duration that is higher than expected (based on the Level of Care Guidelines). A licensed care advocate will outreach the provider telephonically to:

- Review eligibility for service(s)
- Review the treatment plan/plan of care
- Review the case against applicable medical necessity guidelines

The review can lead to one of the following outcomes:

- Close the case (the member is eligible for services, the treatment plan/plan of care is appropriate and care is medically necessary)
- Modification to the treatment plan
- Referral to peer review (member may be ineligible for the service; treatment does not appear to follow service specifications; duration and/or frequency of care does not appear to be medically necessary)

Additional information about ALERT is located on Provider Express. From the home page, select Clinical Resources > [ALERT Program](#).

Child and Adolescent Needs and Strengths (CANS) for MassHealth/ACO Members

The requirement to use the Child and Adolescent Needs and Strengths (CANS) is part of the Final Order resulting from the *Rosie D. v. Patrick* lawsuit (Civil Action Number 01-30199-MAP). This was a class action lawsuit filed in 2001 on behalf of children and adolescents with serious emotional disturbance. The lawsuit alleged that the Massachusetts Medicaid program, MassHealth, failed to meet the obligations of certain federal Medicaid laws, including the Early and Periodic Screening Diagnosis and Treatment (EPSDT) statute.

The Court's Final Order was issued on July 16, 2007. The requirement to use the CANS became effective on November 30, 2008.

All behavioral health clinicians treating children and adolescents who are enrolled in MassHealth and under the age of 21 must use the CANS tool as part of the clinical assessment process. The CANS must be updated every 90 days to ensure that treatment plans address strengths and needs as they evolve.

Services that Require Use of the CANS:

- Outpatient Therapy (diagnostic evaluations and individual, family and group therapy)
- In-Home Therapy Services
- Intensive Care Coordination

The CANS must also be completed as part of the discharge planning process for the following 24-hour level of care services:

- Psychiatric inpatient hospitalization at acute inpatient hospitals, psychiatric inpatient hospitals and chronic and rehabilitation inpatient hospitals
- Community-Based Acute Treatment (CBAT) and Intensive Community-Based Acute Treatment (ICBAT)
- Transitional Care Units (TCU)

Important Reminders:

The CANS is not a clinical assessment tool; it is used to organize information gathered during the assessment process and to guide treatment planning. Clinicians must be trained and certified to use the CANS.

Additional information related to CANS requirement is located on the [Mass.Gov](#) website, including a [“Frequently Asked Questions about the CANS Requirements and Billing”](#) document.

Access Standards for MassHealth/ACO Members

The access standards outlined below are applicable to MassHealth/ACO members.

Emergency Services:

Immediately, on a 24-hour basis, seven days a week, with unrestricted access to members who present at any qualified Provider, whether a Network Provider or a non-Network Provider.

ESP (Emergency Services Program) Services:

Immediately, on a 24-hour basis, seven days a week, with unrestricted access to members who present for such services.

Urgent Care:

Within 48 hours for services that are not Emergency Services or routine services.

All Other Behavioral Health Services:

Within fourteen (14) calendar days.

For Services Described in the Inpatient or 24-Hour Diversionary Services Discharge Plan:

- Non-24-Hour Diversionary Services: within two (2) calendar days of discharge;
- Medication Management: within fourteen (14) calendar days of discharge;
- Other Outpatient Services: within seven (7) calendar days of discharge; and
- Intensive Care Coordination Services: within the time frame directed by EOHHS (Executive Office of Health and Human Services).

Documentation Standards

You are required to maintain high quality medical records for all members that you serve; the standards are outlined below.

General Practice:

- Member charts must be unique and stored in a secure location
- Members must sign appropriate releases of information to facilitate billing and review of member records
- All behavioral health services require consents to treatment prior to *any* behavioral health service being rendered or paid
- The consent to treatment, release of information and any other forms must meet all regulatory requirements including 45 CFR Parts 160, 162 and 164 and 42 CFR Part 2
- Providers are responsible for obtaining the appropriate order, referral and/or determination of medical necessity for the service
- All documentation must be legible
- Each page in the record must have a unique identifier
- All requirements for documentation must be completed prior to the claim form submission date
- All documentation must meet the requirements of the service codes that are submitted on the claims form
 - Best practice is for the progress notes and billing forms to be completed during the session or immediately after the session
- Documentation of treatment should be individualized to the specific encounter; copying and pasting from previous encounters should not occur
- All encounters must have documentation to support the service that is billed
- All changes or corrections to paper or electronic documentation must be signed and dated by the clinician amending or changing the documentation
- Providers should provide a notice to all members regarding clinic procedures, including the member's right to terminate treatment and the process for filing a grievance

All providers must have the following minimum documentation for the consent to treatment, assessment, treatment plan, progress notes and discharge summary to receive payment for all claims billed:

Consent to Treatment:

Consent to treatment is obtained prior to initiating services and includes the following:

- Name and signature of the member, or if appropriate, the legal representative
- Name of the provider (should correspond with license)
- Type of services and/or treatment
- Benefits and any potential risks of treatment
- Date and time consent is obtained
- Statement that treatment and services were explained to member or guardian
- Signature of person witnessing the consent (usually the clinician)
- Name and signature of person who explained the procedure to the member or guardian

Release of Information:

- All releases of information are signed and dated by the member *and* the clinician

Assessment:

Depending on the scope of the assessment, the following components may require multiple visits and/or may be completed by multiple clinicians:

- Presenting concerns
- Current treatment for presenting concerns, including medications
- Treatment history
 - Medical history
 - Psychiatric history, including any medication trials
 - Therapy history
- Substance use history, including any previous treatment
- Developmental/family history
- Allergies/adverse reactions
- Risk assessment, including Overdose Risk Assessment when applicable
- Mental status exam
- Member strengths
- Clinical formulation
- Clinical formulation is validated by clinical data
- Diagnosis is informed by clinical data

- CANS administered and integrated (for members under the age of 21) as applicable by CANS certified clinician
- Outcome tool(s) administered and integrated as applicable
- Initial treatment plan/next steps
- Documentation of time spent and duration of assessments
- Clinician's signature, credentials and signature date

Individual Treatment Plan or Plan of Service

- Must be completed according to service requirements
- Date of treatment plan initiation
- Diagnoses and/or symptoms being addressed
- Goals and objectives are based on the assessment, diagnosis and behavioral health strengths and needs
- Treatment goals are measurable and person-centered
- Treatment objectives describe an integrated program of therapies, activities, experiences and appropriate education designed to meet the stated goals
- Treatment plan or plan of service has established time frames
- Treatment plan or plan of service references less intensive treatment options that were considered
- Treatment plan or plan of service is easy to read and understand
- Treatment plan or plan of service documents the necessity for services
- Treatment plan or plan of service documents the services to be provided
- Treatment plan or plan of service is reviewed in accordance with clinical standards
- Clinician's signature, credentials and signature date
- Evidence that the member or guardian participated in treatment plan development, including member's statement of desired goal(s) or outcomes from treatment and/or member or guardian's signature and signature date

Progress Notes

- Each billable encounter is documented with a progress note
- Documentation for each progress note includes the following
 - Name or member identification number
 - Date of service that matches the date the claim is billed
 - Duration of session in minutes or stop and start time of services to support the procedure code billed
 - State the specific location of services provided; the place of service on the claim is supported in the documentation
 - Reason for session or encounter

- Documentation to support the procedure code that is billed
- Group counseling and group educational session progress notes may describe the session in general, but must also include specific comments on the member's participation and progress in the group
- Documentation in support of the treatment plan or plan of service goals, objectives and interventions
- Documentation of current symptoms and problems addressed, related intervention and response to treatment
- Updated risk assessment, including Overdose Risk Assessment when appropriate
- Next steps and progress in treatment plan or plan of service
- Clinician's signature, credentials and signature date

Discharge Summary

All services should be provided prior to the discharge summary date.

- Summary of services provided
- Status towards meeting goals
- Diagnosis at the time of discharge
- Reason for discharge
- Medications prescribed during course of treatment and at discharge (when applicable)
- Risk assessment completed with any remaining risk issues identified and documented
- Documentation of referrals
- Identification of aftercare options
- Clinician's signature, credentials and signature date

We may review your records during a scheduled on-site audit or may ask you to submit copies of records to Optum for review. Reviews may occur for a number of reasons, including, but not limited to:

- On-site reviews of facilities and agencies without national accreditation such as the Joint Commission, Commission on Accreditation of Rehabilitation (CARF) or other accrediting organizations approved by Optum
- Audits of services and programs including, but not limited to, Applied Behavioral Analysis, CBHI and Residential Rehabilitation Services (RRS)
- Audits of high-volume providers
- Routine audits
- Audits related to claims, coding or billing issues
- Audits concerning quality of care issues

Adverse Incident Reporting

When an adverse incident occurs, the provider must complete the applicable Adverse Incident Report form and submit it to Optum within 24 hours of discovery of the incident; if the incident occurs on a holiday or weekend, the form must be submitted on the next business day.

All reporting forms are available on Provider Express. From the home page, select Our Network > Welcome to the Network > Massachusetts > AllWays Health Partners > Adverse Incident Report Forms. Forms are faxed to Optum once they are complete. The fax number is 844-814-5698.

Behavioral Health reportable adverse incidents include, but are not limited to, the following:

- Any absence without authorization (AWA)
- Any contraband found that is prohibited by provider policy
- Any death (including cause of death if known)
- Any physical assault or alleged physical assault on or by a covered individual or by staff
- Any serious injury resulting in hospitalization
- Any sexual activity in a 24-hour level of care facility
- Any sexual assault or alleged sexual assault
- Any treatment or illness requiring transportation to an acute care hospital for treatment while in a 24-hour program
- Any violation or alleged violation of the Department of Mental Health physical restraint and/or seclusion regulations
- Accidental injuries
- Any unscheduled event that results in the evacuation of a program or facility
- Fall
- Fire Setting
- Homicide
- Medication abuse or error
- Property damage
- Seizure
- Self-Injury
- Substance use
- Suicide attempt or gesture

Network Requirements

Network Requirements are outlined in the Network Requirements section of the [Optum National Network Manual](#).

Member Rights

Member rights are outlined in the Member Rights and Responsibilities section of the [Optum National Network Manual](#). Members who receive benefits through AllWays Health Partners have the right to file a grievance if they have an unsatisfactory experience with either Optum or a provider who is contracted with Optum. All grievances will be reviewed by one or more people who were not involved in the problem or situation that the grievance involves. If the grievance involves a clinical matter, a health care professional will review the grievance.

Members may file a grievance by calling the customer service phone number on the back of their identification card.

Appeals (Provider Disputes)

Non-Urgent (Standard) Appeals:

Non-urgent appeals for commercial members must be requested within 180 days from receipt of the notice of an adverse determination. Non-urgent appeals for MassHealth/ACO members must be requested within 60 calendar days from receipt of the notice of an adverse determination. All appeal determination decisions will be made within 30 calendar days of receipt of the request.

Urgent (Expedited) Appeals:

Urgent appeals must be requested as soon as possible after the adverse determination. All appeal determination decisions will be completed and you will be notified of the decision within 72 hours of receipt of the request.

Submission Information:

Fax: 855-312-1470

Address:

Optum
Appeals & Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512
Phone: 866-556-8166

Claims Information

Claims must be submitted within ninety (90) days of the date of service. Clean claims will be adjudicated within forty-five (45) days of receipt of the claim.

Claims may be submitted in three (3) ways:

- Online via Provider Express
- Online via Electronic Data Interchange (EDI)
- Paper claims via US Mail

Mailing addresses for paper claims:

Commercial Claims	Medicaid Claims
Optum P.O. Box 30757 Salt Lake City, UT 84130-0760	Optum P.O. Box 30760 Salt Lake City, UT 84130-0760

Process for Communication of Policy and Process Changes

When there is a change to an existing policy or process, information will be communicated to providers in multiple ways:

- Provider Alerts sent via email, fax and/or mail.
- Posting on Provider Express: from the Home Page, select Our Network > Welcome to the Network > Massachusetts. All information related to AllWays Health Partners is on the right side of the screen.