

# Network Notes

OptumHealth Behavioral Solutions of California – News and Updates for Contracted Providers

Fall 2019

## Adoption of LOCUS/CASII/ECSII Clinical Criteria

OptumHealth Behavioral Solutions of California (OHBS-CA) is adopting the *Level of Care Utilization System* (LOCUS), the *Child and Adolescent Service Intensity Instrument* (CASII) and the *Early Childhood Service Intensity Instrument* (ECSII) for guidance on clinical criteria decisions for the treatment of behavioral health conditions across most Commercial and Medicaid membership.

- **Level of Care Utilization System (LOCUS)** – a standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make medical necessity determinations and placement decisions **for adults**.
- **Child and Adolescent Service Intensity Instrument (CASII)** – a standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) used to make medical necessity determinations and to provide level of service intensity **for children and adolescents ages 6-18**.
- **Early Childhood Service Intensity Instrument (ECSII)** – a standardized assessment tool developed by the AACAP used to make medical necessity determinations and to provide level of service intensity **for children ages 0-5**.

In California, LOCUS will begin December 14, 2019, with CASII and ECSII becoming effective January 31, 2020.

For more information, visit [Provider Express > Admin News > Adoption of LOCUS/CASII/ECSII](#)

## Medi-Cal Network Training Requirement



OHBS-CA must ensure that behavioral health providers who provide services to members covered under the UnitedHealthcare Community Plan Medi-Cal Managed Care program are in compliance with the state's Medi-Cal requirements. If you are a contracted provider in the OHBS-CA Medi-Cal network, you are required to review the Medi-Cal training documents within ten (10) days of your effective date.

Upon completion of the training, you must also complete and submit the online Medi-Cal Provider Training Attestation. The training materials, including the attestation, can be found on [providerexpress.com](#) under [Medi-Cal Provider Resources > Provider Training Materials](#)

If you are a provider in San Diego County and would like to join the Medi-Cal Network, please send an inquiry to [bnswest@optum.com](mailto:bnswest@optum.com).

---

# Billing for Psychological Assistants and Interns

---

In accordance with OHBS-CA Individual and Group Provider Participation Agreements, the services for which you submit claims must be provided directly by you for all members.

Participating clinicians may not submit claims in their name for treatment services that were provided by a psychological assistant, nurse practitioner, intern, or another clinician.

Services must be provided by a clinician who is licensed by the state of California to practice independently and who is approved through the OHBS-CA credentialing process for participation in the network.

For information regarding billing for test administration by a psychometrician, please refer to the [Psychological/Neuropsychological Testing Guidelines](#) on Provider Express.

These guidelines also address other procedures related to testing and report writing. If you have questions related to these guidelines, you can also contact the Care Advocacy Center for each member using the number on the back of the member's ID card.



---

# Update Your Demographic Profile to Refine Referrals

---

Does your online provider profile paint a thorough picture of your practice? Some of the information we request is optional but we ask that you consider how a more robust profile can benefit not only members but also YOU. When seeking a provider, members make decisions that are based, in part, on clinical areas of expertise or specialty. But there are other factors that also become a part of their decision-making and, by offering them a comprehensive view of your practice, you can help them make informed decisions. It can also prevent some phone calls and inquiries that require you to respond even when it is to tell a member that your practice doesn't meet their needs.

In the list below, we've included some of the details about your practice which can help ensure that you receive referrals that are best suited for your practice.

- **Office hours:** Knowing the hours your office is typically open can be a crucial piece of information for members and can eliminate wasted time and phone calls for both you and the member
- **Ethnicity/Language:** This information may help members feel reassured that a clinician will be able to meet their specific cultural or linguistic needs and incorporate those needs into a treatment plan
- **Public Transportation and Wheelchair Accessibility:** The accessibility of your practice to public transportation and its ability to be accessed by those using wheelchairs are also critical, decision-making elements that can help enable members to find a provider who meets all of their access needs

- **Email address:** While this may not play a major role in a member's decision about whether you are a good "fit" for their needs, the ability to contact you by email offers members a convenient, private way to contact you. It also offers you a convenient option for replying, even during hours that aren't conducive to phone calls
- **Website:** Can provide information about your practice, treatment approach, training and education for members to review

We encourage you to review your demographic data through [providerexpress.com](http://providerexpress.com). Please consider adding information to enhance your profile and be sure that all information displayed in the directory is accurate. You can make updates through [providerexpress.com](http://providerexpress.com) or by contacting Provider Relations at **1-877-614-0484**.



# Timely Access to Care

Improving and expanding member access to care is a priority in the healthcare industry. We continue to explore ways to improve member access to a choice of providers who meet their needs for appointment availability, geographic accessibility, specific areas of expertise, and cultural or linguistic needs.

We are expanding our **virtual visits** (telehealth) network, which takes advantage of technology to enable members to easily connect with providers through convenient, secure, virtual connections that extend access to providers throughout California. We also offer a virtual visits platform, available for use with no licensing cost or monthly fee for network providers and Optum/OHBS-CA members. Once a provider is registered, members are able to view their virtual visit schedule and book appointments. For more information, visit the **virtual visits** page on Provider Express.

Expansion of the **Express Access** network, which includes providers who agree to see members within 5 business days, has also helped to improve member access to care.

It is important for you to be aware of our access standards (shown below). We rely on you to comply with these standards as a part of your business practice.

**Interpreter Services:** Interpreter services are available to members at the time of the appointment if requested by the member or provider. To request interpreter services contact us at **1-800-999-9585**. Language interpretation services are available at no cost to the member or the provider.

**Clinician Timely Response to Member Messages:** One of the most frequent complaints we receive related to appointment access and availability is the failure of a clinician to promptly return a member’s call. Please return all member calls within 24 hours.

**After-Hours Answering System and Messaging:** Be sure your answering machine message includes instructions to members regarding what they should do in an emergency situation. If you update your message, be sure it includes these critical instructions in your new message.

**If you are unable to see new members** due to a full practice or leave of absence, please let us know. You can easily update your availability status online at **Provider Express**. This reduces inappropriate referrals and frustration for members. You may remain unavailable for up to six months. You can also change your availability status by:

- Calling Network Management at **1-877-614-0484**
- Emailing us at **bsnwest@optum.com**
- Faxing change to Network Management at **1-866-641-5947**.

We know you share our commitment to offering clinically appropriate and timely access to care pursuant to Section 1367.031 of the California Health and Safety Code. The DMHC Help Center may be contacted at **1-888-466-2219** to file a complaint if the member is unable to obtain a timely referral to an appropriate provider. Thank you for making these standards a part of the quality care provided by the OHBS-CA network.

**Please note:**

*The time for a particular, non-emergency appointment may be extended if it is determined<sup>1</sup> and documented that a longer waiting time will not have a detrimental impact on the member’s health. Rescheduling of appointments, when necessary, must be consistent with good professional care and ensure there is no detriment to the member.*

<sup>1</sup>An extension to the time for a non-emergency appointment may be determined by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and is consistent with professionally recognized standards of practice.

Standard	Criteria	Anticipated Compliance
Non-Life-Threatening Emergency	A situation in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm to self or others	100% of members must be offered an appointment within 6 hours of the request for the appointment
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	100% of members must be offered an appointment within 48 hours of the request for the appointment
Routine (non-urgent)	A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others	100% of members must be offered an appointment within 10 business days of the request for the appointment
After-Hours Answering System & Messaging	Messaging must include instruction for obtaining emergency care	100%
Network Clinician Availability	Percentage of network clinicians available to see new patients	90%
Clinician Timely Response to Enrollee Messages	Clinicians shall provide live answer or respond to enrollee messages for routine issues within 24 hours	90%

# Monitoring Network Availability

PROVIDER TYPE	STANDARD (URBAN)	STANDARD (SUBURBAN)	STANDARD (RURAL)	PERFORMANCE GOAL
Prescribers (MD, DO, RN w/ prescriptive authority, PA)	10 miles	20 miles	30 miles	95%
Ph.D./Master's Level	10 miles	20 miles	30 miles	95%
Child/Adolescent Clinician	10 miles	20 miles	30 miles	95%
Acute Inpatient Care	15 miles	15 miles	15 miles	90%
Intermediate Care/Partial Hospitalization/Residential	15 miles	30 miles	60 miles	90%
Intensive Outpatient Care	15 miles	30 miles	60 miles	90%
Medication Assisted Treatment (MAT)	15 miles	30 miles	60 miles	90%
<b>MEDI-CAL NETWORK ADEQUACY STANDARDS IN SAN DIEGO COUNTY</b>				
PROVIDER TYPE	TIMELY ACCESS STANDARD	TIME AND DISTANCE STANDARD (DENSE)		
Psychiatric Care (Adult & Pediatric)	Within 15 business days of request	15 miles or 30 minutes from beneficiary's residence		
Mental Health (Non-psychiatry)	Within 10 business days of request	15 miles or 30 minutes from beneficiary's residence		

We developed the standards shown above to ensure that members have appropriate availability of behavioral health clinicians and facilities within a defined geographic distance. This year, a new standard was included to monitor the availability of Medication Assisted Treatment (MAT).

An analysis of the results of the annual measurement of OHBS-CA network geographic availability shows that clinicians and facilities are in geographic positions of availability to provide services to membership in all urban, suburban and rural areas of California with the exception of acute care facilities.

There is an overall scarcity of inpatient behavioral health facility programs throughout California, especially in rural areas. We continue to monitor these areas for new programs that are willing and able to contract with us to enhance the availability of services for the members we serve.

# Improvements Noted in Clinician's Satisfaction

In 2018, 1,322 Network clinicians in California responded to our Provider Satisfaction Survey that measures clinician satisfaction with areas of service including: Network Services staff, the Authorization Process, Claims/Customer Service, Credentialing, and website usage, and measures Net Promoter Scores (NPS).

OHBS-CA saw significant improvements in overall satisfaction and in satisfaction with Network Services staff, Claims/Customer Service, the Authorization Process and Provider Express. The Net Promoter Score also improved substantially over the 2017 results.

We greatly appreciate the valuable feedback you provide through the web-based survey. Your responses help us identify what we are doing well, and where we need to improve our service. Thank you to all of you who took the time to participate in the survey.





# Employee Assistance Program FAQ

To help you learn more about Employee Assistance Program (EAP) services and processes, we are including some of the questions we most often receive about EAP

## WHAT IS EAP?

EAP is a health and wellness benefit provided by one's employer. The EAP benefit is designed to provide assessment and referral, as well as brief counseling interventions for members. The typical EAP benefit offers a limited number of routine, weekly sessions with a clinician for brief counseling services but is not designed to be used for an ongoing course of psychotherapeutic treatment. EAP covers routine individual, family, couples and group therapy.

EAP services are a benefit paid for by the member's employer and remain confidential.

## WHY SHOULD I CHOOSE TO ACCEPT AND BILL EAP?

Members have no financial responsibility for EAP services - **no deductibles, co-payments or coinsurance** amounts for you to collect. EAP claims are paid in full at your in-network contracted rate for routine behavioral health services.

Accepting EAP members can help build your practice and create word-of-mouth referrals.

## WHAT DO I DO IF A MEMBER EXHAUSTED ALL PRIOR AUTHORIZED EAP SESSIONS?

EAP covers the initial assessment and brief counseling for a member's needs. The benefit is purchased by a member's employer and may be separate from the member's behavioral health insurance policy. However, for many members who have EAP benefits through Optum, we also provide their behavioral health insurance. For those members, you can smoothly transition into ongoing counseling, if needed, once a member has exhausted their EAP sessions. You would just continue to bill us using standard behavioral health procedure codes. If a member is not covered by Optum behavioral health insurance, when EAP sessions have been exhausted you should contact the member's behavioral health insurance to determine their coverage and benefit options.

## ARE MEMBERS EVER ELIGIBLE FOR ANOTHER EAP AUTHORIZATION?

Based on company benefits and a member's needs, there are occasions when a member may be eligible for another EAP authorization. Since EAP covers brief assessment, referral, and counseling, a member may be eligible if they have a new presenting problem that is separate from the initial reason they entered counseling. This does not include separate or new symptoms or if problems evolve within the course of treatment. If you believe a member may be eligible for another EAP authorization due to a new, unrelated issue that needs assessment and treatment, call the Optum EAP number on the back of the member's ID card 24/7 to determine eligibility.

## CAN ANY PROVIDER BILL EAP SERVICES?

All therapists contracted with Optum for commercial behavioral health members are allowed to bill for EAP services. Optum does not have a separate EAP network, creating ease in providing ongoing services and billing. Please note that only a few contracts allow psychiatrists to bill for EAP services.

## HOW DO I BILL EAP SERVICES?

Authorizations for EAP services are required and may be initiated by either the member or the provider prior to the first appointment. To request authorization, call the behavioral health number on the back of the member's ID card. EAP authorization letters are sent directly to the member via email or postal service. When a member presents for EAP services, inquire about the EAP authorization code number, effective dates and expiration dates, and whether any of the authorized visits have already been used.

All EAP claims must include an HJ modifier following the allowable CPT code to be processed and paid correctly. The easiest way to bill is through [providerexpress.com](http://providerexpress.com), where you will be prompted to select BH or EAP. If you

select EAP, the HJ modifier will automatically populate.

EAP services can also be provided via virtual visits sessions. When services are provided virtually, the GT modifier must also be included on the claim, in addition to the HJ modifier.

Optum EAP always allows the following procedure codes:

### Accepted CPT Codes

- 90832HJ – 30-37 min individual therapy
- 90834HJ – 38-52 min individual therapy
- 90846HJ – Family therapy without the patient in attendance
- 90847HJ – Family therapy with the patient in attendance
- 90853HJ – group therapy other than family

*Note: extended therapy visits (90837) are not covered by Optum EAP. There are occasions in which a formal diagnostic assessment (90791) may be covered. Please call to discuss further.*

*Also, your contracted rates are the same for EAP services and for routine outpatient therapy services.*

## WHO DO I CONTACT IF I HAVE OTHER QUESTIONS REGARDING EAP?

You can call Optum Employee Assistance Program 24/7. You can find the member's dedicated EAP number on the back of their ID card or you can reach our general EAP team 24/7 at **1-800-358-8515** for assistance.



---

# EAP Management Consultation

---

When an employee's manager or supervisor has concerns about the individual's behaviour or wellbeing related to their job, they will often reach out to Optum Employee Assistance Program (EAP) workplace support services. This resource provides confidential and voluntary support for the employee to address personal or emotional concerns that may be impacting job performance.

As a provider in our network, an Optum Management Consultant may reach out to you to inquire about your availability and willingness to take the referral. The Management Consultant will provide you with background information, including the reason for the referral and expectations of the workplace. Appointments should be made within a 24-72 hour timeframe in consideration of the workplace needs. In addition to addressing the workplace concerns, you will be asked to assess the clinical needs of the employee and determine treatment recommendations, which could range from completing the EAP sessions to a possible need for facility-based care.

These recommendations, along with confirmation of attendance, will be given to the Management Consultant at Optum who is monitoring the adherence and,

with the proper consents in place, is reporting back to the workplace. Note that, with the employee's consent, only attendance and adherence are being reported back to the workplace and no clinical information is being shared.

### Authorization process:

Once you accept the referral, the Management Consultant will send you an authorization letter. Claims can be submitted using your standard process. We recommend submitting your claims through [providerexpress.com](http://providerexpress.com) or Electronic Data Interchange (EDI) but claims can also be submitted on a Form 1500 (CMS 1500 Claim Form). You should always add the HJ modifier after the CPT code for any EAP session. Authorizations will normally include one Initial Diagnostic Interview, CPT code 90791, and the remaining sessions will be for Individual Therapy, CPT code 90834.

The Management Consultant will ask for regular updates, confirming that appointments have been made and kept.

Typical reasons for referral:

- Changes in employee behavior impacting his/her work performance
- Assisting an employee access appropriate mental health referrals



- Workplace violence or threats (risk to self or others)
- Trauma or death of another employee or an employee's family member impacting the workgroup
- Substance abuse or suspected Substance Use Disorder(s)
- Communication strategies
- Identifying and supporting employees at risk for harm to self or others

When you accept an EAP referral, you provide a valuable opportunity for the employee to succeed in their personal life and in the workplace. Within the workplace, this strategic use of the Employee Assistance Program can help improve an employee's performance and their general wellbeing. The value of this, in turn, can include a decrease in absenteeism, help promote a safer work environment for all, and increase the overall engagement of the employee.

---

# California Language Assistance Program

---

The OHBS-CA Language Assistance Program includes provisions for both the provider network and OHBS-CA to ensure that members with limited English proficiency can obtain language assistance when needed:

- Requirements for clinicians and facilities
- Tips for working with interpreters
- Tips for working with members with limited English proficiency

- Grievance forms and notices of language assistance

Learn more on Provider Express > Admin Resources > [California Language Assistance Program](#).

---

# Members Highly Satisfied with Treatment & Services

---

OHBS-CA administers the Member Satisfaction Survey to a sample of members who receive services from an OHBS-CA network clinician. Results are analyzed annually and the findings are used to identify opportunities to improve the member experience.

The 2018 survey assessed member satisfaction along multiple domains including:

- Obtaining referrals or authorizations

- Accessibility and acceptability of the clinician network
- Customer service; treatment/quality of care
- Overall satisfaction

Results of the survey indicate that members experience high overall satisfaction with treatment received. 85% of members indicated that they would use these services again. 91% of members indicated that they were

able to find care that was respectful of language, cultural, and ethnic needs. 93% of the members surveyed reported that the treatment they received from their clinician helped them better manage their problems. Overall member satisfaction with services received from OHBS-CA was 88%.



---

## Public Policy

---

In accordance with California law, U.S. Behavioral Health Plan, California (“USBHPC”) dba OptumHealth Behavioral Solutions of California (“OHBS-CA”) has a Public Policy Committee to provide a formal structure for the comments and participation of covered members, and employer and health plan representatives. This committee consists of at least three subscriber enrollees of OHBS-CA, one contracted clinician and one member of our Board of Directors.

Responsibilities of the Public Policy Committee include:

- Evaluating care and service proposals
- Defining public policy in accordance with the state’s Knox-Keene Act
- Reviewing and discussing member grievance data
- Examining member and provider satisfactions survey results

- Reviewing the company’s financial condition
- Making recommendations to the USBHPC Board of Directors regarding quality of care and service

The Public Policy Committee meets quarterly, and reports to our Board of Directors. For more information regarding committee membership, please contact OHBS-CA at [optumdmhc@optum.com](mailto:optumdmhc@optum.com).

---

## Coordinating Care for Healthier Lives

---



As a specialty, behavioral healthcare has an obligation to foster overall healthier lives. At OHBS-CA, our mission is to help people live their lives to the fullest. One of the important ways in which we work toward that goal is by promoting ongoing coordination of care for patients. We take an active role in this process and expect our network providers to do so as well.

Provider Express offers information regarding the importance of coordination of care and provides tools to make it easier for you to document your coordination of care activities:

- [Coordination of care checklist](#)
- [Coordination of care flyer](#)
- [Other coordination of care tips](#)

# Quality Achievements

The Quality Management (QM) Program monitors access to care and availability of clinicians, quality of care and services, patient safety, and appropriate utilization of resources. Each year, an in-depth evaluation of the QM Program is performed. This includes a review of the processes that support these components of care along with OHBS-CA overall structure. The findings of the most recent evaluation conducted in 2018 include:

- Outstanding performance in the areas of network availability and accessibility
- High performance in the areas of customer service call response time and claims payment accuracy, and turn-around times for claims processing, provider disputes, and non-coverage determinations
- Appointment for emergent care (non-life threatening) offered within 6 hours was at 100%
- Appointment for urgent care offered within 48 hours was at 100%
- Member complaints remain below the performance threshold, with 100% of complaints resolved within 30 days of receipt

An Executive Summary of the most recent QM performance evaluation is available by calling toll-free **1-877-614-0484**.





# AUTISM/APPLIED BEHAVIOR ANALYSIS INFORMATION

Provider Express – Admin Resources – [Autism/ABA Information](#)

## ABA Coding Changes Effective March 30, 2020

Earlier in 2019, the American Medical Association (AMA) announced changes related to coding and billing for some behavioral health services beginning on January 1, 2019. Certain temporary CPT codes, used to bill for Applied Behavior Analysis (ABA) services, expired effective December 31, 2018. Optum currently utilizes Healthcare Common Procedure Coding System (HCPCS) codes for ABA commercial membership and we elected to adopt the changes related to billing and coding at a future date.

**For claims with dates of service on and after March 30, 2020,** replacement CPT codes will apply for applicable ABA services. Claims for dates of service on or after March 30, 2020 that are submitted using the HCPCS codes may be subject to denial. If you are a provider who is currently contracted to bill for ABA services using HCPCS codes, a new fee schedule that includes the updated code set will be sent to you prior to March 30, 2020.

This fee schedule will include eight permanent and two temporary codes and associated rates for ABA services, which are based on our review of the market.

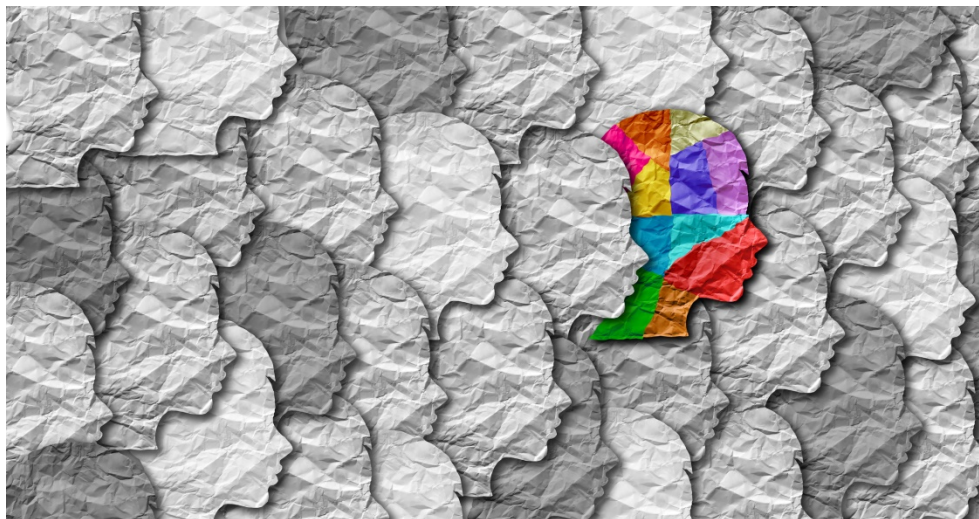
Please note the following changes to our ABA Program with the roll-out of these new codes:

- Ability to utilize BCaBAs as BCBA extenders, billing with the outlined modifiers under your group
- Modifiers are to be used in billing to reflect the credentials of staff delivering services and to allow for proper claims payment (HN = Bachelor's degree level – BCaBA; HM = less than Bachelor's degree level – Behavior Technician)
- Ability to bill concurrently for both Supervisors and Behavior Technicians services during the supervision time, billing with 97153 and 97155
- Ability to utilize Behavioral Technicians for ABA Assessments, billing with 97152

Please inform your billing department of this upcoming change as soon as possible to ensure that all staff is aware of the change and that system updates occur, as needed, to enable submission of claims with appropriate codes beginning with the March 30, 2020 date of service.

You can find Frequently Asked Questions, information about the CPT Code changes, and other ABA resources at: [providerexpress.com](http://providerexpress.com) > Autism/ABA Corner > [Autism/ABA Information](#).

Should you have any questions, please contact the Provider Services Line at **1-877-614-0484**.



---

# ABA Virtual Visit Services: Supervision of Behavior Technicians, Family Training and Guidance

---



Did you know that some ABA services can now be delivered virtually? Beginning in April, 2019, ABA Supervision of Behavior Technicians and Family Training and Guidance services can be provided via virtual visits, that is, via real-time, audio/video sessions with your clients' family member or caregiver. The capability to include the virtual modality will make it easier and more convenient for you and your clients to schedule and participate in training sessions. The reimbursement for these virtual services will be the same as for providing family training in person, but with the added convenience of being able to meet online at a time that works best for both you and your clients.

In order to provide supervision and family training services

virtually, you must be an approved Optum virtual visits provider who has attested to meeting the requirements specific to providing virtual services. If you are already an approved "remote supervision" provider, please complete the online virtual visits ABA provider/groups **Attestation**. Your attestation will be processed in approximately 10 business days, after which you may begin to provide supervision and training services virtually.

When completing the authorization process, be sure to alert the Care Advocate that the training services will be provided virtually. When billing for the authorized virtual ABA Supervision of Behavior Technicians and Family Training and Guidance services, use the same procedure code on your claim that you would

use for an in-person service, H0032 or H2012. Use a "Place of Service" code of "02" to indicate the service was provided through a virtual visit. It's that simple.

Beginning March 30, 2020, when the new 2019 CPT code for this service is implemented, you will use the codes 97155 and 97156 with the "02" place of service on your claims instead of the current H0032 or H2012 code. (See the **ABA Coding Changes Effective March 30, 2020** article on page 9 of this newsletter).

Additional information and resources related to Applied Behavior Analysis services can be found on our Autism/Applied Behavior Analysis page on Provider Express.

# IMPORTANT REMINDERS

## AFFIRMATIVE INCENTIVE STATEMENT

*Note: The Optum Level of Care Guidelines are being replaced by LOCUS, on December 14, 2019, and CASII and ECSII on January 31, 2020. See the [Adoption of LOCUS/CASII/ECSII Clinical Criteria](#) article on page 1 of this newsletter for more information on our transition to LOCUS, CASII and ECSII.*

The clinical guidelines and Psychological and Neuropsychological Testing Guidelines are sets of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and well-being. OHBS-CA's 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.

You will find these, along with Best Practice Guidelines and the Supplemental and Measurable Guidelines, at [Provider Express > Guidelines/Policies & Manuals](#).

OHBS-CA expects all treatment provided to members be outcome-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. Utilization management decision making is based only on the appropriateness of care and service and existence of coverage. OHBS-CA 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.

## CARE ADVOCACY PROCESS PROVIDES PEER REVIEW DISCUSSION

Our care advocacy process offers every clinician the opportunity to discuss a potential adverse benefit determination based on medical necessity with an appropriate peer reviewer at OHBS-CA before a final determination is made. You may request a discussion with a peer reviewer at any time during the decision process or after the decision has been made. You may reach a peer reviewer by calling the number shown in the certification letter or an adverse determination letter or by calling the number on the back of the member's ID card and requesting to speak with a peer reviewer.

## UNIVERSITY OF CALIFORNIA EMPLOYEE CLAIMS

We encourage all clinicians to submit claims electronically, either through our secure web site, [providerexpress.com](#), or via Electronic Data Interchange (EDI). However, if you do not submit your claims electronically, please remember that claims for employees of the University of California must be submitted to their designated claims address:

**Optum  
PO Box 30760  
Salt Lake City, UT 84130-0760**

If you submit your claims electronically, no special handling is required. For more information on electronic submission of claims, see [Provider Express > Admin Resources > Electronic Payments and Statements \(EPS\)](#).



---

# CLAIM TIPS

---

## HOW TO RESOLVE A CLAIM ISSUE:

When the claim was submitted with incorrect/inaccurate information, the following options are available:

1. **Log In** to Provider Express and submit a Corrected or Void claim via the *Claim Entry* transaction.
  - Choose "Corrected" or "Void" as the Claim Frequency Code option
  - Enter the claim number of the original claim (claims must be in a finalized status in order to correct or void them).For additional information, view **Guided Tour – Overview of Filing COB and Corrected Claims**, pages 24 – 28.
2. Complete a Form 1500 (claim form) with corrected information
  - Write "CORRECTED CLAIM" or "VOID CLAIM" across the top of the form
  - Attach a copy of the original statement and mail to the address listed on that statement.

---

To resolve a claim issue where the claim was processed incorrectly, the following options are available:

1. **Log In** to Provider Express and submit a Claim Adjustment Request. For additional information, view **Guided Tour – Claim Inquiry and Claim Adjustment Request** (video).
2. **Log In** to Provider Express and contact a claims representative via "Live Chat" through "Claim Inquiry" or, if claim was submitted online, through "My Submitted Claims".
  - Locate the claim and towards the upper right on either "detail" page (above the member's ID #), click the link "Have questions about claim status?" to access "Claims Live Chat".
  - If you cannot locate the claim, then click the "Can't find claim status online?" link on the main Claim Inquiry page.
3. Call the Claims Department at **1-800-358-8515** (or the number on the back of the member's ID card). A Claims Specialist can review, research and, if necessary, reprocess your claim.
  - When prompted, select "Claims Status"
  - Be prepared with the member's date of birth, date of service and claim number
  - Make note of the reference number you're given, which can help you if any follow-up is needed.

---

## WHERE TO MAIL A CLAIM, APPEAL OR GRIEVANCE

- We recommend submitting your claims electronically. They do not require a mailing address and typically result in faster processing.
- If you must submit your claims on paper, there are a number of different Optum mailing addresses depending upon the member's benefit plan. Find where to submit your claim on *providerexpress.com* > Admin Resources > Claim Tips > **Where to Submit Your Optum Claim**.
- A provider claim appeal or grievance may be submitted through secure "Transactions" on *providerexpress.com* or by using the following contact information:

**Optum Appeals**

**PO Box 30512**

**Salt Lake City, UT 84130-0512**

Fax: **1-855-312-1470**

Phone: **1-800-685-2410**

---

## ELECTRONIC PAYMENTS AND STATEMENTS CONTACTS

- Call **1-877-620-6194** (7:00 a.m. to 6:00 p.m. CST Monday – Friday)

---

## ADDITIONAL CLAIM TOOLS AND TIPS

- **Claim Entry Through Provider Express**
- **Claim Submission Hints**
- **EAP Claims**
- **Electronic Claim Submission (EDI)**
- **Electronic Payments and Statements (EPS)**
- **Improve the Speed of Processing**
- **Inpatient/Facility Claims**
- **Outpatient Claims**