OPTUM HEALTH BEHAVIORAL SOLUTIONS OF CALIFORNIA[1]
REQUESTS FOR BEHAVIORAL HEALTH CARE SERVICES

Optum Health Behavioral Solutions of California ("OHBS-CA" or the "Plan") administers managed behavioral health care benefit plans for eligible members throughout California. These benefit plans vary in types of benefits and amounts of coverage. Written policies and procedures describe the criteria the Plan uses to review and approve, modify, or deny requests for behavioral health care services according to the specific benefit plans administered by the Plan. These policies and procedures are available free of charge to individual providers/facilities, members, authorized member representatives and to the public upon request.

With the goal of delivering high quality behavioral healthcare for member, OHBS-CA adheres to utilization management decision-making timelines, ensures the involvement of appropriately qualified behavioral healthcare professionals in the decision-making process, and gathers relevant clinical information in a consistent manner by personnel who make utilization management decisions. Clinical criteria and guidelines are developed with input from actively practicing network providers who have recognized expertise in various mental health and substance use diagnostic areas. They are evaluated annually by a team of behavioral health professionals including the Plan's medical director, and updated as necessary to include new scientific information regarding effective clinical practice.

WHAT ARE BEHAVIORAL HEALTH SERVICES?

Behavioral Health Services are those services arranged by OHBS-CA for the medically necessary treatment of mental disorders, including treatment for the severe mental illness of an adult or child and/or the serious emotional disturbance of a child, and/or alcohol and drug problems, also known as substance use disorder.

ACCESS TO BEHAVIORAL HEALTH SERVICES

A toll-free number is available to Plan members and providers twenty-four (24) hours a day, seven (7) days a week. When a member (or a provider on behalf of a member) calls seeking a referral to behavioral health services, OHBS-CA staff 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 concern(s). Referrals are based on the clinical, linguistic, cultural, and geographic needs of the member. Members are advised of any deductible, co-payment, and/or coinsurance amount for which s/he is financially responsible.

HOW OHBS-CA REVIEWS REQUESTS FOR BEHAVIORAL HEALTH SERVICES

The Plan reviews requests for routine (non-urgent) and urgent behavioral health services and makes a determination to authorize, modify or deny the request. Routine and urgent requests may be reviewed before services are rendered (prospectively) or while care is underway

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[1]OptumHealth Behavioral Health Solutions of California is also known as U.S. Behavioral Health Plan, California or USBHPC.

(concurrently). Requests for routine services that have already been rendered (retrospectively) may also be reviewed and a determination made. Requests for services are reviewed by appropriately qualified Plan personnel. For facility-based services, only a board certified psychiatrist or addictionologist with a current, unrestricted California license can modify or deny requests for services based in whole or in part on medical necessity. For outpatient services, either a doctoral level clinical psychologist with a current, unrestricted California license and who has the competency to review the case, or a board-certified psychiatrist with a current unrestricted California license, is able to make the decision to modify or deny requests.

Decisions to authorize, modify or deny coverage are based on coverage determination guidelines developed by the Plan. These guidelines are consistent with sound clinical principles and processes that are approved and published by professional organizations such as the American Psychiatric Association.

TIMELINES FOR MAKING DECISIONS ON REQUESTS FOR SERVICES

Decisions on requests for *routine* behavioral health services prospectively or concurrently are made within five (5) business days from the time the Plan receives the information necessary to make a determination. Decisions on requests received for retrospective review are made within thirty (30) calendar days of receipt of the necessary information.

When the member's need is *urgent* or *emergent*, decisions on requests for behavioral health services are made as soon as possible to accommodate the member's clinical condition but do not exceed 72 hours from the request.

COMMUNICATING THE DECISION OF REQUEST FOR SERVICES

When services are approved and authorized, members are notified in writing of the approval. If the services are modified or denied, members and providers are notified in writing within two (2) business days of the Plan's decision. This notice includes: the clinical reason(s) for the modification or denial; a description of the criteria or guidelines used; the right to appeal the decision to the Plan; the right to access relevant portions of the member's medical records; the right to free language assistance upon request, and the member's right to contact the California Department of Managed Health Care regarding a grievance or to apply for Independent Medical Review. Decisions regarding requests for care that is underway are made and communicated to the member's treating provider within 24 hours of the Plan's decision.

If the Plan is unable to make a decision to authorize, modify or deny within the required timeframes, the Plan notifies the member and the provider of any additional information needed to make a decision and of the anticipated date when a decision may be made, within five (5) business days of receipt of the request.

QUALITY ASSURANCE

The Plan has an established quality assurance program which monitors and routinely evaluates the Plan's processes for handling requests from providers and members for behavioral health services. The Plan evaluates complaints, assesses trends, implements actions to correct identified problems, analyzes the impact of corrective actions, and communicates this

information to the Plan’s provider network, as well as to OHBS-CA leadership and functional departments. Opportunities for improvement are addressed within the Plan’s committee structure and recommendations for procedural or operational changes may be made as a result thereof. Also, when indicated, work groups may be chartered to assess root causes and propose interventions.

CONTACT OHBS-CA FOR MORE INFORMATION ABOUT REQUESTING BEHAVIORAL HEALTH SERVICES

For additional questions about the Plan’s process for reviewing, authorizing, approving, modifying or delaying requests for behavioral health care services and/or the applicable procedures, please see the attached related documents or contact OHBS-CA at 1-800-999-9585.

Initial Authorization for Behavioral Health Services.pdf

Non-Coverage Determinations.pdf