Topic	Outpatient
Benefit Plans	
Is there more than one benefit plan type in the Idaho Behavioral health plan	No, there is only one benefit plan.
Waivers	
Are there waivers in place granting additional services to a population of members	No, there are not waivers granting additional services to a population of members in place at this time.
Medical Necessity	
Is medical necessity a requirement in the plan documents/member handbook?	Yes
Does the plan issue denials based on medical necessity reviews?	Yes
If YES, for what services/procedures/diagnoses - in each benefit classification - is medical necessity applied?	Medical Necessity is applied to all services offered. The following services require prior authorization: Psychological Testing, Neuropsychological Testing, Community Based Rehabilitation Services, Skills Training and Development (or Partial Care), Community Transition Support Services. Additionally, if the established threshold is exhausted during the calendar year for the following services, a prior authorization is required: BH Case Management, Case Management- Substance Abuse, Telephonic Case Management, Peer Support by a qualified Peer Support Specialist, Family Support by a qualified Family Support Specialist, Extended Office Visits, Community-Crisis Intervention, BH Assessment and Individualized BH Treatment Plan.
How is 'medical necessity' defined in your organization?	Per Idaho Administrative Procedures Act (IDAPA) 16.03.09.011.16, a service is medically necessary if: a) it is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and b) there is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. Per IDAPA 16.03.09.880, 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. In addition, Optum uses nationally recognized guidelines in developing Level of Care Guidelines (available at www.OptumIdaho.com).

Is your medical necessity criteria internally or externally developed?	The Level of Care Guidelines are developed by Optum for each service are available at www.OptumIdaho.com.
If developed internally, please describe the process (e.g., literature review, other considerations)	Optum's Level of Care Guidelines Workgroup and Utilization Management Committee utilize the following sources to develop Level of Care Guidelines (LOCGs): APA Guidelines, American Academy of Child & Adolescent Psychiatry, ASAM, Diagnostic and Statistical Manual of Mental Disorders. All level of care guidelines are submitted to IDHW for review and approval.
What are your criteria for choosing to apply medical necessity? Even if all services are SUBJECT to medical necessity, describe where it is APPLIED (when, why how?)	All services must be medically necessary. The following services do not require a prior authorization: Comprehensive Diagnostic Assessment (including treatment plan), Comprehensive Diagnostic Assessment by a Prescribing Professional (including treatment plan), Individual Assessment and Treatment Plan for Substance Abuse (including administration of the GAIN), Drug/Alcohol Testing, Office Outpatient-New Patient, Office Outpatient-Established Patient, Individual Psychotherapy by Physician (30 minutes),Individual Psychotherapy by Physician (45 minutes), Therapeutic, prophylactic or diagnostic injection, Telehealth Transmission, Telehealth Originating Site Facility Fee, Language Interpretation Services. The following services require an open authorization: Individual Psychotherapy (30 minutes), Individual Psychotherapy (45 minutes), Family Psychotherapy without patient present, Family Psychotherapy with patient present, Group Psychotherapy, Transportation Modifier to be used only with home-based family therapy and individual therapy in the home with the member present, Individual Drug/Alcohol Counseling, Group Drug/Alcohol Counseling. The following services require a provider specific authorization: Psychological Testing, Neuropsychological Testing, Community Based Rehabilitation Services (CBRS), Skills Training and Development (or Partial Care), Community Transition Support Services. The following services do not require authorization (prior or retro) up to a pre-determined threshold: BH Case Management, Case Management-Substance Abuse, Telephonic Case Management (either BH or Substance Abuse), Peer Support by a qualified Peer Support Specialist, Family Support by a qualified Family Support Specialist, Extended Office Visits, Community-Crisis Intervention (at earliest opportunity), BH Assessment, Individualized BH Treatment Plan. There is uniform application of medical necessity across all service offerings. This is applied at all levels of clinical review, beginning with Care Advocate and clinic interaction, extending through peer reviews, at all appeal levels. Optum also provides medical necessity information to support the State Fair Hearing process. Relevant documents include Management of Behavioral Health Benefits Policy, Clinical Model 2017 and Level of Care Guidelines.
Does the plan limit any medical services based on a behavioral diagnosis (e.g., nutritional counseling is limited to 10 annual visits for eating disorders, but unlimited for all other diagnoses)?	There are no hard limits for services covered in the Idaho Behavioral Health Plan. The following thresholds are in place and can be exceeded if additional units are requested and are medically necessary: 60 hours annually of Case Management; 104 hours annually of Peer Support; 52 hours annually of Family Support; 10 hours annually of Crisis Intervention. Additionally, there is a threshold in place for 12 hours annually of extended psychotherapy for diagnoses of PTSD using an EMDR intervention or prolonged exposure approach. It can be exceeded if additional units requested are medically necessary.

Authorization/Notification	
Do you require notification?	No
Do you require prior authorization/pre-determination?	Yes
If YES, what information do you require and how do you use this information?	Service Request Forms are available at www.OptumIdaho.com. Optum applies the Level of Care Guidelines (available at www.OptumIdaho.com) to the information to submitted through the process described in the Clinical Model (available at www.OptumIdaho.com).
Which services/procedures/diagnoses require prior authorization/pre-determination? Please list for each benefit classification	There are no hard limits for services covered in the Idaho Behavioral Health Plan. The following services do not require a prior authorization: Comprehensive Diagnostic Assessment (including treatment plan), Comprehensive Diagnostic Assessment by a Prescribing Professional (including treatment plan), Individual Assessment and Treatment Plan for Substance Abuse (including administration of the GAIN), Drug/Alcohol Testing, Office Outpatient-New Patient, Office Outpatient-Established Patient, Individual Psychotherapy by Physician (30 minutes),Individual Psychotherapy by Physician (45 minutes), Therapeutic, prophylactic or diagnostic injection, Telehealth Transmission, Telehealth Originating Site Facility Fee, Language Interpretation Services. The following services require an open authorization: Individual Psychotherapy (30 minutes), Individual Psychotherapy (45 minutes), Family Psychotherapy without patient present, Family Psychotherapy with patient present, Group Psychotherapy, Transportation Modifier to be used only with home-based family therapy and individual therapy in the home with the member present, Individual Drug/Alcohol Counseling, Group Drug/Alcohol Counseling. The following services require a provider specific authorization: Psychological Testing, Neuropsychological Testing, Community Based Rehabilitation Services (CBRS), Skills Training and Development (or Partial Care), Community Transition Support Services. The following services do not require authorization (prior or retro) up to a pre-determined threshold: BH Case Management, Case Management-Substance Abuse, Telephonic Case Management (either BH or Substance Abuse), Peer Support by a qualified Peer Support Specialist, Family Support by a qualified Family Support Specialist, Extended Office Visits, Community-Crisis Intervention (at earliest opportunity), BH Assessment, Individualized BH Treatment Plan.
Can an prior authorization/pre-determination result in a medical necessity or coverage determination denial?	Yes, subject to the outcome of appeals and fair hearing process.
What criteria do you use to determine which services/procedures/diagnoses require prior authorization/pre-determination (e.g., cost of service, procedure, diagnosis, case complexity, attending and facility)?	Utilization data is reviewed on a regular basis by diagnosis, procedure, and case complexity to determine which services have the most variation among providers, as well as deviation from standard utilization.

Is there a penalty for failure to prior authorize/pre-determine?	Yes
If YES, what is the penalty?	Partial or Full denial
Is the penalty (including denial) to the member (based on benefit plan) or the providers (based on network agreement) by the specific service/procedure in each benefit classification	Provider
Retrospective Review	
Do you allow for back date for services when prior authorization/pre-determination is required?	Yes, when there are retrospective enrollment and services provided where medically necessary or decision is overturned upon outcome of a provider contractual dispute or member appeal / fair hearing.
Prior to the submission of a claim, are retrospective reviews provided on request any time after the initial grace period?	Yes
If YES, please provide the guidelines.	A retrospective review may be requested when extenuating clinical circumstances (e.g., member eligibility, coordination of benefits) prevent the provider's ability to obtain a required pre-service review and prior authorization, and a claim has not been filed. Retrospective review requests must be submitted within 365 calendar days following the date(s) of service. For all retrospective reviews, Optum will issue a determination within 30 calendar days of receipt of the request. Detailed guidelines for the submission are available on page 46 of the Provider Manual (available on www.OptumIdaho.com).
Concurrent Review	
Do you conduct concurrent review?	Yes
If YES, what information do you require and how do you use this information?	When continued services are medically necessary, providers are expected to request additional services in advance of the expiration of the current authorization, with requested dates that do not overlap the existing authorized services. Providers request continued services utilizing the Service Request Form. Optum applies the Level of Care Guidelines (available at www.OptumIdaho.com) to the information submitted through the process described in the Clinical Model (www.OptumIdaho.com).
Can a concurrent review result in a modification of the services requested?	Yes

Can a concurrent review result in a medical necessity or coverage determination denial?	Yes
What criteria do you use to determine which services/procedures/diagnoses require concurrent review (e.g., cost of service, procedure, diagnosis, case complexity, attending and facility)?	Criteria is based on utilization patterns and procedures.
Which services/procedures/diagnoses require concurrent review? Please list for each benefit classification.	The following services require a provider specific authorization and are subject to concurrent review: Psychological Testing, Neuropsychological Testing, Community Based Rehabilitation Services (CBRS), Skills Training and Development (or Partial Care), Community Transition Support Services. The following services do not require authorization (prior or retro) up to a pre-determined threshold and are subject to concurrent review: BH Case Management, Case Management-Substance Abuse, Telephonic Case Management (either BH or Substance Abuse), Peer Support by a qualified Peer Support Specialist, Family Support by a qualified Family Support Specialist, Extended Office Visits, Community-Crisis Intervention (at earliest opportunity), BH Assessment, Individualized BH Treatment Plan.
For each of these services, what criteria do you use to determine the frequency of concurrent review (e.g., external benchmarks such as Milliman, ALOS, cost of service, procedure, diagnosis, case complexity, attending and facility)?	Criteria used to determine frequency of concurrent review includes external benchmarks, procedure, diagnosis, and case complexity.
In the context of concurrent review, do you retrospectively deny services deemed to be unnecessary or provided at a higher level of care than necessary?	No
For OP, if additional sessions are not given via concurrent review, please indicate how new auths are obtained once the original authorized services are exhausted?	New authorizations are obtained by the provider submitting the Service Request Form (available at www.OptumIdaho.com). Service Request Forms are submitted on Provider Connect (web portal). Coverage determinations for non-urgent cases will be made as expeditiously as enrollee condition requires and within 14 calendar days. Coverage determinations for urgent/expedited cases will be made as expeditiously as enrollee condition requires and within 72 hours of the receipt of a telephonic or written request. Expedited service authorizations are intended for cases where the provider, attending health care professional, indicates that following the standard timeframe could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function.

Post-Service Review	
Upon receipt of claims, are services tha**t do not require prior authorization/pre-determination** identified and reviewed post-service for medical necessity or benefit coverage?	Yes via a proprietary algorithm that is a routine and consistent method that looks for outliers. At the point an outlier is found medical necessity is reviewed.
Do you conduct post-service review on 100% of such claims?	No, see answer above. Only those identified bya proprietary algorithm are reviewed, but all are eligible for purview of review.
If s**ervices require prior authorization/pre-determination/notification and it is not obtained**, are claims penalized/denied without further review, or are medical records requested for post-service review?	Claims deny if a service requiring prior authorization is provided without an authorization on file. Medical records are not requested, but rather provider records are reviewed if/when they submit them when filing a dispute.
Once medical necessity or coverage is determined during appeal or post service review, is an administrative penalty (including denial) applied for failure to follow prior authorization/pre-determination/notification guidelines, or are services paid without penalty to member or provider?	If authorized during appeal, claims are paid for services rendered without penalty to provider. If not authorized during appeal, claims would be denied.
Exclusion for Experimental/Investigational Services	
Does the plan exclude coverage for experimental/investigational services?	Yes
What criteria are used to determine what services are considered experimental/investigational?	The Level of Care Guidelines is a set of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum. The Level of Care Guidelines is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The Level of Care Guidelines is also derived from input provided by clinical personnel, providers, professional specialty societies, consumers, and regulators.

Describe the process used to develop these criteria, including whether these criteria developed internally or externally.	The Level of Care Guidelines is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The Level of Care Guidelines is also derived from input provided by clinical personnel, providers, professional specialty societies, consumers, and regulators.
Network Reimbursement	
Describe the plan's in-network reimbursement methodology, e.g., fee schedule developed on internal factors, market factors, % of Medicare.	The Optum Network Pricing Team determines the rates. Rates are based on market factors, Medicare, internal factors and in accordance with 42 CFR 438.14.
Does reimbursement vary by physician specialty (e.g., cardiologist vs. internist) for the same E&M code? If YES, describe in detail.	No
Does reimbursement vary by license/facility type? (e.g., Provider: MD vs. RN vs. PA, Facility: acute hospital vs. SNF). If YES, describe in detail.	Reimbursement varies by license for MD, PhD, Master's Level and APRN or other Prescribing Nurse Practitioner or Physician Assistant.
Does the plan limit benefits based on geographic location (e.g., State, County, etc.). If YES, describe in detail.	No
Does the plan have contractual or systematic "inflators"? If YES, describe in detail.	No
Does reimbursement vary based on provider/facility quality and/or efficiency or any other performance metrics? If YES, describe in detail.	Providers are paid a uniform rate based on their fee schedule. The ACE program rewards providers with positive outcomes to bill a 3% premium on services as a platinum provider.
Does the plan contract with behavioral health providers directly (e.g., neuropsychologists, social workers, etc.)? If YES, describe in detail. If YES, we will need to discuss alignment of reimbursement	Optum Idaho contracts directly with MDs, PhDs, Masters level clinicians (LCPC, LPC, LMFT, LCSW) and APRNs. Optum also contracts with groups who roster clinicians and agree to a Supervisory Protocol to ensure these non-contracted clinicians are supervised by a Master's level clinician. Reimbursement varies by license for MD, PhD, Master's Level and APRN or other Prescribing Nurse Practitioner or Physician Assistant.

Out-of-Network (OON) Reimbursement - Accommodations (out of network provider utilized for in-network benefit)	
What is the criteria for allowing members to utilize non-contracted providers as in-network?	Optum's Chief Medical Officer and/or acting Medical Director retains the authority at any time to authorize services on a case-specific basis for a member, including services provided by an out of network provider, in which case an Accommodation Agreement is used. Criteria used to make this determination includes accessibility and availability of evidence-based practices. Optum and the out of network provider have an agreement in place for the provider to treat the member. The provider does not become an in-network provider unless they complete the steps to become a credentialed and contracted provider.
What methodology is used to determine OON reimbursement, if applicable?	Rates are negotiated on a case by case basis. Optum uses the rate on the fee schedule as a basis of negotiating the rate.
Please describe how allowed amounts for OON reimbursement is determined, if applicable	Rates are negotiated on a case by case basis. Optum uses the rate on the fee schedule as a basis of negotiating the rate.
If % of Medicare/Medicaid rate is used, at what level is % set?	N/A
If % of billed charges is used, at what level is % set?	N/A
Does OON reimbursement vary by provider license/facility type?	Out of network reimbursement is set on a case by case basis and not just by provider license/facility type. Provider license/facility type may impact the reimbursement, as the OON reimbursement is based on the fee schedule which varies by provider license/facility type.
Credentialing Criteria/Network Admission	
Describe the process to determine who is allowed into the plan’s network.	Optum credentials and contracts with outpatient behavioral health providers for the Idaho Behavioral Health Plan. Optum credentials and contracts with all qualified providers that apply to join the network.

Provide your credentialing criteria.	Optum Idaho follows the guidelines of National Committee for Quality Assurance (NCQA) for credentialing and recredentialing unless otherwise required by law. As part of the credentialing and re-credentialing process, agencies are required to submit documentation supporting their professional and community standing and defining their program offerings. This documentation includes, but is not limited to: Current copies of all licenses required by Idaho for the services you offer including Idaho Medicaid credentialing reports, Current copy of accreditation certificate and/or letter from each accrediting body, General and professional liability insurance coverage (a minimum of $1 million/$3 million), W-9 forms, Disclosure of Ownership and Control Interest Statement, Signed malpractice claims statement/history, Staff roster, Program description including services provided. In addition, documentation confirming completion of criminal background checks on agency employees, in accordance with Idaho Department of Health & Welfare requirements, may be reviewed during site audits.
Does the plan utilize need based criteria (e.g., GeoAccess data) to limit admission to the network? If YES, describe in detail.	No
Describe the process used to terminate network providers when necessary.	A provider's participation with Optum Idaho can end for a variety of reasons. Both parties have the right to terminate the Agreement upon written notice, pursuant to the terms of the Agreement. Notice of the termination including the proposed effective date, a summary of the basis for the action, and, if applicable, the Participating Clinician's or Participating Facility's option to request a hearing on the termination, the time limit within which to request such a hearing, and a general description of the Appeal process.
Does the plan vary member benefits (e.g., co-pay, co-insurance) based on facility/provider tiering? If YES, describe in detail, including the specific benefit variation and the criteria for the tiering.	No
Does the credentialing process affect access?	Optum consistently meets contractually required access standards. In July 2017 Optum reported 100% access in Area 1 (provider within 30 miles in Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties) and 99.8% access in Area 2 (provider within 45 miles in all other counties).
Exclusions for failure to complete a course of treatment	
Does the plan include provisions that exclude coverage for failure to complete a course of treatment?	No
Fail-First/Step Therapy Protocols	
Does the plan include fail-first or step therapy provisions?	No

Pharmacy	
Please confirm that the formulary does not discriminate or apply separate criteria or requirements to drugs used to treat MH/SUD.	Not applicable. The Idaho Behavioral Health Plan only covers outpatient behavioral health services and does not include pharmacy.
Other	
How can someone request the criteria for a service from Optum?	Level of Care Guidelines (LOCGs) are posted at www.OptumIdaho.com. Requests can also be made by phone at 855-202-0983.
How is court ordered or involuntary treatment handled?	Optum recognizes that some SUDS and other services are court related, and that when the member is Medicaid eligible, the SUDS and other providers for these services need to follow the required authorization process. Optum will work closely with the courts and SUDS providers to facilitate compliance with this process. Optum also recognizes that not all court ordered services will meet medical necessity, in which case Optum will work with the provider and court to help the member receive the appropriate services.

What is required in the member's treatment record?

Optum requires that all non-electronic treatment records are written legibly in blue or black ink. All treatment records must include the following: Each member receiving treatment will have an individual treatment record, Each record contains the member's name, address, phone numbers, employer or school information, emergency contact information, relationship and legal status, and guardianship information (when relevant), All entries in the treatment record are dated and include the rendering provider's name, professional degree and license information (when applicable); each entry includes a signature, Appropriate consent for treatment form(s) are present in the record, Documentation of a DSM diagnosis consistent with the presenting problem(s), history, mental status examination, and other assessment data: List medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of mental health condition, The presenting problems and conditions are documented, A behavioral health history, including previous treatment dates and providers, therapeutic interventions and responses, previous medication history, and relevant family history information are documented as obtained during the initial diagnostic assessment, A medical history and/or physical exam (appropriate to the level of care) are documented, A medical health history, including known medical conditions, any drug allergies, previous treatment dates and providers, previous medication history, current treating clinicians, current therapeutic interventions and responses, and relevant family history are documented, Each record indicates what medications have been prescribed, the dosages of each, and dates of initial prescriptions or refills. Informed consent for each medication is present in the record, When a member is prescribed medication, the progress notes include evidence of medication monitoring, A complete mental status exam is documented, A risk assessment including the presence or absence of suicidal or homicidal risk and any behaviors that could present a danger towards self or others is documented. This includes any previous history of risk behaviors, The record includes an assessment of any abuse the member has experienced or perpetrated, The record includes an assessment of the following elements: trauma the member has experienced; spiritual and cultural variables impacting treatment; educational status (appropriate to the member's age); legal issues; and identification of community resources the member and member's family are currently accessing, For adolescents and children, prenatal and perinatal events are documented, along with a complete developmental history (physical, psychological, social, intellectual, and academic). For adolescents only, a sexual behavioral history is documented, The initial assessment includes an assessment for depression, For members 10 and older, a substance abuse screening, including alcohol, drugs, prescription and over the counter medications, and nicotine is present, When a substance abuse issue is identified, the Global Appraisal of Individual Needs (GAIN) is completed. An intervention to address the substance issue is documented, On an annual basis, the member is reassessed. The reassessment includes the member's current status and a new mental status exam, Coordination of care between the provider and other medical or behavioral providers and institutions is documented in the record, The treatment plan is geared towards the individual member's needs and includes treatment goals in the member's own words, There is documentation that the member or legal guardian has agreed to the treatment plan. Member and, when applicable, family involvement in treatment is documented, The treatment plan is consistent with the diagnosis and includes objective and measurable short and long term goals with time frames for goal attainment. The plan also includes an initial discharge plan, Treatment plan updates occur when goals are achieved or new problems are identified, Progress notes document the start and stop time for each session, Progress notes document who is in attendance at each session, Progress notes document the billing code that was submitted for the session, Progress notes identify the type of intervention used during the session, Progress notes reflect reassessments, including on-going risk assessments, Progress notes document progress or lack of progress towards treatment goals, Progress notes include identification of member strengths and

weaknesses and how those impact treatment, Progress notes document the use of any preventive services and referrals to other providers or services, When lab work is ordered, the documentation includes evidence that the provider reviewed the lab results and educated the member about the lab results, When the member is discharged, a discharge summary is completed that includes the reason for discharge, the extent to which treatment goals were met, and any recommended follow up activities, The dates of follow up appointments are documented, Is a member misses an appointment, there is documentation indicating why the appointment was missed (if this is known) and what efforts were made to reengage the member in treatment, The record includes documentation supporting medical necessity for services that are rendered. This includes identification of functional deficits the member is experiencing and how the services that are rendered will address these deficits. The treatment that is provided should be at the lowest level of care necessary to prevent decompensation and the need for a higher level of care, The record includes documentation of any education provided to the member related to treatment options, participation in treatment, coping with behavioral health issues, prognosis and outcomes of treatment, and risks of not participating in treatment, If the member has limited English proficiency, there is documentation indicating that interpreter services were offered and if the member accepted or declined the services During the chart review process, reviewers will make an assessment of the improvement of the member's level of functioning and overall symptom reduction.

Type of FR, QTL, or AL/ADL	Benefit/service(s) to which the limitation applies	Limitation	Benefit Package/Population Description (Adult / Child)	Outpatient	Emergency Services	Can Limit be Exceeded when medically	Notes
Financial Requirement (e.g., deductible, copay, out of pocket maximum)							
n/a	n/a	n/a	n/a	n/a	n/a	n/a	No financial requirements from members
Inpatient, Outpatient, Emergency Services Quantitative Treatment Limit (e.g., day/visit/unit limits, age limits, dollar limits)							
Unit Limits	Peer Support by certified Peer Support Specialist (H0038)	This "Category Four" service is a specialized outpatient service that can be performed up to a certain threshold before a provider specific authorization is needed. Members will receive a specific amount of hours or units each calendar year before authorization is required for additional services. Threshold is 416 units per calendar year. Additional services must be authorized via the prior authorization process (before units run out).	Service is available to all members when medically necessary.	X		Yes	Detailed information provided in Optum Clinical Model posted on www.OptumIdaho.com.
Unit Limits	Family Support by certified Family Support Specialist (H0046)	This "Category Four" service is a specialized outpatient service that can be performed up to a certain threshold before a provider specific authorization is needed. Members will receive a specific amount of hours or units each calendar year before authorization is required for additional services. Threshold is 208 units per calendar year. Additional services must be authorized via the prior authorization process (before units run out).	Service is available to all members when medically necessary.	X		Yes	Detailed information provided in Optum Clinical Model posted on www.OptumIdaho.com.

Unit Limits	Case Management-Substance Abuse (H0006)	This "Category Four" service is a specialized outpatient service that can be performed up to a certain threshold before a provider specific authorization is needed. Members will receive a specific amount of hours or units each calendar year before authorization is required for additional services. Threshold is 240 units per calendar year. Additional services must be authorized via the prior authorization process (before units run out).	Service is available to all members when medically necessary.	X		Yes	Detailed information provided in Optum Clinical Model posted on www.OptumIdaho.com.
Unit Limits	BH Targeted Case Management (T1017)	This "Category Four" service is a specialized outpatient service that can be performed up to a certain threshold before a provider specific authorization is needed. Members will receive a specific amount of hours or units each calendar year before authorization is required for additional services. Threshold is 240 units per calendar year. Additional services must be authorized via the prior authorization process (before units run out).	Service is available to all members when medically necessary.	X		Yes	Detailed information provided in Optum Clinical Model posted on www.OptumIdaho.com.

Unit Limits	Telephonic Case Management (H0023)	This "Category Four" service is a specialized outpatient service that can be performed up to a certain threshold before a provider specific authorization is needed. Members will receive a specific amount of hours or units each calendar year before authorization is required for additional services. Threshold is included with calendar year limits on BH Targeted Case Management (T1017) and Case Management-Substance Abuse (H0006). Additional services must be authorized via the prior authorization process (before units run out).	Service is available to all members when medically necessary.	X		Yes	Detailed information provided in Optum Clinical Model posted on www.OptumIdaho.com.
Unit Limits	Extended Office Visits (90837-90838)	This "Category Four" service is a specialized outpatient service that can be performed up to a certain threshold before a provider specific authorization is needed. Members will receive a specific amount of hours or units each calendar year before authorization is required for additional services. Threshold is 12 hours per calendar year. Additional services must be authorized via the prior authorization process (before units run out).	Service is available to all members when medically necessary.	X		Yes	Detailed information provided in Optum Clinical Model posted on www.OptumIdaho.com.

Unit Limits	Community- Crisis Intervention (H2011)	This "Category Four" service is a specialized outpatient service that can be performed up to a certain threshold before a provider specific authorization is needed. Members will receive a specific amount of hours or units each calendar year before authorization is required for additional services. Threshold is 40 units per calendar year. Additional services must be authorized retroactively through utilization management process.	Service is available to all members when medically necessary.	X		Yes	Detailed information provided in Optum Clinical Model posted on www.OptumIdaho.com.
Unit Limits	BH Assessment (HOO31)	This "Category Four" service is a specialized outpatient service that can be performed up to a certain threshold before a provider specific authorization is needed. Members will receive a specific amount of hours or units each calendar year before authorization is required for additional services. Threshold is units per calendar year (PECFAS/CAFAS); 3 units each for case management, family support and peer support. Due to discreet age delineations for the services, BH assessments for family support and peer support should not be completed for the same member. Additional services must be authorized via prior authorization process; updating with a new PECFAS/CAFAS is dependent upon Member's clinical presentation at the point of transfer, to be determined by the new Provider.	Service is available to all members when medically necessary.	X		Yes	Detailed information provided in Optum Clinical Model posted on www.OptumIdaho.com.

Unit Limits	Individualized BH Treatment Plan (H0032)	This "Category Four" service is a specialized outpatient service that can be performed up to a certain threshold before a provider specific authorization is needed. Members will receive a specific amount of hours or units each calendar year before authorization is required for additional services. Threshold is 16 units per calendar year. Additional services must be authorized via the prior authorization process (before units run out).	Service is available to all members when medically necessary.	X		Yes	Detailed information provided in Optum Clinical Model posted on www.OptumIdaho.com.
Annual Dollar Limits or Lifetime Dollars Limits							
Annual Dollar Limits	n/a	n/a	n/a	n/a		n/a	No annual dollar limits for members.