

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

Chapter III **PROVIDER RELATIONS SERVICES**

Credentialing/Re-credentialing

Gateway Health Plan[®] has delegated to CBHNP responsibility for credentialing and re-credentialing providers of behavioral health services for Gateway Health Plan *Medicare Assured*[®].

CBHNP has an established network of behavioral health providers for Gateway Health Plan *Medicare Assured*[®] that is capable of offering the full scope of care and service resources within established standards of access and choice. All network providers are credentialed and re-credentialed to provide clinical care and services. Gateway Health Plan[®] has formally assigned responsibility for the credentialing and re-credentialing review function to the CBHNP Credentialing Committee. The Credentialing Committee, part of the Provider Network Operations Department, performs the review of behavioral health provider credentials, for credentialing and re-credentialing activities. The Credentialing Committee reviews information and makes recommendations for approval or disapproval of each entity.

The following types of provider organizations, facilities and individual behavioral health providers fall under the scope of authority of the credentialing/re-credentialing process:

- Board Eligible or Board Certified Psychiatrists
- Licensed Psychologists
- Licensed Clinical Social Workers
- Physician Assistants
- Certified Registered Nurse Practitioners
- Hospital/Inpatient Facilities
- Community Mental Health Centers
- Substance Abuse Treatment Organizations

Individual Provider Application

In order to be credentialed for the Gateway Health Plan *Medicare Assured*[®], CBHNP requires each individual behavioral health practitioner to have an active Medicare number. The practitioner must complete a credentialing application. Practitioners interested in joining the Gateway Health Plan *Medicare Assured*[®] network must contact CBHNP Network Development or Credentialing staff and provide a representative with your name, address, date of birth and Medicare number. Before receiving the credentialing application, the provider will receive a Gateway Health Plan *Medicare Assured*[®] provider agreement. The provider must submit the signed agreement to CBHNP. After CBHNP receives the signed agreement, CBHNP credentialing staff will forward the information listed above to our primary source verification provider (Med Advantage CVO). CVO will forward a credentialing application to you for completion. You must complete the application and provide evidence such as copies of diplomas, licenses, insurance riders, documentation of privileges, etc. You may contact CBHNP Credentialing at 1-888-700-7370.

Following the primary source verification processes, the Credentialing Committee makes a determination regarding network participation.

With the exception of information obtained from NPDB and peer references, you have the right to review, if you desire, information received by CBHNP that supported the credentialing decision. Additionally, it is your right to correct any erroneous information that varies substantially from that which you reported and to be made aware of the status of your credentialing/re-credentialing application, upon request.

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Professional Provider Organization and Facility Application Process

Other than Hospitals and Partial Hospitalization Programs, facility and professional provider organizations do not need to complete a Facility Application or be credentialed. These facilities and provider organizations must have all of their Medicare approved practitioners credentialed. The facility or provider organization must complete a Provider Payee Form, Provider Assignment Form and Provider Acceptance form in order to receive payment for those practitioners under that facility or group. To participate in the Gateway Health Plan *Medicare Assured*[®], you must have approval from Original Medicare to provide the service. For example, Medicare may have approved you for outpatient mental health services but not for partial hospitalization. Even though you carry a valid license from DPW for partial hospitalization services, you would not be permitted to bill for *Medicare Assured*[®] Members through Gateway Health Plan[®] until you have approval from Medicare for partial hospitalization services.

You may request an application from the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov. Once in the website, in the search box, enter 855i for individual application, 855b for group or clinic application or 855a for facility application. You may call CBHNP Provider Relations at 1-888-700-7370 to request assistance.

With the exception of information obtained from NPDB and peer references, you have the right to review, if you desire, information received by CBHNP that supported the credentialing decision. Additionally, it is your right to correct any erroneous information that varies substantially from that which you reported and to be made aware of the status of your credentialing/re-credentialing application, upon request.

Credentialing Site Visit

Initial site visits will be required for any potential high volume Provider (licensed organization) or potential high volume independent practitioner. Outpatient services (individual, family and group therapy, medication management and psychiatric evaluations) are considered to be high volume services. Outpatient is typically the gateway to higher levels of care and captures the largest segment of unique Members served. In order to be identified as a potential high volume provider who would require a site visit, the provider/practitioner will indicate that they have existing capacity to serve more than 200 Members. The initial site visit to the office of potential high-volume behavioral healthcare providers and practitioners will occur prior to the credentialing decision. The office site visit includes evaluation of the facility for accessibility, appearance, adequacy of waiting and treatment rooms, appointment availability, and appropriate treatment record keeping practices.

The minimum score for initial and re-credentialing visits is 80%. The Provider Relations Representative will assist the Provider to the extent practical and appropriate relative to improvement. The Provider Relations Representative will provide a report with recommendations for improvement to the Provider, and if a score below 80% is received, will re-visit the site within six (6) months to assess progress. Assistance will be documented in the provider file and will include dates and assistance that was provided. This will continue until the Provider meets standards or declines further participation in the process.

Initial site visits will be required for any non-accredited Provider Organization using the same criteria as indicated above with the following exception. CMS or State review or certification does not serve as accreditation of an organization. However, in the case of non-accredited organization; NCQA permits that CBHNP may substitute a CMS or State review in lieu of the required site visit. State licensing tools have been reviewed and are acceptable to meet CBHNP's standards. CBHNP will obtain the report

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directly from the organization. Should the organization have not obtained full licensure, CBHNP will conduct a site visit.

The application and site visit report are reviewed by the CBHNP Credentialing Committee for an approval or disapproval determination regarding the organization /facility's CBHNP network participation.

Re-credentialing

Re-credentialing involves the periodic review and re-verification of clinical credentials of CBHNP network providers. The Provider Network Operations Department maintains an active file of all CBHNP credentialing decisions. A tickler system ensures each professional provider organization, facility, and individual behavioral health provider is re-credentialed as scheduled. As part of this process, CBHNP periodically reviews provider information from the National Practitioner's Data Bank.

At a minimum the re-credentialing process occurs every three years. The re-credentialing process includes an up-to-date re-examination of all the materials and a review of the following:

- Member complaints and grievances
- Results of quality indicators monitoring and evaluating activities
- Care Management provider profiles, as available
- Utilization Management provider profiles, as available
- Member satisfaction surveys, as available
- Re-verification of licensure standing
- Re-verification of hospital privileges
- Review of incident reports

Adding a New Site or Service

When a high volume provider relocates or opens a new site CBHNP must evaluate the new site. Providers are contractually bound to report changes that affect referrals. CBHNP must review the new site as soon as possible but before the provider's re-credentialing date. Providers who are adding a new service should complete Part II of the initial credentialing application and submit it with required attachments to the attention of the Provider Relations Representative. The Provider Relations Representative will notify you if a site visit is necessary.

Policies for Suspension, Reduction of Privileges and Termination

Progressive Discipline Policy

CBHNP retains the right and responsibility to credential and recommend for approval all new professional provider organizations, facilities, and individual behavioral health providers.

Professional provider organizations, facilities, and individual behavioral health providers may have their provider status reduced, suspended, or terminated for failure to perform according to the clinical, quality, or other administrative criteria of the provider agreement. Recommendations to adjust individual privileges and/or the Gateway Health Plan *Medicare Assured*[®] Plan network status of a qualified provider organization or facility are rendered on behalf of the organization by the CBHNP Credentialing Committee.

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The Credentialing Committee assumes responsibility for notification of any changes in the Gateway Health Plan *Medicare Assured*[®] network status to the affected professional provider organizations, facilities and/or individual behavioral health providers. Notification is given fourteen (14) days prior to the effective date of reduction, suspension, termination or change in status. This provision for advanced notification is set aside in the event that any activities by the professional provider organizations, facilities and/or individual behavioral health providers place Members receiving care and/or services in danger, or if there is evidence of fraud or criminal activity.

The written notice to the professional provider organizations, facilities and/or individual behavioral health providers states the circumstances warranting the adjustment and, at the discretion of the CBHNP Credentialing Committee, specifies a reasonable period within which the professional provider organizations, facilities and/or individual behavioral health providers may remedy the failure to perform according to standards. The professional providers are advised of the right to appeal the decision.

Reporting of Serious Quality Deficiencies to Appropriate Authorities

In any case in which the adjustment of qualified provider status of any professional provider organizations, facilities and/or individual behavioral health providers is based upon ethical, criminal, or other serious quality performance concerns, CBHNP follows established guidelines of reporting to the appropriate authorities. The guidelines are set forth by the corporate office of the organization.

Provider Appeal Process

The professional provider organizations, facilities and/or individual behavioral health provider may appeal the decision to reduce, suspend, or terminate clinical privileges or change provider status by formally requesting such a review at any time before the effective date of adjustment. The right to appeal and procedures to follow is included in the notification of the original decision. The steps to the appeal process are as follows:

- The professional provider organization, facility and/or individual behavioral health provider must formally file an appeal in writing with the CBHNP Executive Director and/or the CBHNP Director of Quality Improvement (QI). The request for appeal is logged, and the issue is tracked until resolution.
- Written acknowledgement of the request to appeal is sent within 72 hours of receipt of the appeal by the CBHNP Executive Director and/or the CBHNP Director of QI.
- The initial level in the network status change appeal process is reviewed by the CBHNP Medical Director. The CBHNP Medical Director makes a determination within ten (10) days.
- The CBHNP Executive Director and/or Director of Quality Improvement sends “Notification of disposition of appeal” to the professional provider organization, facility and/or individual behavioral health provider.
- If the provider is dissatisfied with the decision, a second and final level appeal may be requested. The request is made in writing to the CBHNP Chief Executive Officer.
 - The provider appeal is presented to a representative panel of peer advisors with no previous involvement in the decision to change the provider’s network status. The provider is given advance written notice of the panel’s meeting, including the date; time and place the disputed matter will be considered.
 - The provider is afforded the opportunity to present supporting statements and documentation. The panel renders a decision within fifteen (15) days of the meeting, and advises the professional provider organization, facility and/or individual behavioral health provider of the final decision in writing.

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- The provider contract contains a provision for arbitration of any disputes that cannot be resolved through the internal appeal process. The parties agree not to bring any judicial action against the other until all administrative remedies have been exhausted.

Contracting and Rate Notices

Gateway Health Plan *Medicare Assured*[®] uses a standard Provider Agreement that has been approved by Gateway Health Plan[®] and CBHNP. CMS approved the agreement to assure that it includes all required language per Gateway Health Plan *Medicare Assured*[®] as well as rules and regulations around managed care services.

Gateway Health Plan *Medicare Assured*[®] payment structure mirrors Original Medicare. Providers will use the same procedure codes and rates established by Original Medicare. Gateway Health Plan[®] will reimburse services at 100% of the Medicare Physician Fee Schedule based on the place of service code and rendering practitioner's type less any deductible and/or coinsurance amounts. The Gateway Medicare Specialist Fee Schedule shall be implemented and updated in accordance with the release and implementation of updates by the Center for Medicare and Medicaid Services.

As a network Provider, you will occasionally receive a "Rate Notice" which is an official amendment to the Provider Agreement. Providers will have 30 days notice of rate changes. Providers who do not accept the terms of the Rate Notice may terminate the Agreement upon 30 days written notice.

Inpatient services are not addressed on the fee schedule, rather they are negotiated rates. Providers of inpatient services may request rate increases at any time. Gateway Health Plan *Medicare Assured*[®] will consider the request and respond accordingly. **Please know that rate adjustments will never be made retroactively at any time.**

Your Provider Agreement automatically renews each year. An amendment to the agreement will be generated only if new services are added due to new CMS changes. Rate Notices are used to document rate or per diem changes to existing services.

Provider Data Updates

It is critical that Providers notify their Provider Relations Representative immediately if anything has changed which will affect our ability to refer Members to your organization or practice. Further notification must be provided in writing to avoid any miscommunication. CBHNP has created a form called "Provider Data Update Form." Providers are welcome to use the form however; that specific format is not required. Information can be faxed to Provider Relations at 717-671-6522.

Regular reporting will benefit the Provider, in that they will be updated appropriately in the Provider Directory.

Provider Profiling

CBHNP recognizes that its Quality Improvement Program is dependent on the quality of service rendered by network providers. To this end, it will monitor providers using specific outcome measures.

The CBHNP Credentialing Committee establishes indicators and performance standards, reviews and trends results, and recommends corrective action when necessary. Network providers that consistently

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fail to meet standards will be placed on probationary status pending corrective action, and are in jeopardy of contract termination. Provider Indicators and Standards Provider Profiling Reporting) are integrated into the re-credentialing decision process.

Provider Profile Reporting

On a monthly basis, the Provider Relations Department produces reports of select performance indicators for each provider who is undergoing re-credentialing during that particular month.

Performance will be compared against following standards:

1. 90% of the Members responding to provider surveys conducted by CBHNP will report positive experiences.
2. No negative trends or single serious, substantiated complaints are identified for any single provider based on the Provider Complaint database system.
3. Additional measures may be designated by the Credentialing Committee or Quality Improvement Committee and included for review by providers, Members, family Members, and Counties.

Individual Outcome Measures

The CBHNP Credentialing Committee will meet to credential and re-credential Providers on a monthly basis. Provider Relations will report outcome measures for those providers who are undergoing re-credentialing during that particular month. This report gives a detailed review that allows the Credentialing Committee to further refine the Provider Profile Methodology as well as provide consistent and frequent feedback to the provider regarding performance. The Credentialing Committee will determine the need for follow-up site visits and specific performance indicators for providers based on available data from performance measures collected. Follow-up areas may include, but are not limited to:

- **Access to Care** - Providers will be expected to offer/schedule appointments and/or admission consistent with Gateway Health Plan[®] access standards for Emergent, Urgent, and Routine care.
- **Medical Record Completeness and Accuracy** - Gateway Health Plan *Medicare Assured*[®] will conduct medical record reviews, either using redacted charts or with properly signed Release of Information forms, to review documentation for completeness of information, accuracy, appropriate signatures, current treatment plan and supporting documentation, and discharge planning.
- **Level of Care Consistency** - The diagnosis, treatment plan and documentation must be consistent, and must reflect that the level of care delivered was appropriate to treatment needs presented by the Member.
- **Accreditation, Certification, and Licensure** - Each provider must meet qualifications/licensure requirements as designated by CMS, Gateway Health Plan *Medicare Assured*[®] and CBHNP.
- **Compliance with Gateway Health Plan *Medicare Assured*[®] requirements** – Providers are rated on standards that measure compliance with administrative requirements of Gateway Health Plan *Medicare Assured*[®]. This includes requests for authorizations for admission and continuation of care; claims and encounter data submissions; coordination of care; aftercare planning and follow-up.

Complaints against Providers

All complaints against network providers, subsequent appeals, and resolution of such activities are entered into the complaint and grievance database system by the Quality Improvement Department.

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The database will be queried monthly for information regarding Providers who are ready for re-credentialing. Complaint and Grievance information will be used in the re-credentialing decision.

Actions

The Credentialing Committee may make one or more of the following recommendations to the CBHNP Quality Improvement Committee and JAC (Joint Administrative Committee), based on the provider not reaching acceptable levels of performance:

1. No action
2. Probationary status with a specified period for continued observation
3. Corrective Action Plan, documentation, and monitoring required
4. Suspension
5. Termination of the provider from the network

All Providers must be actively enrolled and in good standing with the Medicare Program and not be included on the:

List of Excluded Individuals/Entities; <http://oig.hhs.gov/fraud/exclusions.asp>,
Or the Medicare “Opt-Out” List; <http://www.hgsa.com/bene/optout.html>.

Provider Staff Credentialing

Licensed provider organizations have a responsibility to verify the credentials of their staff. Prior to credentialing any organizational Provider, CBHNP verifies that there is an acceptable process in place for provider staff credentialing. Providers must verify and maintain documentation to verify the following:

- 1) Primary source verification that the Practitioner’s license is in good standing (for PA State Licensed Practitioners, search <http://licensepa.state.pa.us/>.)
- 2) Verification that there are no sanctions on a practitioner’s license. (for PA State Licensed Practitioners, search <http://licensepa.state.pa.us/>.)
- 3) Primary source verification of the highest level of education for all employees. Note that for Board Certified Psychiatrists, primary source verification of Board Certification is acceptable to meet this requirement.
- 4) Verification that the employee has not been terminated, suspended, precluded or excluded from the Medicare and/or Medical Assistance Program. (See <http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/DoingBusiness/FraudAbuse/003673510.aspx> OR <http://exclusions.oig.hhs.gov/>)
- 5) A resume that shows continuous employment for the past five years. Any breaks in employment must be explained in writing.
- 6) For licensed practitioners, a query to the National Practitioners Databank (NPDB).
- 7) Verification of the DEA certificate for psychiatrists.

These elements will be reviewed at credentialing and re-credentialing site visits. Providers are encouraged to review NCQA Standards for more information. Please see NCQA’s website at <http://www.ncqa.org>

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Provider Appeals of Payment Denial

Clinical Care Managers are not permitted to backdate any request for authorization. Such requests must be submitted through the provider payment denial appeal process. The process for appeal requests is outlined below.

Providers are expected to follow all prior authorization requirements as defined in the Provider Manual and Provider Infos. This policy is intended to address claims denial only. Any denial that occurs after the service has been rendered is subject to review under the provider appeal process or reconsideration, but not both types of reviews. For services not yet provided, the Gateway Health Plan[®] reconsideration policy and procedure will apply.

Reversal of payment denials should be regarded as an exception and will not be routinely approved without compelling evidence that the Provider did not follow protocol due to legitimate special circumstances as determined by CBHNP. CBHNP will evaluate all requests and take into consideration factors that caused the procedural error as well as remedies in place to prevent future occurrences.

CBHNP will be responsible for all first and second level internal review appeals. The provider must initiate the formal Provider Payment Denials Appeal process through a written appeal request. All requests must go to:

Gateway Health Plan[®]
Attention: Medicare Complaint Administrator
U.S. Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

Claims appeals are subject to the Member Reconsideration/Appeal process outlined in Chapter VIII. Members may request reconsideration of prior authorization denials or of claim payment denials. Providers may address claim payment denials via the Provider Appeal Process.

Providers requesting review of a payment denial will be instructed to send a letter stating the following:

- Plan Name (Gateway Health Plan *Medicare Assured*[®])
- Member name
- Members Gateway Health Plan *Medicare Assured*[®] ID Number
- Documentation of Members seen/dates services provided and billable amount(s)
- The service that was delivered
- Reason for the delay or failure to get authorization
- Explanation of circumstances
- Steps taken to correct and prevent future occurrences
- Desired action from CBHNP
- Documentation relevant to the request (i.e.... Eligibility slips verifying that Eligibility was checked and wrongly indicated enrollment status, fax confirmation page, etc...)
- **ALL** relevant information should be included with your appeal.

Appropriate reasons for approval (reversal of the non-authorization decision) include but are not limited to:

1. Documentation of eligibility verification issues beyond the control of the provider.
2. Documentation of processing errors by CBHNP or Gateway Health Plan[®].
3. Documentation of continued stay review issues beyond the control of the provider.

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4. Unavoidable delays caused by another provider.
5. Any other reason as decided by the review committee.

Reasons to uphold a non-authorization decision include but are not limited to:

1. Failure in authorization management by the provider.
2. Submission of the request for review beyond 90 days of the initial notice or service delivery date.
3. Failure to check eligibility prior to service delivery.
4. Failure in claims or billing management by provider.
5. This was a MNC denial when services have already been provided.
6. Any other reason as decided by the review committee.

A decision will be made within 30 days of receipt of the documentation and a written decision will be mailed within 5 days of the decision but must also be mailed within 30 days of receipt of the appeal request. If the request is approved and the claim is in the Gateway Health Plan[®] claims processing system, CBHNP will contact Gateway Health Plan[®] to adjudicate the claim. The approval letter serves as authorization and you should retain it in your records.

Second Level Review

A provider may request a second level internal review. The provider must request the second level review in writing and the request must be received at Gateway within 30 days of the date of the first level internal review decision letter. All second level appeal requests must set forth the specific reason why the provider feels that the first level decision was in error.

A second level determination will be completed within 45 days of receiving the payment denial appeal. The provider may elect to participate in the review by telephone or in person to present information. The provider's written appeal request must indicate the provider's intention to participate in these proceedings.

You should direct questions on this process to CBHNP Provider Relations at 1-888-700-7370.

All relevant information must be submitted with the appeal, as the decision of the Second Level Committee review is final.