

# Gateway Health Plan *Medicare Assured*<sup>®</sup> Provider Manual 2010

## **Chapter IV**

## **PROVIDER RESPONSIBILITIES**

### **Compliance with Law and Regulation**

Per the participating provider agreement, Providers must comply with all applicable Rules, Regulations and Requirements of CMS and any other applicable entity.

### **Members Rights and Responsibilities**

The member's rights and responsibilities are listed in the Gateway Health Plan *Medicare Assured*<sup>®</sup> Evidence of Coverage (EOC). This information is available on the internet at [www.gatewayhealthplan.com](http://www.gatewayhealthplan.com). Members also receive a copy of the EOC from Gateway Health Plan *Medicare Assured*<sup>®</sup> every year.

### **Compliance with the Americans with Disabilities Act**

Gateway Health Plan *Medicare Assured*<sup>®</sup> Network Providers have a responsibility to remove “non-physical” barriers to service and to make available at the request of its clients the following:

- Assisted listening devices
- Large print or Braille forms
- Sign language services
- Telecommunications devices for the deaf

Section 504 of the Rehabilitation Act of 1973 (Section 504) and Titles II and III of the Americans with Disabilities Act of 1990 (ADA) set forth requirements for Providers in serving persons who are deaf and hard of hearing or have other disabilities. This manual strives to alert Providers to their responsibilities. *Providers should consult their legal counsel with questions or concerns.*

A person with a disability cannot be denied or excluded from services or treated differently. Auxiliary aids and services must be available at no additional cost to ensure effective communication.

Section 504 at 45 CFR Part 84 of the Rehabilitation Act of 1973 prohibits discrimination applying to service availability, accessibility, delivery, employment and the administrative activities and responsibilities of organizations receiving Federal financial assistance. Relative to Health Care and Human Services settings, a recipient of Federal financial assistance may not, on the basis of disability:

- ✓ Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits.
- ✓ Deny access to programs, services, benefits or opportunities to participate as a result of physical barriers.

The ADA states that Public Entities must:

- ✓ Provide services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

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- ✓ Make reasonable modifications in their policies, practices and procedures to avoid discrimination on the basis of disability, unless they can demonstrate that a modification would fundamentally alter the nature of their service, program or activity.
- ✓ Ensure that individuals with disabilities are not excluded from services, programs and activities because buildings are inaccessible
- ✓ Provide auxiliary aids to individuals with disabilities, at no additional cost, where necessary to ensure effective communication with individuals with hearing, vision or speech impairments. Auxiliary aids include but are not limited to qualified interpreters, assistive listening headsets, television captioning and decoders, telecommunications devices for the deaf (TDD's), videotext displays, readers, taped texts, brailled materials and large print materials.

*The material presented above comes from the OCR Fact Sheet U.S. Department of Health and Human Services Office for Civil Rights Washington DC 20201. Copies can be obtained by calling: 1-800-368-1019 (voice); 1-800-537-7697 (TDD); or e-mail ocr@os.dhhs.gov*

## **Suggestions:**

- ✓ All Provider staff should be aware of Members' rights as well as the Provider's responsibilities as defined in Titles II and III of the ADA of 1990, Section 504 of the Rehabilitation Act of 1973, Mental Health Procedures Act of 1966 and the Drug and Alcohol Abuse Control Act of 1972. Contact the Pennsylvania Office for the Deaf and Hard of Hearing for additional information on resources that may assist you. It is suggested that you use the Pennsylvania ODHH Main Office number to speak with the Administrative Assistant to reach your regional representative.
- ✓ Awareness of language and communication barriers at the beginning of treatment is critical in order to support success in treatment. A good initial assessment should include questions about communication methods.
- ✓ Modes of communication could consist of Computer Assisted Real-time Transcription (CART), Assistive Listening Devices (ALD), Qualified Sign Language Interpreter, PC, and writing. Ask the Member what is their preferred method of communication. Do not assume that all Members who are deaf or hard of hearing read lips.
- ✓ When using writing as a method of communication accommodation, be aware of the vocabulary level of the individual.
- ✓ Make connections with specialized services so they are readily available when you need them. Have Agreements in place before the need presents (i.e. .... interpreters). Be proactive and budget for this expense.

## **Use of an Interpreter**

- ✓ The interpreters' role is to facilitate communication and serve as a source of cultural information when necessary. An interpreter must never offer an opinion about a subject he/she is not an expert in.
- ✓ Never use a family Member, as objectivity may be affected, the Member may be inhibited and not comfortable to speak freely, the Member's right to confidentiality is breached and it

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becomes impossible for a clinician to get a true, uncompromised picture of the Member's skills.

- ✓ Don't assume that a staff person who knows sign language is qualified to interpret.
- ✓ Always use certified interpreters with experience or training.
- ✓ Encourage pre-and post-session meetings between the practitioner and the interpreter. Allow for longer sessions when an interpreter is used.

## Resources for Consumers and Providers

### **Disability Law Project**

(215) 238-8070 (Voice)  
(215) 789-2498 (TDD)  
(215) 772-3126 (Fax)

### **Pennsylvania Protection & Advocacy**

800-692-7443 (Voice)  
877-375-7139 (TDD)

### **Pennsylvania Assistive Technology Lending Library**

800-204-7424 (Voice)  
800-750-7428 (TTY)

### **Pennsylvania TTY/Assistive Communications**

800 670-7303 (Voice) or 717-236-2400 (Voice)  
800-440-0374 (TTY)  
717-236-5733 (TTY)  
717-236-5733 (Fax)

### **Pennsylvania Office for the Deaf and Hard of Hearing**

800-233-3008 (Voice/TTY)  
717-783-4912 (Voice/TTY)  
717-783-4913 (Fax)

### **National Association for the Deaf**

301-587-1788 (Voice)  
301-587-1789 (TTY)  
301-587-1791 (Fax)

### **American Society for Deaf Children**

703-739-1049 (Voice)  
703-739-0874(TTY)

### **Self for Hard of Hearing People**

301-657-2248 (Voice)  
301-657-2249 (TTY)  
301-913-9413 (Fax)

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**National Institute on Deafness and other Communication Disorders Clearing House**  
800-657-2248 (Voice)  
800-241-1055 (TTY)  
301-907-8830 (Fax)

Gateway Health Plan<sup>®</sup>/CBHNP Member Services Department will assist Members with a request for special needs and Gateway Health Plan *Medicare Assured*<sup>®</sup> Provider Relations Department will assist the Provider in meeting this goal when applicable.

## **Cultural/Ethnic/Racial Sensitivity**

All Providers are expected to be aware of and sensitive to their organization's cultural competency, creating an environment whereby the developmental, cultural and linguistic needs of Members are taken into consideration. Providers must have policies and procedures to assure that requests be initiated by non-English speaking Members, and that the organization staff is equipped to handle the requests appropriately. Gateway Health Plan<sup>®</sup> may monitor this area during provider profiling, site visits, or other activities.

## **Confidentiality**

Gateway Health Plan *Medicare Assured*<sup>®</sup> Providers will ensure that Members personal and clinical information are kept secure and confidential, and that access will be limited to authorized persons only as identified by Member signed releases.

Providers are required to abide by all state and federal laws and regulations in regards to Member confidentiality, including HIPAA.

## **Release of Information Forms**

Gateway Health Plan *Medicare Assured*<sup>®</sup> Providers will coordinate care with the Member's PCP, other behavioral health care providers, etc., as needed. A signed release form must be documented and kept on file. A Provider may use his/her own release forms for this purpose as long as they meet all requirements of statute and law.

To guarantee Member confidentiality, Gateway Health Plan<sup>®</sup> and CBHNP complies with federal and state regulations governing the release of client information (disclosure of confidential information) and record retention. Gateway Health Plan<sup>®</sup> and CBHNP maintain strict policies concerning internal security, review processes, disposal of confidential documents and distribution of statistical information. Gateway Health Plan<sup>®</sup> and CBHNP also require all Providers to adhere to strict confidentiality measures including:

- Password protection of on-line Member information.
- Written consent from Member/guardian is required before disclosure of any information, except as allowed by law, (e.g., emergency treatment, under court-order, etc.). Drug and Alcohol services require Member consent regardless of age.
- Members, 14 years and older, receiving mental health services shall control the release of their medical record. Any release of information forms needed shall be signed by the Member, when the Member is 14 years or older. Drug and Alcohol services require Member consent regardless of age.

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- Members who are under the age of 14 years or who are incapacitated, except for Members in drug and alcohol treatment, may not sign their own release of information forms. In these cases the parent or guardian shall sign the release of information forms.
- Members of any age receiving drug and alcohol services shall control the release of their medical records, in accordance with state and federal laws.
- Gateway Health Plan *Medicare Assured*<sup>®</sup> Providers have the responsibility to make sure the release of information form is explained and understood by the Member/guardian prior to being signed.
- A copy of the signed release of information form will be filed in the Member's medical record and a signed copy given to the Member/guardian.
- Gateway Health Plan *Medicare Assured*<sup>®</sup> Providers may release information when the Member's condition is life threatening and it is impossible to obtain the Member's/guardian's consent. All such occurrences must be thoroughly documented in the Member's record.
- Verbal disclosure about a Member can only be made if the Member/guardian has a signed release of information form specifying the information to be released.
- Any documents released or exchanged between Gateway Health Plan<sup>®</sup>, CBHNP and a Gateway Health Plan *Medicare Assured*<sup>®</sup> Provider must include a statement regarding the confidentiality of the information exchanged.
- Any Gateway Health Plan *Medicare Assured*<sup>®</sup> Provider violating any of the confidentiality policies and procedures will be subject to disciplinary action.
- Release of information forms should be signed by the Member/guardian during the first session and retained in the Member's chart. If the Member/guardian refuses to allow the release of information, this must be clearly documented in the Member's chart.

Providers may use their own consent form to release information in accordance with the federal and state laws that govern confidentiality for mental health, e.g. Federal Regulations 42 CFR, part 2; Pennsylvania stature D&A Control Act & State Regulations, 28 PA Code Subsection 255.5, PA Code Title 55, Subsection 5100.33-39, 5200.41, 5210.56, 5221.52; Health Care Financing Administration, 42 CFR Chapter IV, 10-1-93.

## Appointment Availability

Providers are required to maintain hours sufficient to meet the demand of the practice. If a provider site cannot meet the Member's need within the specified timelines for emergent, urgent, or routine care, as indicated below, Providers must inform the Member that they can contact Gateway Health Plan *Medicare Assured*<sup>®</sup> Member Services Department to obtain additional Provider options. The Member has the right to choose to wait for the next available appointment; however this must be clearly documented in the Member's medical record.

## Access Standards

The required Provider responses time for emergent, urgent and routine services as follows:

### Life Threatening Emergencies

Providers must ensure that Gateway Health Plan *Medicare Assured*<sup>®</sup> Members receive an appointment within **one hour** of the request for services.

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**Definition of Life Threatening Emergency:** A situation requiring immediate care to a Member to prevent death, serious injury or deformity of the Member.

## **Non-Life Threatening Emergencies**

Provider must ensure that Gateway Health Plan *Medicare Assured*<sup>®</sup> Members receive an appointment within **six hours** of the request for services.

**Definition of Non-Life Threatening Emergency:** A behavioral health condition where the Member may suffer significant physical or emotional deterioration resulting in hospitalization or partial hospitalization unless an intervention is made within **six hours**.

## **Urgent**

Providers must ensure that Gateway Health Plan *Medicare Assured*<sup>®</sup> Members receive an appointment within **twenty-four (24) hours** of the request for services.

**Definition of Urgent:** The diagnosis and treatment of medical conditions that are serious or acute but pose no immediate threat to life and health, but which require medical attention within **24 hours**.

## **Routine**

Providers must ensure that Gateway Health Plan *Medicare Assured*<sup>®</sup> Members receive an appointment within **10 business days** of the request for services.

**Definition of Routine:** Routine services are those services not deemed emergent or urgent.

## **Critical Incident Reporting**

The following information on Critical Incident Reports is **targeted for implementation** in the **near future**. It is being provided here to assist you with any planning for implementation of this future requirement.

Gateway Health Plan *Medicare Assured*<sup>®</sup> providers are expected and required to develop written policies and procedures for an incident management process, take strong measures to prevent the occurrence of critical incidents, investigate and report on those that occur, and to take reasonable corrective action to prevent reoccurrence.

All Gateway Health Plan *Medicare Assured*<sup>®</sup> providers will be required to report critical incidents within 24 hours of the time at which the provider becomes aware of the occurrence.

The following incidents must be reported immediately:

1. Death of a Member.
2. Suicide attempt.
3. Medication error.
4. Any event requiring the services of the fire department, or law enforcement agency.
5. Abuse or alleged abuse involving a Member.

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6. Any injury or illness (non-psychiatric) of a Member requiring medical treatment more intensive than first aid.
7. A Member who is out of contact with staff for more than 24 hours without prior arrangement, or a Member who is in immediate jeopardy because he/she is missing for any period of time.
8. Any fire, disaster, flood, earthquake, tornado, explosion, or unusual occurrence that necessitates the temporary shelter in place or relocation of residents.
9. Seclusion or restraint.
10. Other incident identified by Providers as Critical, Adverse or Unusual.

## **Some definitions:**

### **Medication Error:**

Any missed medication, incorrect medication or incorrect dosage, where a Member requires treatment greater than first aid for adverse effects of the medication.

### **Abuse:**

Any act of alleged or suspected abuse, neglect of a consumer which could include physical, verbal, psychological or sexual abuse, exploitation, neglect and misuse of a Member's funds.

### **Injury or Illness of a Member:**

Any injury or illness where the Member requires medical treatment more intensive than first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a band aid, etc. Treatment beyond first aid includes but is not limited to lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb. Evaluation/assessment of an injury by emergency personnel in response to a "911" call is reportable even if the individual is not transported to an emergency room. This incident type includes:

- Diseases reportable to the Department of Health, defined as any disease reportable on the Pennsylvania Department of Health List of Reportable Diseases. Report is only required when disease is initially diagnosed.
- Emergency Room Visits are defined as the use of a hospital emergency room. This includes situations that are clearly "emergencies" as well as those when an individual is directed to an emergency room in lieu of a visit to a primary care physician (PCP) or as a result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of a physician's office is not reportable.
- Hospitalization, defined as an inpatient admission to an acute care facility for the purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable.

### **Restraint:**

Any chemical, mechanical, or manual technique used for the purpose of restricting movement. A chemical restraint is a medication used to control acute or episodic behavior that is not the standard treatment for the Member's medical or psychiatric condition, and is intended to significantly lower the individual's level of consciousness and restricts the movement of a Member. A medication ordered by a physician as part of the ongoing individualized treatment plan for treating the symptoms of mental, emotional, or behavioral disorders is not a chemical restraint. A mechanical restraint is a device used to control acute or episodic behavior that restricts movement or function of a Member or portion of a Member's body. Examples of mechanical restraints are handcuffs that are locked around the wrists, elbow restraints, foot restraints, cloth harnesses applied to any portion of the body, and blanket wraps. Mechanical restraints do not include measures to promote body positioning to protect the Member and others from injury, or to prevent the worsening of a physical condition. Devices also used for medical

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treatment such as helmets for prevention of injury during seizure activity, mitts, and muffs to prevent self-injury are not considered restraints. A manual restraint is a physical hands-on technique that restricts the movement or function of a Member's body or portion of a Member's body. Prompting, escorting, or guiding a Member who does not resist assisting in the activities of daily living is not a manual restraint.

## **Seclusion:**

Restriction of a Member in a locked room, and isolating the person from any personal contact. The term "locked room" includes any type of door locking device such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door closed, preventing the individual from leaving the room. Seclusion does not include the use of a time-out room. Locking an individual in a bedroom during sleeping hours is considered seclusion.

## **Time-out Room:**

An unlocked room used to remove an individual from the individual's immediate environment to reduce stimulation and assist the individual to regain self-control. Use of a time-out room constitutes a potential alternative to the use of seclusion and restraint.

## **Medical Records Standards**

The Quality Improvement Program provides guidelines for medical record documentation for Gateway Health Plan *Medicare Assured*<sup>®</sup> Providers. These guidelines are consistent with the standards of national accrediting organizations. Gateway Health Plan *Medicare Assured*<sup>®</sup> Medical Records standards for behavioral health providers are as follows:

### **Accessibility and Availability of Medical Records**

Provider contracts include provisions to permit Gateway Health Plan<sup>®</sup> and CBHNP Quality Improvement staff, and appropriate/required agencies access to the medical records of Gateway Health Plan *Medicare Assured*<sup>®</sup> Members. Records may be reviewed to monitor quality, medical necessity, coordination of care, and continuing care planning.

Gateway Health Plan *Medicare Assured*<sup>®</sup> Providers are contractually obligated to maintaining medical record documentation of each encounter with Gateway Health Plan *Medicare Assured*<sup>®</sup> Members.

### **Recordkeeping**

Standards are established for organization, content, and readability of the Gateway Health Plan *Medicare Assured*<sup>®</sup> Member's medical records. The Member medical record documentation may be either paper based or electronic. Documentation must be current, detailed, organized, comprehensive, and legible, promote effective care, and facilitate quality review. Providers must adhere to all applicable federal and state confidentiality regulations for treatment records. By provider contract, treatment records must be made available for review by Gateway Health Plan<sup>®</sup>, CBHNP and appropriate/required agencies for quality improvement purposes. Data elements for Member medical records include:

- The Member's name and/or client number on each page of paper documentation and on every entry of electronic records.
- The Member's identifying information and demographics to include:

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- Name
- Age and Date of Birth (DOB)
- Address and County of residence
- Home, work telephone number and/or method of contact
- Employer or school
- Marital status
- Legal status
- Parent/Guardian Name (for children and non-adjudicated adolescents)
- Name and contact information of Primary Care Physician (PCP)
- All entries are dated; author of documentation is identified by name, title, credential and signature (paper) or key identifier (electronic).
- Written documentation is legible to someone other than writer or affiliated staff colleagues. Legibility is determined through review by CBHNP Staff.
- Allergies to include medication allergies and adverse reactions. Absence of allergies is noted as “no known allergies – NKA”.
- Risk factors/Risk assessments
- Past Medical History/Treatment History to include:
  - Significant Health Events – accidents, operations, hospitalizations
  - Developmental History (for children and adolescents)
  - History of past behavioral health interventions/treatment to include dates and duration of services and level of care
  - DSM-IV diagnoses for all axes I through V
- Medication Information to include medication name, frequency, dosage, effectiveness of treatment regime and any known side effects for:
  - Past medications for physical conditions
  - Past psychotropic medications
  - All current medications
  - Evidence that current medication has been consistently provided as prescribed and reevaluated as necessary; changes in medication, dosage and reason for change
- Past history and current use of alcohol/drugs to include kind, type, frequency and amount
- Consultations, Referrals and Specialists’ Reports to include laboratory results and review psychological evaluations, summaries and review as applicable
- Record of all emergency care, how directed and emergencies’ surveys
- Discharge summaries
- Individualized Treatment Plan to include:
  - Goals and objectives
  - Discharge criteria to move to lesser level of care
  - Therapeutic interventions/modalities
  - Client’s response to treatment/client progress towards goal achievement
  - Documentation of evidence and results of any behavioral health screening
  - Documentation of all treatment/interventions provided and results of treatment/interventions
  - Documentation of team Members involved in the multi-disciplinary team of Gateway Health Plan *Medicare Assured*<sup>®</sup> Member needing specialty care
- Documentation of behavioral health and medical surgical integration to include:
  - Screening for behavioral health conditions which may be affecting physical health
  - Screening for physical health conditions which may be affecting behavioral health
  - Screening and referral to Gateway Health Plan *Medicare Assured*<sup>®</sup> Primary Care physician when appropriate
  - Documentation of Gateway Health Plan *Medicare Assured*<sup>®</sup> Primary Care Physician referral to Gateway Health Plan *Medicare Assured*<sup>®</sup> Provider.

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- Quarterly summary of the Gateway Health Plan *Medicare Assured*<sup>®</sup> Member's progress in behavioral health treatment, prepared by the Gateway Health Plan *Medicare Assured*<sup>®</sup> Provider(s) for the Gateway Health Plan *Medicare Assured*<sup>®</sup> Member's Primary Care Physician.  
Summary is prepared more frequently when clinically appropriate.
- Documentation that behavioral health professionals are included in the primary and specialty care service teams when a Gateway Health Plan *Medicare Assured*<sup>®</sup> Member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.
- Documentation of GAF scores at initiation of treatment and delineated treatment intervals through episode of care/illness but at a minimum at termination of treatment for all Gateway Health Plan *Medicare Assured*<sup>®</sup> Members.
- Documentation of reason for termination of treatment.
- Documentation of date(s) of family, therapy/intervention/visits for any Gateway Health Plan *Medicare Assured*<sup>®</sup> Member under the age of 18.

### **Communication Requirements and Continuity of Care**

- The treating Gateway Health Plan *Medicare Assured*<sup>®</sup> Provider is required to make and maintain contact with the Gateway Health Plan *Medicare Assured*<sup>®</sup> Member's PCP when clinically appropriate and to provide, at a minimum, quarterly treatment summaries to the PCP.
- The treating Gateway Health Plan *Medicare Assured*<sup>®</sup> Provider is required to make and maintain contact with other service Providers who are also treating the Member.
- When indicated, the Gateway Health Plan *Medicare Assured*<sup>®</sup> Provider refers the Member to the PCP for assessment, evaluation, treatment, and further referral as needed. In those situations in which the Gateway Health Plan *Medicare Assured*<sup>®</sup> Member does not know/have a PCP, the Gateway Health Plan *Medicare Assured*<sup>®</sup> Provider refers the Member to Gateway Health Plan<sup>®</sup> Member Services.
- Providers facilitate coordination and continuity of care among the multi-providers treating a Gateway Health Plan *Medicare Assured*<sup>®</sup> Member and communicate regularly with Gateway Health Plan<sup>®</sup>.
- Providers must communicate admission and discharge of a Gateway Health Plan *Medicare Assured*<sup>®</sup> Member into Inpatient or Partial Hospitalization even if there is a primary insurer.

### **Referral for Medically Necessary Behavioral Health Services**

Gateway Health Plan *Medicare Assured*<sup>®</sup> through CBHNP coordinates medically necessary behavioral health services for Members through the Care Manager. The Care Manager is responsible during the assessment, screening, and referral process to determine whether the Member may be in need of behavioral health services and to facilitate an appropriate referral to a behavioral health provider based on Medical Necessity Criteria. The Care Manager will collaborate with physical health services on a case-by-case basis when a Member's physical health care needs impact behavioral health treatment. Providers should contact a Clinical Care Manager to facilitate referral as necessary for behavioral health treatment.

Gateway Health Plan *Medicare Assured*<sup>®</sup> together with CBHNP facilitates orientation and education for Gateway Health Plan *Medicare Assured*<sup>®</sup> Providers to increase Providers' awareness of the Member's needs for medically necessary medical-surgical, specialty, secondary, and tertiary services and to establish the referral process and procedures.

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## Provision of Emergency Care

Gateway Health Plan *Medicare Assured*<sup>®</sup> ensures the provision of emergency services to Gateway Health Plan *Medicare Assured*<sup>®</sup> Members. Gateway Plan *Medicare Assured*<sup>®</sup> ensures that Members know where and how to obtain medically necessary care in emergency situations. “Emergency Services” means covered inpatient or outpatient Covered Behavioral Health Services that are (1) furnished by a provider who is qualified to furnish those services under Title XIX of the Social Security Act and (2) needed to evaluate or stabilize an Emergency Medical Condition.

## Broken/Missed Appointments and AMA Discharge

CBHNP has tasked its contracted network Providers with following up on a CBHNP Member’s chronic broken and/or missed appointments. Providers are expected to contact CBHNP if a Member’s treatment is compromised or there is a risk of termination of services due to non-compliance.

When a Member leaves routine care, this is typically not an area of concern. There are two types of terminations, however, which do necessitate further follow-up: “no shows” and discharges against medical advice (AMA). These terminations are often considered treatment “drop outs” and could be a liability/danger.

The following methods are used for handling “no shows” to appointments based on the nature of care:

- For all “no shows” and AMAs, document this fact in the medical record.
- For Members who are AMA or fail to keep a scheduled appointment for emergency or urgent care:
  - Call the Member at least three times to attempt to make contact.
  - If no contact has been made, document in writing to the Member that they have terminated care AMA.
  - Whether telephonically or in writing, offer the Member treatment alternatives.
  - Ensure that there is Member safety, or initiate emergency procedures.
- For Members who “no show” for initial routine care, the Provider will send a letter requesting that the Member contacts their Provider if they wish further services.
- Providers are required to make contact by phone or letter for individuals who miss on-going routine treatment appointments, depending on clinical circumstances.
- If there is a referring party for a “no show” Member, that party will be notified in writing, if permissible.

## Continued Stay Review

Gateway Health Plan *Medicare Assured*<sup>®</sup> and CBHNP have the responsibility to review treatment received by Members in order to assure that the appropriate services are delivered based on established medical necessity criteria. Continued stay reviews are utilized to discuss specifics of Member care with the Provider so that appropriate decisions can be made. The Provider must give accurate and complete information. Specific review information is found in Chapter V, Clinical Handbook.

## Determination of Medical Necessity

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The CMS definition of medically necessary specifically states that a service must be medically necessary to be covered. “Medical Necessity” and “Medically Necessary” means that it must be reasonable and necessary for the purpose of diagnosing or treating illness or injury to improve the functioning of a malformed body member. It refers to services or supplies that: are proper and needed for the diagnosis or treatment of the member's medical condition; are used for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of the member or the doctor. The Medical Necessity Criteria that will be used for Gateway Health Plan *Medicare Assured*<sup>®</sup> is ASAM PPC-2R (Second Edition Revised) for Substance Abuse. Mental health inpatient and partial hospitalization will use McKesson’s InterQual Proprietary Criteria.

### **Discharge Planning**

While basic requirements for Providers are provided in regulation and licensing standards, discharge planning is an essential part of treatment and is expected to begin upon admission. Gateway Health Plan *Medicare Assured*<sup>®</sup> and CBHNP expects that the discharging Provider will assure that continuity of care is maintained and that appointments are scheduled in new levels of care as appropriate, according to regulations, licensing requirements and quality standards. Discharging inpatient Providers are expected to assure that follow-up appointments are in place. Members should not be asked to take responsibility for this activity. Gateway Health Plan *Medicare Assured*<sup>®</sup> and CBHNP have identified critical elements that must be addressed in discharge plans and outlines expectations in Chapter V, Clinical Handbook.