

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

Chapter V CLINICAL HANDBOOK

Definitions

MSS – Member Services Staff
CCM – Clinical Care Manager
MNC – Medical Necessity Criteria
ICM – Intensive Case Management/Manager
POC – Plan of Care
SA – Substance Abuse
MH – Mental Health
CI – Crisis Intervention
ASAM – American Society of Addiction Medicine
PHP – Partial Hospitalization Program

Non-Incentive Statement

Gateway Health Plan *Medicare Assured*[®] and CBHNP do not provide incentives to employees who conduct utilization management activities for approving, denying, limiting or discontinuing medically necessary services.

Member Services (MSS)

Member Services is a great resource for Providers. It is available 7 days a week/24 hours a day/365 days a year. When calling MSS please be prepared to provide the following information so that we can best serve you.

When you call Member Services Staff, they will ask:

- The caller's name
- Facility/Agency they are calling from, if applicable
- The purpose of the call
- Member name
- Member social security number
- If requesting to speak with a CCM, indicate the reason for this request as MSS may be able to assist you.

It is imperative that callers provide the information needed in order for the MSS to appropriately meet your needs as well as the needs of our Members.

Member Services Staff can assist with questions about:

Authorizations

Questions regarding status of approval, authorization numbers, etc. Authorization questions will be forwarded to the appropriate CBHNP staff.

Eligibility Questions

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MSS should not be contacted routinely to check Member eligibility. However, if you come across a situation where you are unsure if the person is a Gateway Health Plan *Medicare Assured*[®] Member or not after properly checking the available eligibility verification resource, we can assist. Providers are expected to check eligibility prior to initiation of service and periodically through the course of treatment.

Locating Providers

MSS can help Members/family Members find outpatient providers that are conveniently located near the Member home or work.

Inpatient Referral and Emergency Intake

MSS is the first point of contact for Providers and families during times of crisis. MSS will ask for information about the emergency and pass the information to the CCM as appropriate. Please provide all possible information to the MSS.

Authorization Procedures by Level of Care

Utilization management for the Gateway Health Plan *Medicare Assured*[®] has been delegated to CBHNP for Behavioral Health Services. CBHNP is responsible to authorize services and conduct pre-certification and concurrent review for services that require prior authorization and register outpatient treatment sessions.

Mental Health Outpatient Treatment Registration

Gateway Health Plan *Medicare Assured*[®] does not require par (in-network) providers to complete the Mental Health Outpatient Treatment Registration Form. However, psychological testing, neuropsychological testing and outpatient ECT must be pre-certified using a separate form.

The Outpatient Treatment Registration form is required for all outpatient non-par providers. Remember in order to be eligible for Gateway Health Plan *Medicare Assured*[®], the par and non-par providers must have a Medicare number. If the provider does not have a Medicare number, the provider will get an administrative denial of their request. Eligible non-par providers must do the following:

a. Initial Request

MH outpatient services should be requested within 10 business days from the time a Provider sees a Member using the Outpatient Treatment Request form for MH services (i.e. individual, family, group therapy; psychiatric evaluations and medication management).

The provider will receive a phone call to enter the network. If the provider agrees to be credentialed, the service will be authorized for 90 days.

If the provider does not wish to enter the network, the provider will be asked for a clinical reason why the member cannot go to an in-network provider. If clinical appropriate, the provider will be given a 90 day authorization in order to transition the member to an in-network provider. Any services provided after the 90 day period will be denied and the provider may not seek reimbursement from the Member.

b. Ongoing Services/ Reauthorization Requests

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Only those non-par providers that choose to enter the network will receive continuation authorizations provided that their credentialing application is in process with CBHNP. Reauthorizations will be limited to an additional 90 day period. Reauthorization should be requested using the Outpatient Treatment Request form for MH services, which is the same form used for initial authorization requests. Providers may submit a reauthorization request up to two weeks prior to the requested authorization start date or up to ten (10) business days after the requested start date of the authorization.

All current authorization request forms are available at our website, www.cbhnp.org. Please print and copy these forms.

SA Outpatient Treatment Registration

Gateway Health Plan *Medicare Assured*[®] does not require par (in-network) providers to complete the Substance Abuse Outpatient Treatment Registration Form. However, psychological testing, neuropsychological testing and outpatient ECT must be pre-certified using a separate form.

The Outpatient Treatment Registration form is required for all outpatient non-par providers. Remember in order to be eligible for Gateway Health Plan *Medicare Assured*[®], par and non-par providers must have a Medicare number. If the provider does not have a Medicare number, the provider will get an administrative denial of their request. Eligible non-par providers must do the following:

a. Initial Request

SA outpatient services should be requested within 10 business days from the time a Provider sees a Member using the Outpatient Treatment Request form for SA services (i.e. individual, family, group therapy; psychiatric evaluations and medication management).

The provider will receive a phone call to enter the network. If the provider agrees to be credentialed, the service will be authorized for 90 days.

If the provider does not wish to enter the network, the provider will be asked for a clinical reason why the member cannot go to an in-network provider. If clinical appropriate, the provider will be given a 90 day authorization in order to transition the member to an in-network provider. Any services provided after the 90 day period will be denied and the provider may not seek reimbursement from the Member.

b. Ongoing Services

Only those non-par providers that choose to enter the network will receive continuation authorizations provided that their credentialing application is in process with CBHNP. Continued authorization is based on Member meeting American Society of Addiction Medicine (ASAM) criteria. Reauthorizations will be limited to an additional 90 day period. Reauthorization should be requested using the Outpatient Treatment Request form for SA services, which is the same form used for initial authorization requests. Providers may submit a reauthorization request up to two weeks prior to the requested authorization start date or up to ten (10) business days after the requested start date of the authorization.

All current authorization request forms are available at our website, www.cbhnp.org. Please print and copy these forms.

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MH Partial Hospitalization

More specific information needed for pre-certification and continued stay reviews is discussed later in this chapter.

a. **Initial Request**

Must be pre-certified by contacting CBHNP by phone prior to initiating services. Approval is based on Member meeting MNC.

b. **Ongoing Services**

Continued authorization is based on Member meeting MNC, which is discussed during the live continued stay review conducted over the phone with a CBHNP Care Manager.

If a Member has a primary insurance, Gateway Health Plan *Medicare Assured*[®] through CBHNP **will require** pre-certification.

MH Inpatient

More specific information needed for pre-certification and continued stay review is discussed later in this chapter.

a. **Initial Request**

Must be pre-certified by contacting a CBHNP Care Manager by phone prior to initiating services.

b. **Ongoing Services**

Continued authorizations are based on Member meeting MNC received during a live continued stay review with a CBHNP Care Manager.

If a Member has a primary insurance, Gateway Health Plan *Medicare Assured*[®] **will require** pre-certification. A CBHNP Care Manager must be notified upon admission and discharge.

SA Hospital Based Detoxification and Rehabilitation

a. **Initial Request**

Must be pre-certified by contacting CBHNP by phone prior to initiating services.

b. **Ongoing Services**

Continued authorizations are based on Member meeting ASAM criteria received during a live continued stay review with a CBHNP Care Manager

If a Member has a primary insurance, Gateway Health Plan *Medicare Assured*[®] **will require** pre-certification. A CBHNP Care Manager must be notified upon admission and discharge.

Discharge Planning

Discharge planning should begin as soon as the Member enters treatment. Providers should be developing treatment goals and discharge criteria that involve the Member and family, as appropriate, in this process. There must be an understanding of the Member's needs and goals in order to successfully complete treatment at the current level of care. While the Member is in active treatment, the Provider, in cooperation with Gateway Health Plan *Medicare Assured*[®] and CBHNP, will discuss how to affect a successful discharge. For inpatient treatment, this may involve the inpatient Provider working with the targeted case manager. Discharge planning will be discussed at every continued stay review for inpatient and partial hospitalization.

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Gateway Health Plan *Medicare Assured*[®] through CBHNP will conduct live discharge reviews with all network Providers for inpatient and PHP. The following information must be included in the **discharge review** with the CBHNP Critical Care Manager.

- Date of discharge
- Axis I- Axis V Diagnosis information (confirm and review changes)
- Discharge plan (level of care, date, time and location of step down appointment)
- Risk/Safety Status:
 - Present active SI or attempts
 - Present violent ideation or behavior
 - Present psychotic symptoms posing risk to self/others
 - Present suspected/confirmed harm to Member by others
 - **Were risk/safety issues communicated to Provider/next LOC?
- Member's clinical symptoms/presentation and relevant situational information since the last continued stay review.
- Next level of care, date of aftercare appointment
- Family involvement in treatment and outcome

Discharge plans are critical in documenting progress and planning for ongoing services. **Discharge plans must be provided within 2 weeks after discharge from any Gateway Health Plan *Medicare Assured*[®] funded service.** Documents may be submitted via U.S. Mail or Fax. *The discharge plan is considered part of the service purchased from you, therefore, in accordance with the Provider Agreement, lack of receipt of the discharge plan by Gateway Health Plan *Medicare Assured*[®] may delay payment for services rendered. This becomes especially important when the discharge summary recommends other levels of care.*

Outpatient Discharge

Gateway Health Plan *Medicare Assured*[®] through CBHNP should also be notified when a Member discontinues outpatient services within the same timeframe. The discharge plan must include:

- Specific information about where the follow-up services will be provided, including the Provider address.
- Background information
- Presenting problems
- All five (5) Axes Diagnoses and clinical indicators supporting discharge treatment recommendations.

The discharge plan is also expected to reflect use or development of natural supports. CBHNP strongly advocates for the development of natural supports.

AMA and Discharge Plans

If a Member leaves treatment against medical advice and there are no grounds for commitment, Gateway Health Plan *Medicare Assured*[®] and CBHNP requires that the Provider notifies the CBHNP CCM in a timely fashion so that outreach efforts by CBHNP, if authorized, can be initiated quickly.

Medical Necessity Denial

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An MNC denial is defined as a determination made by a CBHNP Medical Director or Physician Advisor on behalf of Gateway Health Plan *Medicare Assured*[®] in response to a Provider or Member request for approval to provide a service of a specific amount, duration and scope which:

- disapproves the request completely, or;
- approves provision of the requested service(s), but for a greater or lesser amount, scope or duration than requested, or;
- disapproves provision of the requested service(s), but approves provision of an alternative service(s), or;
- reduces, suspends, or terminates a previously authorized service.

Notice of Denial of Medical Coverage are printed and reviewed by the CBHNP Care Manager for accuracy prior to mailing.

Denial notices follow the format approved by Medicare. Advanced notice will be given to the Member for filing a complaint or grievance if the Member disagrees with the decision. For continued stay inpatient denials, the inpatient facility is contacted by telephone and the notice is sent via regular mail, consistent with HIPAA guidelines, rather than mailed to the inpatient facility. The notice is then to be hand-delivered to the Member by that facility.

For any denial, if the practitioner would like to discuss this case with a physician reviewer or appropriate behavioral health reviewer, please call CBHNP at 1-866-755-7299, reference the denial notice, and request to speak to the assigned Care Manager. The assigned Care Manager will assist the Provider in arranging a time to discuss the case with an appropriate reviewer. It is not guaranteed that this will be the original reviewer of the case, and this is not intended to be an additional complaint or grievance level. The intent of this discussion is for clarification of any Provider issues related to the denial or denial notice. Please refer to Chapter VIII of this Provider Manual for a full discussion of Appeals and Grievance Procedures.

Community Integration

Whenever possible, Members should receive services in community-based programs and in the least restrictive environment.

Improvement of Quality of Life

Beyond maintenance of baseline functioning, services should help Members define, choose, and achieve the most constructive and satisfying lifestyle possible. Gateway Health Plan *Medicare Assured*[®] will promote this philosophy, develop appropriate resources, and monitor the quality standards to ensure the recovery emphasis.

Outcome Focus

Systems of care and Provider services are guided by defined outcomes, measurable goals, and research-supported best practice approaches to treatment. Gateway Health Plan *Medicare Assured*[®] has developed and monitors standards of care, providing research and training on outcomes-proven treatment technologies. The development of outcomes that include a focused assessment of how well treatment addresses the needs of priority and special needs populations is critical.

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Cultural Competence

Providers must strive to eliminate barriers to treatment caused by failures to understand or address issues of cultural differences. Gateway Health Plan *Medicare Assured*[®] stresses the importance of providing clinical assessment, which addresses the developmental, cultural and linguistic needs of Members. Gateway Health Plan *Medicare Assured*[®] does not make assumptions regarding cultural preferences but asks Members directly which type of provider they would prefer. Gateway Health Plan *Medicare Assured*[®] through CBHNP contracts with community treatment centers that are capable of addressing cultural, linguistic, and developmental needs to provide direct assessments and ongoing care.

Clinical Practice Guidelines

Gateway Health Plan *Medicare Assured*[®] Provider Advisory Committee (PAC) adopts Clinical Practice Guidelines for various levels of care. These guidelines are intended to act as a reference for best practice. While adverse action may not be taken with Providers when not followed, it does serve to identify expectations when providing services to Members. The PAC has set a goal of adopting several Clinical Best Practice Guidelines to serve as a framework for future quality improvement initiatives. The PAC includes representation from our Provider network as well as county representation from our five counties. PAC meets quarterly to consider proposals for new services and to consider adoption of clinical practice guidelines. The committee has focused on the most common diagnoses with Major Depression, ADHD, Drug & Alcohol Disorders and Schizophrenia as the initial areas of interest. So far the committee has adopted 4 clinical practice guidelines:

1. Major Depression. Adopted the American Psychiatric Association Practice Guideline for the Treatment of patients with Major Depression (2nd. Ed. April, 2002). Available on-line at: http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm
2. Substance Use Disorders. Adopted the American Psychiatric Association Practice Guideline For The Treatment Of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids (1995). Available on-line at: http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm
3. Bipolar Disorders. Adopted the American Psychiatric Association Practice Guidelines for the Treatment of Patients with Bipolar Disorder (Revision 2002). Available online from APA at www.psych.org/psych_pract/treatg/pg/bipolar_revisebook_index.cfm
4. Schizophrenia. Adopted the American Psychiatric Association Practice Guidelines for the treatment of Patients with Schizophrenia Second Edition (2004) Available on-line at http://www.psych.org/psych_pract/treatg/pg/SchizPG-Complete-Feb04.pdf

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CBHNP MH Inpatient and Partial Hospitalization Initial Assessment, Continued Stay Review and Discharge Information

Initial Assessment – Pre-certification for Inpatient/Partial Hospitalization

Information on physical health plan and any other primary insurance.

Presenting Problem: Clinical information/symptoms. Why Member needs requested level of treatment.

Risk Assessment: Information related to harm to self, self-injurious behaviors, harm to others and harm to Member by others. This would include current as well as past risk issues.

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Drug/Alcohol Use/Abuse: Substance and amount.

Medications: Name of medication, dose and frequency.

Treatment: Level of care, facility/provider, month/year for current and past treatment.

Axis I through Axis V

Natural Supports: Examples include: Boy/Girl Scouts, clubs, 4H, YMCA, YWCA, friends, church, volunteer time, community events, educational/self-improvement, hobbies, vocational training, school, recreational activities, support groups, employment.

Structured Supports: MH Case Manager, MR Case Manager, CYS Case Manager, legal issues, work and school.

Emergency contact information

Can the Member return home following treatment (if applicable?)

Medical necessity criteria

Continued Stay Review

Axis I- Axis V Diagnosis information: Upon admission. Changes to be reported at time of review.

Medication/Dose/Frequency: Upon admission. Changes to be reported at time of review.

Ancillary services with contact information: Upon admission. Changes to be reported at time of review.

Natural supports: Upon admission. Changes to be reported at time of review. The goal is to increase natural supports.

Risk/Safety status: Asked at each review.

- Present active SI or attempts
 - Present violent ideation or behavior
 - Present psychotic symptoms posing risk to self/others
 - Present suspected/confirmed harm to Member by others

Treatment goals: The following information is required for each goal. Each goal is addressed in its entirety before discussion of the next goal. Completed at each review.

- Identify goal
- Identify method for above goal
- Detail progress, lack of progress on goal
- Identify any changes in goal and/or method based on Member progress

Recent significant changes: Reserved for relevant clinical information NOT related to treatment goals.

Discharge Plans: Discharge planning should be discussed at each review.

Family Involvement: Family involvement in treatment, number of family sessions and outcome.

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Discharge Information

Discharges will need to be completed live with a CBHNP Clinical Care Manager in the same manner as continued stay reviews are conducted. Your CBHNP Clinical Care Manager will let you know when your facility is expected to do the live discharge call. At this point it will no longer be acceptable to call and leave a voicemail message with discharge information.

The discharge reviews should be scheduled with the CBHNP Clinical Care Manager and should occur prior to the actual discharge.

The following is the information needed at the time of the discharge review:

Date of discharge

Axis I- Axis V Diagnosis information: Confirm diagnosis at discharge and discuss changes from last continued stay review.

Discharge plan: Level of care, date, time and location (including the site address of the provider office, phone number and the name of who will be seeing the Member for the aftercare appointment). Members should be discharged with a scheduled aftercare appointment.

Risk/Safety Status:

-Present active SI or attempts

-Present violent ideation or behavior

-Present psychotic symptoms posing risk to self/others

-Present suspected/confirmed harm to Member by others

**Were risk/safety issues communicated to provider/next LOC?

Member's clinical symptoms: Presentation and relevant situational information since the last continued stay review.

Family involvement: Family involvement in treatment, number of family sessions and outcome.

CBHNP must be notified of inpatient stays and discharge plans even if the Member has other primary insurance. If a Gateway Health Plan *Medicare Assured*[®] Member has a primary insurance, we will still require pre-cert.

Excluded Services

The following exclusions are not covered and therefore not paid for by Gateway Health Plan *Medicare Assured*[®]:

1. Services that aren't covered under the Original Medicare Plan.
2. Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by Gateway Health Plan *Medicare Assured*[®] as a covered service.
3. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. In 2008 CMS will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage

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Determination that are provided to MA plan members. Experimental procedures and items are those items and procedures determined by Gateway Health Plan *Medicare Assured*[®] and the Original Medicare Plan to not be generally accepted by the medical community.

4. Surgical treatment of morbid obesity *unless* medically necessary and covered under the Original Medicare plan.
5. Private room in a hospital, *unless* medically necessary.
6. Private duty nurses.
7. Personal convenience items, such as a telephone or television in the Member's room at a hospital or Skilled Nursing Facility.
8. Nursing care on a full-time basis in the Member's home.
9. Custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
10. Homemaker services.
11. Charges imposed by immediate relatives or members of the Member's household.
12. Meals delivered to the Member's home.
13. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
14. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as the unaffected breast, to produce a symmetrical appearance.
15. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine) and is limited according to Medicare guidelines.
16. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
20. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hypogasmia.
21. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
22. Acupuncture.

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23. Naturopath services.
24. Counseling or referral services that Gateway Health Plan *Medicare Assured*[®] objects to based on moral or religious grounds. In the case of Gateway Health Plan *Medicare Assured*[®], we won't give counseling or referral services related to contraceptive services, female sterilization services, male sterilization services and abortion services. To the extent these services are covered by Medicare, they will be covered through an alternative process.
25. Services provided to veterans in **V**eterans **A**ffairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under Gateway Health Plan *Medicare Assured*[®], we will reimburse veterans for the difference. Members are still responsible for Gateway Health Plan *Medicare Assured*[®] cost-sharing amount.
26. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.
27. Effective January 1, 2008 limited dental care will be offered Pennsylvania Gateway Health Plan *Medicare Assured*[®] members. Refer members to their Evidence of Coverage (EOC).

At any time during the year, the Medicare Program can change its national coverage. Since Gateway Health Plan *Medicare Assured*[®] covers what Original Medicare covers, we would have to make any change that the Medicare Program makes. These changes could be to increase or decrease benefits, depending on the Medicare Program changes.