

North/Central Region HealthChoices Provider Manual

- 2007 -

**Bedford/Somerset, Blair, Franklin/Fulton, and
Lycoming/Clinton Counties**

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

TABLE OF CONTENTS

INTRODUCTION AND SUMMARY OF CHANGES.....	5
Chapter I INFORMATION PAGE	6
Chapter II QUALITY IMPROVEMENT	8
Goals	8
Scope	8
Quality Indicators for Monitoring	9
Clinical Care	9
Administrative Services	9
Methodology and Time Frames	9
Objectives	10
Chapter III Member Complaints and Grievances.....	12
Complaints	12
Expedited Complaint Process	12
Grievances	13
External Grievance Reviews	14
Fair Hearing	14
Expedited Fair Hearing	14
Manager of Consumer and Family Affairs	15
Chapter IV PROVIDER COMPLAINTS	16
Provider Surveys	16
Chapter V PROVIDER RELATIONS SERVICES.....	17
Credentialing/Re-credentialing	17
Practitioner / Provider Rights	17
Right to Review Information Submitted	17
Right to Correct Erroneous Information	17
Right to be Informed of Application Status	17
Application Process	18
Individual Provider Application	18
Professional Provider Organization and Facility Application Process	18
Credentialing Site Visit	18
Credentialing Committee Decision	19
Re-credentialing	19
Adding a New Site or Service	19
Policies for Suspension, Reduction of Privileges and Termination	20
Progressive Discipline Policy	20
Reporting of Serious Quality Deficiencies to Appropriate Authorities	20
Provider Appeal Process	20
Contracting and Rate Notices	21
Provider Data Updates	21
Provider Profiling	22
Individual Outcome Measures	22
Complaints against Providers	22
Provider Profile Reporting	22
Credentialing Committee Actions	23
Medical Assistance Enrollment	23
Supplemental Service Enrollment	24

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Psychologist / Psychiatrist Supervision and Medical Assistance Enrollment	24
Supplemental Services.....	27
Administrative Appeals (Administrative Denial Appeal)	27
Administrative Appeal Request Form.....	29
Availability of CBHNP Policies and Procedures	30
Chapter VI PROVIDER RESPONSIBILITIES.....	31
Compliance with Law and Regulation.....	31
Provider Staff Credentialing Requirements	31
Members Rights and Responsibilities.....	32
Members Choice and Freedom of Choice	33
Assurance of Freedom of Choice Form.....	34
Cooperation with Consumer Family Satisfaction Team (C/FST) Survey Process	35
Compliance with the Americans with Disabilities Act	35
Suggestions.....	36
Use of an Interpreter.....	36
Resources for Consumers and Providers	37
Cultural/Ethnic/Racial Sensitivity	38
Confidentiality	38
Release of Information Forms.....	38
Access Standards	39
Emergent.....	39
Urgent.....	39
Routine	40
Appointment Availability.....	40
Provider Reporting.....	40
Measurement of Ability to Meet Access Standards.....	40
“First Offered” Date	40
Performance/Outcomes Measurement System (POMS) Data Reporting	41
Critical Incident Reporting	41
Medical Records Standards	42
Accessibility and Availability of Medical Records	42
Record Keeping	42
Communication Requirements and Continuity of Care	43
Referral for Medically Necessary Care	44
Provision of Emergency Care.....	44
Referral Requirements	44
Broken/Missed Appointments and AMA discharge	44
Continued Stay Review	45
Medical Necessity Criteria.....	45
Discharge Planning.....	45
Chapter VII SUSPECTED/SUBSTANTIATED FRAUD AND ABUSE	46
Chapter VIII PROVIDER INFO’S	47
Chapter IX CLINICAL HANDBOOK.....	48
Definitions:	48
Non-Incentive Statement Regarding CBHNP Staff.....	48
Member Services Staff (MSS).....	48
Authorization Procedures By Level of Care	49
MH Outpatient Services Registration	49
SA Outpatient Service Registration.....	49
Crisis Intervention Services Registration.....	50

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

MH Partial Hospitalization	50
SA Intensive Outpatient Services.....	50
MH Behavior Health Rehabilitation Services, BHRS.....	51
MH Family Based Mental Health Services, (FBMH).....	51
Residential Treatment Facility, (RTF).....	51
SA Non Hospital Residential.....	51
MH Inpatient	52
SA Hospital Based Rehab	52
Discharge Planning.....	52
Outpatient Discharge.....	53
Medical Necessity Denial.....	53
Priority Populations	54
Special Needs Populations.....	54
Child/Adolescent Services System Program (CASSP Principles) as defined by OMHSAS:	55
Community Integration	55
Whole Person Focus	55
Improvement of Quality of Life.....	56
Outcome Focus.....	56
Cultural Competence	56
Clinical Practice Guidelines.....	56
Community Support Program (CSP) Principles defined by OMHSAS	57
CBHNP MH Inpatient and Partial Hospitalization.....	58
Initial Assessment, Continued Stay Review and Discharge Information	58
1. Initial Assessment – Pre-certification for Inpatient/Partial Hospitalization	58
2. Continued Stay Review	58
3. Discharge Information	59
Chapter X CLAIMS HANDBOOK	61
Completing & Submitting Claims Forms	61
Authorization Number	61
Electronic Billing.....	61
Paper Claim Submission	61
CMS 1500 Form and UB 92 Form.....	62
CMS 1500 Claim Form Completion Guidelines	62
UB92 Claim Form Completion Guidelines.....	64
Claim Payment Disagreements.....	66
Claim Re-submission	66
Resubmission of Corrected Claims	66
Resubmission for Coordination of Benefits (COB) Request.....	66
TPL Submission	66
Expectations for CBHNP Response to Claims Submission.....	67
Checking on the Status of a Claim	67
Claims Appeals.....	67
Chapter XI FREQUENTLY ASKED QUESTIONS.....	68
Clinical Operations and Authorization Questions.....	68
Claims and Eligibility Questions	71

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

INTRODUCTION AND SUMMARY OF CHANGES

This Provider Manual was developed to provide an understanding of our treatment delivery system. Our organizational goal is to ensure Members receive the most effective treatment services within the scope of resources available, and the highest quality of care.

CBHNP Clinical Care Managers are licensed, experienced clinicians with advanced training in mental health / chemical dependency conditions so that they may appropriately assess needs, monitor services, and enable our network Providers to provide treatment services in a managed care delivery model.

CBHNP Clinical Care Managers and Member Services Specialist staff are available 24-hours a day, seven days a week, to address your needs as well as the needs of our Members. Member Services Specialist staff can be reached at the phone number identified for the Members County of residence identified in Chapter 1 of this manual.

CBHNP together with its Providers set the standards for progressive, high quality care that is also cost effective. We are happy that you have chosen to be part of our team. Please do not hesitate to phone us if you need assistance or have recommendations for improvement. Our Provider Relations staff can be reached by calling 1-888-700-7370 or you may contact the Provider Relations Representative located at a satellite office near you.

This document is current at the date of printing. Be alert for Provider Info's and form changes. Please check the website frequently, www.cbhnp.org.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter I INFORMATION PAGE

Operations Center: Houses Claims, Credentialing, Care Management, Member Services, Administration and Contacts, Care Management and Member Services.

Mailing Address:

Community Behavioral HealthCare Network of Pennsylvania (CBHNP)
P.O. Box 6600
Harrisburg, PA 17112

Satellite Operation Sites: Satellite sites house a Program Manager, Provider Relations Representative, and Quality Improvement/Utilization Management contact for Bedford, Blair, Clinton, Franklin, Fulton, Lycoming and Somerset County HealthChoices Programs.

Bedford Somerset Office: 145 Clark Building Road, Suite 8
Bedford, PA 15522
Phone: 814-623-0550 Fax: 814-623-0551

Blair Office: 1904 North Juniata Street
Hollidaysburg, PA 16648
Phone: 814-696-3961 Fax: 814-696-3962

Franklin/Fulton Office: 2764 Lincoln Highway West, Suite 3
Chambersburg, PA 17202
Phone: 717-263-8723 Fax: 717-264-8727

Lycoming/Clinton Office: 1316 Commerce Park Drive
Williamsport, PA 17701
Phone: 570-320-0410 Fax: 570-320-0409

Telephone Numbers

General Phone Number	717-671-6500
Provider Relations	1-888-700-7370
Claims Helpdesk	1-888-700-7370

Complaints and Grievances

Bedford/Somerset:	1-866-773-7891
Blair:	1-866-773-7892
Franklin/Fulton:	1-866-773-7917
Lycoming/Clinton:	1-866-733-7991

Member Services / Care Management

Bedford/Somerset:	1-866-773-7891
Blair:	1-866-773-7892
Franklin/Fulton:	1-866-773-7917
Lycoming/Clinton:	1-866-733-7991

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Operations Center FAX Numbers (All County Programs)

Member Services / Care Management FAX	1-888-296-4002
Provider Relations / Claims FAX	717-671-6522
Administration FAX	717-671-6521

Website Address www.cbhnp.org

Click on CBHNP HealthChoices Provider tab for Authorization Request Forms, Provider Info's, Provider Newsletters, Medical Necessity Criteria and more.

Physical Health Services Contact

Access Plus (All Counties)	1-800-543-7633
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www.accessplus.org

Medical Assistance Transportation

Bedford County:	1-888-338-1335 or 814-623-2002
Blair County:	814-946-1235 or 814-695-3500
Clinton County:	1-800-206-3006
Franklin County	717-264-5225 or 1-800-548-5600
Fulton County	717-485-0931
Lycoming County:	570-323-7575 or 1-800-222-2468
Somerset County:	814-445-9628 or 814-948-6537

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter II QUALITY IMPROVEMENT

CBHNP, Inc. is committed to providing the highest quality of behavioral health care services possible to its Members, by actively supporting Members and Providers with appropriate medical decisions by dedicated professionals. Quality of care is defined by:

- Ease of access to services that are medically necessary,
- Services that are clinically appropriate, cost effective, efficient,
- Services that are delivered at the least restrictive/least intrusive level of care,
- Services that result in optimal clinical outcomes and a high level of Member satisfaction, and
- Services that are provided by qualified/credentialed professionals demonstrating a high level of clinical proficiency.

CBHNP is committed to actively pursuing continuous efforts to develop an effective Continuous Quality Improvement Program. This program coordinates activities designed to monitor and insure high quality administrative and clinical services provided to CBHNP Capital Area HealthChoices Members. To achieve this goal, the Quality Improvement (QI) program incorporates National Committee for Quality Assurance (NCQA) standards in its design and operation, as well as standards based upon state regulations, clinical best practices, and ethical guidelines.

Goals

CBHNP Capital Area will systematically monitor and evaluate the quality and effectiveness of systems, services, and Member treatment. The following Continuous Quality Improvement Program goals provide the focus for all QI activities:

- Members are provided with consistently accessible medically necessary care.
- The level, frequency, and duration of care are clinically appropriate to identified Member needs.
- Clinical services are rendered by Providers credentialed according to CBHNP, Inc. professional standards and established guidelines for licensure, education, training, and experience.
- Treatment services are outcome oriented, clinically appropriate, and in compliance with CBHNP Capital Area medical necessity criteria (Appendix T) and best practice standards.
- Members are informed about and have access to a comprehensive complaint and grievance process.
- The operations, systems, and services of the CBHNP Capital Area program are continuously monitored for problem resolution and improvement to meet the needs of Members and other stakeholders.
- Benchmarking data from quality monitoring, outcomes, and focus studies are used to improve quality of Member care.

Scope

The Director of Quality Improvement has the authority and responsibility to ensure that all quality improvement findings, conclusions, recommendations, actions taken, and results are documented and reported to appropriate individuals within CBHNP Capital Area, including the Executive Director, senior management, and other supervisory staff for use in daily operations and to insure a focus on quality. Within CBHNP's Capital Area programs and operations, the Director of Quality Improvement ensures that information generated through QI activities is used to improve quality, including:

- Access to care, screening, assessment and referral,

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- Complaint, grievance and appeals processes,
- Network management, peer review, Provider credentialing and re-credentialing criteria,
- Care and treatment coordination, integration, and continuity,
- Prevention and outreach services,
- Member services and education,
- Provider composition and service capacity,
- Member behavioral health care benefits,
- Utilization management,
- Coordination of care with Physical Health MCOs,
- Feedback to Providers regarding quality profiling and improved practice standards, and
- Billing and claims processing.

Quality Indicators for Monitoring

Within each of these areas, quality indicators for monitoring and evaluation are identified and the methodology, time frames, and performance standards by which indicators are measured are outlined. Indicators help monitor service provision and allow a review of a full range of demographic groups, treatment settings, and types of services. Areas monitored include:

Clinical Care

- Crisis intervention and stabilization services,
- Inpatient treatment,
- Outpatient/ambulatory services,
- Other treatment services such as partial hospitalization, intensive outpatient treatment, crisis respite/group homes, and
- Nontraditional behavioral health services governed by the program.

Administrative Services

- Access to treatment,
- Availability and accessibility of care/Provider,
- Coordination and integration of care,
- Continuity of care,
- Member Services,
- Screening, assessment, authorization, and referral,
- Utilization Management, and
- Network/Provider Services.

Methodology and Time Frames

The following defines the methodology to monitor and evaluate quality of care, appropriateness of care, treatment services provided to Members, and general CBHNP Capital Area operations.

Performance improvement projects will be identified to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. The projects will include Quality Planning, Quality Improvement, and Quality Control/Measurement activities focused on:

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- Measurement of performance, using objective quality indicators, to be monitored, with an emphasis on indicators that provide an efficient, accurate, and reliable means of monitoring quality of services and treatment within targeted areas.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation and initiation of activities for increasing and sustaining improvement.
- Develop appropriate data collection methods, including scheduled audits, focused studies (e.g. studies by population, diagnostic group or service type), standardized measurement of outcomes, and routine analysis of treatment generated data.
- Identify research methodology, reporting mechanisms, and time frames for data collection for each indicator.
- Compare CBHNP Capital Area performance data with benchmarking data, professional standards, and internal baseline data to establish performance thresholds and guidelines.
- Utilize routine assessment of Member satisfaction data to insure that services are responsive to the needs of Members.
- Develop and implement system interventions to achieve quality improvement and implement through remedial/corrective action(s).
- Evaluate improvement activities to insure that identified problem areas are effectively addressed.
- Initiate activities to increase and sustain improvement.

Time frames for monitoring of quality indicators may include any of the following:

- Continuous, ongoing monitors,
- Multiple review periods (e.g. monthly, quarterly and annually),
- Upon occurrence,
- Concurrent review, and
- Retrospective review.

Objectives

CBHNP has established the following Continuous Quality Improvement Program objectives. These objectives are intended to guide the development of the annual QI Plan. Strategies to achieve these objectives may vary according to specific details of the current year QI Plan:

- Indicators related to administrative and clinical services are outlined in the CQIP Work Plan and are reported and analyzed to guide potential program improvements, special studies, and appropriate modifications within the Clinical Care Management system.
- Availability and accessibility of services for Members and internal systems are monitored and evaluated for optimum care delivery.
- Appendix T is the established medical necessity criteria for in plan behavioral health services. Medical necessity criteria are established for services other than those covered by Appendix T, and approved by DPW. In all cases, medical necessity criteria are implemented to guide determinations and Clinical Care Management services. Internal audits are performed to ensure consistent application of criteria.
- Aggregate data on level, frequency, and duration of treatment services is tracked and analyzed to ensure appropriate utilization and identify over- and under-utilization patterns.
- Quality profiling protocols are initiated for CBHNP network Providers. Protocols include data collection from Member complaints and grievances, utilization management, Member satisfaction surveys, committee reports, and Work Plan data sets. Data is analyzed, aggregated, and, when appropriate, recommendations are made to correct deficiencies, enhance clinical proficiency, and improve care delivery. Substantive issues are integrated into the re-credentialing process and the design of Provider education and training.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- Opportunities for clinical care improvement are identified and documented. Appropriate action(s) for remediation and enhancement are developed, implemented, and monitored for effectiveness.
- Complaints and grievances are monitored and evaluated for timely and appropriate processing.
- Members and Providers are routinely surveyed to determine satisfaction with services provided through CBHNP Capital Area and its network Providers.
- Services related to claims payment are monitored regularly to insure that efficiencies in fiscal management of services are maintained.
- An evaluation process is implemented to ensure ongoing compliance with contractual requirements, performance guarantees, and established standards as defined by the National Committee for Quality Assurance (NCQA), other licensing and accrediting agencies, and oversight bodies. This includes compliance with reporting regulations related to Commonwealth of Pennsylvania Performance/Outcome Measurement System data (POMS).
- Effectiveness and efficiencies of the Continuous Quality Improvement Program activities are monitored and modifications to the QI Plan and/or Work Plan are made as needed to insure that QI activities are consistent with the changing needs of the organization and its Members.

You may receive a copy of the CBHNP Continuous Quality Improvement Plan upon request by contacting your Provider Relations Representative.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter III Member Complaints and Grievances

CBHNP has a well defined, specific process for filing Member complaints and grievances, including Fair Hearings and expedited reviews. Members may ask Providers to file on their behalf, provided a signed, written authorization (containing specific required information) is obtained by the Provider before pursuing such efforts. A copy of the policy and procedure regarding complaints and grievances is available by contacting the CBHNP Provider Relations Department at 1-888-700-7370.

Some key highlights within the complaint and grievance policy and procedure include the following. It is important to note that this information is not comprehensive and provides a snapshot of main points, not complete processes.

Complaints

- The Member may file a complaint either orally or in writing. An oral complaint will be committed to writing by CBHNP and provided to the Member for signature.
- The Member may file a request for a Second Level Complaint through CBHNP's complaint process, within 45 days from the date the Member receives written notice of the CBHNP First Level Complaint decision.
- The Member may file a request for an external review of the second level decision with either the Department of Health (DOH) or the Department of Insurance (DOI) within 15 days from the date the Member receives the written notice of CBHNP's second level complaint decision.
- This request must be in written form. If the Member cannot give it in written form, DOH will assist the Member in writing the request. CBHNP cannot file on behalf of a Member nor can we transcribe for the Member. All External reviews for complaints must be handled directly between the Member and DOH.
- The DPW Fair Hearing process may also be applicable to some complaints.

Expedited Complaint Process

- CBHNP will provide the opportunity for a single expedited review of a complaint at any point prior to the first level complaint decision if a Member provides CBHNP with a written certification from his or her physician that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular complaint process. This certification is necessary even when the Member's request for the expedited complaint is made orally. The certification will include the physician's signature.
- A request for an expedited review of a complaint may be filed either in writing or orally. Oral requests will be committed to writing by CBHNP. The Member's signature is not required.
- Upon receipt of an oral or written request for expedited review, CBHNP will inform the Member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.
- If the Provider certification is not included with the request for an expedited complaint, CBHNP will inform the Member that the Provider must submit a Provider certification as to the reason why the expedited review is needed. CBHNP will make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within three business days from the Member's oral or written request for an expedited review, CBHNP will decide the complaint within the standard complaint timeframes as set forth in this policy.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- CBHNP will make a reasonable effort to give the Member prompt oral notice of this decision, and will send a written notice of the decision to decide the complaint within the standard timeframes within two days of the decision.

Grievances

A grievance in the HealthChoices Program is an appeal of a medical necessity decision made by CBHNP.

- CBHNP will permit a Member or the Member's representative, which may include the Member's Provider to file a grievance either orally or in writing. Oral requests must be committed to writing by CBHNP and must be provided to the Member for signature. The Member's signature may not delay the grievance process. The Member will be given 45 days from the date the written notice was received to file a grievance.
- In order for the Provider to represent the Member in the filing of a grievance, the Provider will obtain the written consent of the Member. A Provider may obtain the Member's written permission at the time of treatment. A Provider may NOT require a Member to sign a document authorizing the Provider to file a grievance as a condition of treatment. The written consent will include:
 - The name and address of the Member, the Member's date of birth and identification number,
 - If the Member is a minor, or is legally incompetent, the name, address and relationship to the Member of the person who signed the consent,
 - The name, address and plan identification number of the Provider to whom the Member is providing consent,
 - The name and address of the plan to which the grievance will be submitted,
 - An explanation of the specific service for which coverage was provided or denied to the enrollee to which the consent will apply, and
 - The following statement: "The Member or the Member's representative may submit a grievance concerning the services listed in this consent form unless the Member or the Member's representative rescinds consent in writing. The Member or Member's representative has the right to rescind consent at any time during the grievance process." CBHNP can provide forms for grievance representative.
- The Member may file a request for a Second Level Grievance within 45 days from the date the letter is received containing CBHNP's First Level Grievance decision.
- The Member may file a request with CBHNP for an external review of the second level grievance decision (External Grievance Review) by the Department of Health. The request must be filed by phone or in writing within 15 days from the date the Member receives the written notice of the CBHNP second level grievance decision.
- CBHNP must conduct expedited review of a grievance at any point prior to the second level grievance decision, if a Member or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or take action on the Member's behalf, provides CBHNP with a certification from his or her Provider that the Member's life, health or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular grievance process. This certification is necessary even when the Member's request for the expedited grievance is made orally. The certification must include the Provider's signature.
- A request for expedited review of a grievance may be filed either in writing or orally. Oral requests will be committed to writing by CBHNP. The Member's signature is not required.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

External Grievance Reviews

There is no cost involved with filing an External Review if the request is submitted by the Member or a Member's relative or guardian. If the External Review is requested by a Provider, there may be a cost to the Provider which cannot be passed on to the Member, Member's relative or guardian. In cases where a Provider is filing an External Grievance Review on behalf of a Member, the following Act 68 clause applies – If the Certified Review Entity's (CRE) decision in an external grievance review filed by a health care Provider is against the health care Provider in full, the health care Provider shall pay the fees and costs associated with the external grievance. Regardless of the identity of the grievant, if the CRE's decision is against the plan in full or in part, the plan shall pay the fees and costs associated with the external grievance review. If the enrollee or the enrollee's representative files an external grievance, and the plan prevails, the plan shall pay the fees and costs. For purposes of this section, fees and costs do not include attorney's fees.

Fair Hearing

- A Member does not have to exhaust the complaint or grievance process prior to filing a request for a fair hearing.
- A Member or the Member's representative may request a fair hearing within 30 days of the date on the initial written notice of decision and within 30 days from the date on a complaint or grievance notice of decision at any level, of any of the following:
 1. the denial, in whole or in part, of payment for a requested service if based on lack of medical necessity;
 2. the denial of a requested service on the basis that the service is not a covered benefit;
 3. the denial or issuance of a limited authorization of a requested service, including the type or level of service;
 4. the reduction, suspension, or termination of a previously authorized service;
 5. the denial of a requested service but approval of an alternative service;
 6. the failure to provide services in a timely manner, as defined by DPW;
 7. the failure of CBHNP to decide a complaint or grievance within the timeframes specified in this policy;
 8. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program, or
 9. a denial of payment after a service has been delivered because the service is not a covered benefit.

Expedited Fair Hearing

- A request for an expedited fair hearing may be filed with DPW either in writing or orally.
- A Member does not have to exhaust the complaint or grievance process prior to filing a request for an expedited fair hearing.
- An expedited fair hearing will be conducted if a Member or a Member's representative provides DPW with written certification from the Member's Provider that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular fair hearing process. This certification is necessary even when the Member's request for the expedited fair hearing is made orally. The certification must include the Provider's signature

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Manager of Consumer and Family Affairs

CBHNP has a Manager of Consumer and Family Affairs who is available to assist Members and their families navigate the behavioral HealthChoices program, provide information and education about how things work at CBHNP and in the HealthChoices system and to assist Members and families with advocacy issues or needs that may arise.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter IV PROVIDER COMPLAINTS

CBHNP is an organization of Providers and, as such, promises to make every effort towards a cooperative and collaborative relationship with Providers. CBHNP personnel are professionals who recognize the importance of good customer service. We also understand that there will be occasions where differences or complaints arise in the course of business. Therefore, CBHNP encourages Providers to make complaints.

Complaints should be directed to the Complaints and Grievances (C&G) Department. You can access the C&G Department by calling Member Services at 1-888-722-8646. The Complaints & Grievances staff will obtain information from you and can explain the process that will be followed. Complaints can also be submitted to CBHNP in writing to:

CBHNP
Complaints and Grievances Department
P.O. Box 6600
Harrisburg, PA 17112

CBHNP will respond to all Provider complaints.

In addition, CBHNP tracks all Provider complaints in a database for analysis to identify trends that need to be addressed by CBHNP for improving our performance. This type of analysis is also reviewed by the Quality Improvement Committee.

Provider Surveys

Two Provider network surveys are conducted annually by CBHNP.

The first survey is sent to Providers by CBHNP and offers the opportunity for Providers to give CBHNP feedback about our organization and relationship with the network. This information is critical to improving support to Providers, making program improvements, and maintaining positive relationships.

A second survey is sent to Members by CBHNP to measure their satisfaction with our network Providers. The survey data is used for Provider profiling, identifying strength and need areas, and can lead to improvements in services to our Members and the community.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter V Provider Relations Services

Credentialing/Re-credentialing

CBHNP has an established network of behavioral health care Providers and strives to offer 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. CBHNP has formally assigned responsibility for the credentialing and re-credentialing review function to the CBHNP Credentialing Committee. The Credentialing Committee, part of the Provider Relations 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/disapproval of the entities. You may request a copy of the full Credentialing/Re-Credentialing policy and procedure by contacting a Provider Relations Representative at 1-888-700-7370.

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

- Licensed Physicians
- Licensed Psychologists
- Hospital/Inpatient facilities
- Licensed Partial Hospitalization Programs
- Licensed Outpatient Clinics
- Substance abuse treatment organizations
- Supplemental services Providers

Practitioner / Provider Rights

Right to Review Information Submitted

Providers have the right to review information submitted to support the credentialing application with the exception of peer references and National Practitioner Data Bank (NPDB) reports. Currently CBHNP does not require peer references. In addition, the Provider has the right to be notified if information received from the credentials verification organization (CVO) is substantially different than was reported by the Provider. The practitioner will be notified of this right in the credentialing decision notification letter.

Right to Correct Erroneous Information

The Provider has the right to correct erroneous information submitted by another party. Corrections will be submitted in writing to the Credentialing staff identified in the letter within ten (10) business days of notification. Corrections or information received will be reviewed and documented in the practitioner's file. The practitioner will be notified of this right in the credentialing decision notification letter as described above.

Right to be Informed of Application Status

A Provider may request information about the status of their application at any time upon request. Such requests will be made to the Credentialing Coordinator who is free to provide all information about the status of the application such as that it was received, sent to the CVO for primary source verification, that it is scheduled to be presented to credentialing committee, etc.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Application Process

Individual Provider Application

The application process for individual behavioral health practitioners requires that a complete application be submitted. Evidence such as copies of diplomas, licenses, insurance riders, documentation of privileges, etc. must be included. Applications can be requested by contacting a Credentialing Specialist at 1-888-700-7370: Practitioners need to supply their credentials, a mailing address, phone number and date of birth in order to request an application.

The application will be mailed to you from MedAdvantage CVO. Upon completion, it will be returned to MedAdvantage for review and primary source verification of information included in the application. The advantage to Providers of using the CVO in this way is that Providers will receive a partially pre-populated application at the time of re-credential. Following the primary source verification process, the CBHNP Credentialing Committee makes a determination regarding network participation.

Professional Provider Organization and Facility Application Process

Facility and professional Provider organizations complete a Facility Application. The following types of organizations are considered to be facilities.

- Hospitals
- Free Standing Psychiatric Facilities
- Chemical Dependency Treatment Centers
- Crisis Intervention Programs
- Partial Hospitalization Programs
- Other facility based services/programs

Applications can be downloaded from the website at www.cbhnp.org. You may also request an application from Provider Relations at 1-888-700-7370.

Credentialing Site Visit

Following receipt and review of the facility application, the CBHNP Provider Relations representative schedules a site visit if the facility is not accredited by JCAHO, CARF or COA or if the Provider is anticipated to be a high volume Provider. The credentialing site visit includes a tour of all program areas of the organization, interview with senior administrative, clinical and direct care staff and review of additional written material and documentation. On site documentation review may include:

- Policy and procedure manuals
- Licensing documentation
- Accreditation documentation
- Program, treatment or other service protocols
- Program schedules
- Quality Improvement/Assurance Plan and reports
- Discussion about medical record documentation practices, review of a blind treatment record and review of documentation policy and procedure

A score of 80% on the site visit is required. 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 will re-visit the site within six (6) months to assess progress. Assistance will be documented in the Provider file

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

and will include dates and assistance that was provided. This will continue until the Provider meets standards or declines further participation in the process.

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

Credentialing Committee Decision

In developing its network, CBHNP strives to meet the cultural and special needs of Members. CBHNP does not make credentialing / re-credentialing decisions based on the applicants' race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients (e.g., Medicaid) in which the practitioner specializes.

Applicants are notified of their initial credentialing approval within 20 days of the Committee meeting. Should the CBHNP Credentialing Committee elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (with the exception of NPDB reports and peer references).

Re-credentialing

Re-credentialing involves periodic review and re-verification of clinical credentials of CBHNP network Providers. The CBHNP Provider Relations Department maintains an active file of all CBHNP credentialing decisions. A tickler system ensures each Provider organization, facility, and individual behavioral health practitioner is re-credentialed as scheduled. As part of this process, CBHNP periodically reviews Provider information from the National Practitioner's Data Bank (NPDB) as well as Office of Inspector General list of individuals who have been excluded from participation in Medicare and Medical Assistance programs.

At a minimum the re-credentialing process occurs every two 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. The new site must be properly enrolled in the Pennsylvania Medical Assistance Program to receive payment for services. Non-accredited, high volume or potential high volume Providers require a site visit prior to seeing CBHNP Members so please plan accordingly. A high volume Provider is one who sees 200 or more unique Members in a twelve month period.

Providers who are adding a new service or site 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.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

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 organization, 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 CBHNP network status of a qualified Provider organization or facility are rendered on behalf of the organization by the CBHNP Credentialing Committee.

The Credentialing Committee assumes responsibility for notification of any changes in CBHNP 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 Chief Operating Officer and the CBHNP Director of Quality Improvement. 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 Chief Operating Officer and the CBHNP Director of QI.
- The initial level in the network status change appeal process is a review by the CBHNP Medical Director. The CBHNP Medical Director makes a determination within ten (10) days.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- The CBHNP Chief Operating Officer 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.
- 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

CBHNP uses a standard Provider Agreement that has been approved by the Pennsylvania Department of Health (DOH) and the Office of Mental Health and Substance Abuse Services (OMHSAS). DOH and OMHSAS must approve the agreement to assure that it includes all required language per the HealthChoices Program as well as rules and regulations around managed care services.

CBHNP is a Provider organization and as such, strives to direct dollars to care. The fee schedule is reviewed regularly and rates are adjusted as necessary. As a network Provider, you will occasionally receive a “Rate Notice” which is an official amendment to the Provider Agreement. Providers will have 30 day notice of rate changes. Providers who do not accept the terms of the Rate Notice may terminate the Agreement upon 30 days written notice.

Residential and inpatient services are not addressed on the fee schedule, rather they are negotiated rates. Providers of inpatient and RTF services may request rate increases at any time. Requests should be submitted in writing to your Provider Relations Representative. CBHNP will consider the request and respond accordingly. **Please know that rate adjustments will never be made retroactively at any time.** CBHNP and its County partners make every effort to keep rate payment consistent between County and BH-MCO funding.

Your Provider Agreement automatically renews each year. An amendment to the agreement will be generated only if new services are added due to a new MA Enrollment. 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 CBHNP’s 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” which is available on the CBHNP website. 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.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Regular reporting will benefit the Provider, in that they will or will not get referrals as appropriate and Members will not be frustrated by being referred to a Provider inappropriately.

Provider Profiling

CBHNP Capital Area 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 Credentialing Committee has established indicators and performance standards, reviews and trends results, and recommends corrective action when necessary. Network Providers that consistently fail to meet standards will be placed on probationary status pending corrective action, and are in jeopardy of contract termination. Provider Indicators and Standards are integrated into the re-credentialing decision process.

Individual Outcome Measures

The Credentialing Committee will meet to credential and re-credential Providers on a monthly basis. For Providers who are undergoing re-credentialing during a particular month, Provider Relations will report the measures for those Providers. 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 CBHNP Capital Area access standards for Emergent, Urgent, and Routine care.
- **Medical Record Completeness and Accuracy** – CBHNP 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 the Department of Public Welfare for participation in the Pennsylvania Medicaid program.
- **Compliance with CBHNP Capital Area Requirements** – Providers are rated on standards that measure compliance with administrative requirements of the CBHNP HealthChoices Program. 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. 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.

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.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Performance will be compared against following standards:

1. 90% of the Members responding to Provider surveys conducted by CBHNP Capital Area 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. Based on comparisons between Providers and sorted by service type, annually establish baseline data for average length of stay. After baseline is established, Providers remain within the average length of stay based on the reporting and aggregate data obtained the eCura data system.
4. Additional measures may be designated by the Credentialing Committee or Quality Improvement Committee and included for review by Providers, Members, family members, and Counties.

Credentialing Committee Actions

The Credentialing Committee may make one or more of the following recommendations to the CBHNP Quality Improvement Committee and JAC, 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 of the Provider from the network pending correction
5. Termination

Medical Assistance Enrollment

All Providers must be enrolled in the Pennsylvania Medical Assistance Program in order to participate as a CBHNP Network Provider.

CBHNP credentials and utilizes the following Provider Types and specialties:

- 31 339 – Licensed Physician (Psychiatrist)
- 01 010 – General Hospital (Psychiatric Services)
- 01 019 – Free Standing Drug and Alcohol Hospital
- 01 011 – Free Standing Psychiatric Hospital
- 08 184 – Drug and Alcohol Outpatient Clinic
- 08 084 – Methadone Clinic
- 11 128 – Drug and Alcohol IOP
- 08 110 – Mental Health Outpatient Clinic
- 11 113 – Mental Health Partial Hospitalization (Child)
- 11 114 – Mental Health Partial Hospitalization (Adult)
- 19 190 – Licensed Psychologist
- 11 115 – Family Based Mental Health Services
- 11 118 – Crisis Intervention
- 17 174 – Art Therapist
- 17 175 – Music Therapist
- 52 520 - Child Residential Services (3800 licensed group home)
- 52 523 – CRR / MH Host Home
- 56 560 – Non-JCAHO RTF
- 01 013 – JCAHO RTF
- 11 129 – SA Partial
- 11 131 – SA Halfway House

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- 11 132 – SA Medically Monitored Detox
- 11 133 – SA Rehab Short Term
- 11 134 – SA Rehab Long Term
- 12 138 – SA TCM

Medical Assistance sets standards for enrollment of all Providers. Providers are required to be licensed in order to be enrolled. All Provider addresses where service will be delivered must be included on the OMAP enrollment file with the appropriate Provider type and specialty for the services being delivered. The following website can be used for fast access to enrollment information and forms, <http://www.dpw.state.pa.us/omap/promise/omappromise.asp>

Providers can also visit DPW's website at www.dpw.state.pa.us or call them at 717-772-6456 24 hours per day, 7 days per week for more information on enrollment. To check the status of your application to be a Medical Assistance Provider call 717-772-6140 Monday through Friday 8:30 – 12:00 or 1:00 – 5:00 pm. CBHNP Provider Relations Department assists with supplemental service enrollment when appropriate.

Supplemental Service Enrollment

LCSW's, LSW's, LPC's and LMFT's are enrolled in the CBHNP Network at the option of Medical Assistance. Limits may apply to the types of services that can be provided. This type of enrollment will only be permitted if a person in your care becomes a CBHNP Member during treatment or if the clinicians' participation provides choice to Members in areas without appropriate Member choice. CBHNP will assist with this enrollment as part of the Credentialing process.

As the process for Medical Assistance enrollment and credentialing with CBHNP can change, please refer to above paragraph for information on enrolling in Medical Assistance and call CBHNP Provider Relations Department at 717-671-6500 for current information relative to the enrollment of these types of practitioners.

Psychologist / Psychiatrist Supervision and Medical Assistance Enrollment

All *licensed* practitioners, including psychiatrists and psychologists must be credentialed by CBHNP and appropriately enrolled in the Pennsylvania Medical Assistance Program if they are in private practice. Psychiatrists and licensed psychologists can visit DPW's website at www.dpw.state.pa.us or call the office at 717-772-6456, 24 hours per day, 7 days per week for more information on Medical Assistance enrollment. .

All licensed practitioners not employed and clinically supervised by a licensed MA Enrolled Psychiatrist, Psychologist, inpatient or outpatient organization MUST be credentialed by CBHNP individually and appropriately enrolled in the Pennsylvania Medical Assistance Program. According to information received in March 2005, a licensed psychologist may supervise licensed practitioners (LCSW's, LPC's, LMFT's and LSW's) and bill those services to CBHNP using his/her own MAID. Effective October 2005, CBHNP will not require formal credentialing of these practitioners however; the supervising licensed, MA enrolled clinician must submit an attestation form to notify CBHNP that the clinician is practicing under his/her supervision.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

If a CBHNP Credentialed, MA enrolled Clinician intends to use an LSW, LCSW, LPC, LMFT or unlicensed practitioner to see Members, CBHNP must be notified immediately upon hire using the attestation form. A new attestation form must be sent to CBHNP each January in order for the supervised practitioner to remain in good standing. **Please note that the MA enrolled, credentialed Clinician takes full responsibility for all services provided by the practitioner under his/her supervision.** CBHNP requires that primary source verification be completed on the employees highest level of education, and requires Providers to verify and maintain documentation that there are no Medicare/Medicaid sanctions against the practitioner.

In regard to supervising practitioners, please reference PA Code, Chapter 41.58, State Board of Psychology, which states psychologists licensed by the Board may employ “professional employees with graduate training in psychology,” who “shall perform their duties under the full direction, control and supervision of a licensed psychologist.” According to Policy Clarification RFP 11-97-66 & RFP 3-96-181, “you may hire unlicensed masters prepared therapists to perform certain services and bill for the services performed by that individual under the practitioner’s MAID in the HealthChoices program.” **This does not include specialized evaluations.**

For the purpose of billing Medical Assistance or CBHNP, licensed, MA enrolled psychologists are permitted to supervise no more than three FTE’s. No such limit is imposed for Psychiatrists.

The required attestation form follows this section.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

CBHNP Licensed Psychologist/Psychiatrist Attestation
LSW, LCSW, LPC, LMFT and Non-Licensed Practitioners

I, _____ intend to employ the following person, an LSW, LCSW, LPC, LMFT or unlicensed masters level practitioner to see CBHNP HealthChoices Members and bill using my Medical Assistance Identification Number:

Name:

License Type, if applicable:

I affirm that these persons will be used in accordance with PA Code, Chapter 41.58, State Board of Psychology, which states psychologists licensed by the Board may employ “professional employees with graduate training in psychology,” who “shall perform their duties under the full direction, control and supervision of a licensed psychologist.” And according to Policy Clarification RFP11-97-66 & RFP 3-96-181, which states “you may hire unlicensed masters prepared therapists to perform certain services and bill for the services performed by that individual under the practitioners MAID in the HealthChoices program.” **This does not include specialized evaluations.** I recognize for the purpose of billing CBHNP, **a licensed psychologist is only permitted to supervise three (3) FTE clinicians. No such limit exists for Psychiatrists.** I recognize that I may employ licensed Clinical Social Workers, Licensed Social Workers, Licensed Professional Counselors and Licensed Marriage and Family Therapists as well as unlicensed practitioners.

I further attest that;

- 1) I have verified this individual’s highest level of education at the primary source. _____
Initial Here
- 2) I have verified that this person meets the requirements outlined in PA Code Chapter 41. _____
Initial Here
- 3) I have verified that this individual has no Medicare or Medicaid sanctions against him/her _____
Initial Here
- 4) This individual will not be see CBHNP Members until notified of CBHNP approval _____
Initial Here

Psychiatrist /Licensed Psychologist Signature License Number & Type Date

CBHNP Use:

Verified by: _____ Date: _____

Provider Notification Date: _____

Method of notice: FAX (keep coversheet confirming deliver attached)
 Mail (keep letter attached)

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Supplemental Services

Supplemental services are services that the BH-MCO provides above and beyond in-plan services. They are services that cannot be provided under any existing service delivery model or Provider type. Periodically, CBHNP together with County oversight staff will request proposals from Providers for new and creative services. Proposals are jointly reviewed by the County and CBHNP. Please see Provider Info AD03—013 for more information about submitting a proposal. Ultimately, approval of any service as a supplemental service will rest with the OMHSAS Advisory Committee.

Administrative Appeals (Administrative Denial Appeal)

Clinical Care Managers are not permitted to backdate any request for authorization. Such requests must be submitted through the administrative appeal process, formerly referred to as administrative denial appeal. 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 apply to denials which resulted from administrative non-compliance and is not applicable to denials, based on medical necessity decisions by CBHNP.

Reversal of Administrative Denial decisions 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 which caused the procedural error as well as remedies in place to prevent future occurrences.

All requests for review of an Administrative Denial **must be submitted in writing within 60 days of the receipt of the Administrative Denial notification or date of service.**

Providers requesting review of an Administrative denial will be instructed to send either the form which follows this section or a letter to the attention of PROVIDER RELATIONS, ADMINISTRATIVE DENIAL REVIEW stating the following:

- Member name and dates of service
- Explanation of circumstances
- Steps taken to correct and prevent future occurrences
- Documentation of Members seen/dates services provided and billable amount(s). For BHRS or FBMH requests, all clinical notes for the month requested as well as the treatment plan must be submitted. In any case where service was provided without medical necessity review, the medical record must be submitted with the request.
- Desired action from CBHNP
- Documentation relevant to the request (i.e.... EVS slip verifying that EVS was checked for eligibility and wrongly indicated enrollment status, fax confirmation page, etc...)
- ALL relevant information should be included with your appeal since the decision of the committee is final.

The Administrative Appeal Committee consists of the Provider Relations Manager, Director of Quality Improvement and a Provider Relations Representative. The Committee reviews and researches each request. 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

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

2. Documentation of processing errors by CBHNP
3. Documentation of continued stay review issues beyond the control of the Provider
4. Reasons to uphold a non-authorization decision include but are not limited to:
5. Failure in authorization management by the Provider
6. Submission of the request for review beyond the latter of 60 days of the initial notice or service delivery date
7. Failure to check EVS prior to service delivery
8. Failure in claims or billing management by Provider

The Administrative Appeal Committee will evaluate the request, consulting with the senior management team as appropriate. 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. All relevant information must be submitted with the appeal as the decision of the review process is final. Incomplete requests will be returned.

**Community Behavioral HealthCare Network of PA (CBHNP)
Provider Manual 2007**

Administrative Appeal Request Form

Date: _____ **Member name:** _____
Member MA ID number: _____

Provider: _____ **Name of person submitting request:** _____
Provider phone number: _____ **Type of service:** _____

Please circle the appropriate healthcare plan below:

Line of Business					
HealthChoices					Medicare
Capital Region	Blair	Franklin/Fulton	Bedford/Somerset	Lycoming/Clinton	Gateway

Member's primary insurance _____ **Members secondary insurance** _____

Dates of services Provider is requesting to be reviewed for CBHNP payment: _____

Provider's requested action: _____

Reason for the delay in the authorization: _____

Steps taken to correct and prevent future occurrences: _____

REVIEW SECTION:

Supporting narrative to substantiate Provider claim: Please submit additional documentation of services rendered, such as clinical notes, treatment plans, EVS verification or other documentation that will support the request. Please include a typed narrative of additional supporting documentation to justify the request

TO BE COMPLETED BY CBHNP **Date reviewed by Administrative Appeals Committee:** _____

LOG NUMBER: _____ **Claims Submitted: YES NO** **Eligibility checked:** _____

Sent to clinical reviewer: _____ **Date:** _____

Summary to request a clinical review: **Authorization dates under appeal:** _____

Date of clinical/Doctor review: _____ **Date returned to Appeal Committee:** _____

Outcome: **Approval** **Denial** **Decision reason:** _____

Final decision date: _____

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Availability of CBHNP Policies and Procedures

CBHNP makes all policies and procedures available upon request. Contact your Provider Relations Representative for additional information.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter VI

PROVIDER RESPONSIBILITIES

Compliance with Law and Regulation

Providers must comply with all applicable Rules, Regulations and Requirements of Pennsylvania Medical Assistance Program, Department of Health, Department of Public Welfare, Federal Law and any other applicable entity.

Providers must be aware that they are obligated to comply with all of the rules and regulations that apply to the fee-for service Medical Assistance Program. Appendix BB of the HealthChoices RFP provides a listing of rules and regulations that the BH-MCO may choose to exclude or are simply not applicable. However, if in doubt, assume that any given rule or regulation applies under HealthChoices.

At a minimum, Chapter 1101 (Medical Assistance Manual) and 1150 (Medical Assistance Program Payment Provisions) apply to all MA enrolled Providers. In addition, Medical Assistance has specific rules and regulations by Provider type that can be found on-line at www.pacode.com. Applicable licensing Regulations set forth by OMHSAS must also be followed. Providers should have a self audit mechanism to assure that they are compliant with all applicable rules and regulations as well as a mechanism to self report instances of potential fraud or abuse to CBHNP within 72 hours of the finding.

Provider Staff Credentialing Requirements

Licensed Provider organizations and supervising clinicians 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 for their staff:

- 1) Primary source verification that the Practitioners license is in good standing (for PA State Licensed Practitioners, search http://licensepa.state.pa.us/default.asp?sid=775177542&facility=False&l_pers)
- 2) Verification that there are no sanctions on a practitioner's license. (for PA State Licensed Practitioners, search http://licensepa.state.pa.us/default.asp?sid=775177542&facility=False&l_pers)
- 3) Primary source verification, the highest level of education for all employees
- 4) Verification that the employee has not been terminated, suspended, precluded or excluded from the Medical Assistance Program. Such practitioners or employees are not permitted to provide service for any Medicaid Funded program, including HealthChoices. (See <http://www.dpw.state.pa.us/Business/FraudAbuse/003673510.aspx> OR <http://exclusions.oig.hhs.gov/>)

These elements may 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>

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Members Rights and Responsibilities

CBHNP Providers are encouraged to ask all new CBHNP Members if the Member has received and understand his/her written rights and responsibilities. CBHNP Providers are expected to review and discuss these rights and responsibilities with the Member as necessary, and refer the Member to a CBHNP Member Services representative if there are questions or concerns. Provider Relations Representatives will review these rights with you at credentialing, re-credentialing and routine site visits on a regular basis.

Member Rights

- **Receive Information.** Each Member has the right to receive information about CBHNP, our policies and procedures, our services, our practitioners and Providers, and the Members rights and responsibilities.
- **Dignity and Privacy.** Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- **Receive information on available treatment options.** Each Member is guaranteed the right to receive information on medically necessary available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
- **Participate in decisions.** Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- **Free from restraint or seclusion.** Each Member is guaranteed the right to be free of any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- **Copy of medical records.** Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request they be amended or corrected as specified in 45 CFR part 164.
- **Free exercise of rights.** Each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Member is treated by CBHNP and the Provider.
- **Voice Complaints or Appeals.** Each Member has the right to voice complaints or appeals about CBHNP or the care provided to them. Members should be advised to let us know if they are unhappy about any decision made by us or one of our Providers.
- **Make recommendations.** Each Member has the right to make recommendations regarding CBHNP's Members rights and responsibilities policies.
- **To Supply Information.** Each Member has the responsibility to supply information (to the extent possible) that CBHNP and our practitioners and Providers need in order to provide care.
- **To Follow Instructions.** Each Member has the responsibility to follow plans and instructions for care that they have agreed on with practitioners.
- **To Understand.** Each Member has a responsibility to understand their health problems and participate in mutually agreed-upon treatment goals to the degree possible.

In addition, Members of CBHNP also have the following rights and responsibilities:

- **To choose his/her Provider**
- **To ask for a therapist who understands his/her language and culture**
- **To receive needed services at convenient times and places**
- **To receive emergency care within 1 hour**
- **To receive urgent care within 24 hours**
- **To receive care within 7 days of his/her request for routine care requests**

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- To treat others with consideration and respect
- To be at appointments on time
- To call if he/she must cancel
- To be part of the treatment team by telling your doctor or therapist about symptoms and to ask questions
- To tell the doctor or therapist if you do not agree with recommendations
- To tell the doctor or therapist when/if you want to end treatment
- To take medication as prescribed and to tell the doctor if there is a problem
- To carry his/her insurance cards
- To tell the Provider if you have other insurance

SECOND OPINION

Another important right CBHNP Members need to know about is the right to request a **second opinion**. Members can request a second opinion from a qualified health care professional within CBHNP's network. CBHNP will provide for a second opinion from an appropriate behavioral health care professional within the network or arrange for the Member to get one outside the network at **no cost to the Member**.

Members Choice and Freedom of Choice

Per HealthChoices, CBHNP requirements and Provider Agreements, all CBHNP network Providers are required to assure that Members are aware that they have a right to choose the Provider they wish to work with. CBHNP must be able to verify that choice was offered to each Member entering service.

CBHNP expectations relative to documentation that Members have been informed of choice are outlined below. Note that this format is applicable to every service EXCEPT BHRS or Family Based Services since there are already formats specific to those services.

In order to assure that the Member understands this right, CBHNP will be looking for documentation by the Provider confirming that Members were informed that they have the right to select from at least two (2) Providers for the service authorized by CBHNP. Validation that Providers are documenting this requirement will occur at the time of re-credentialing. CBHNP offers a sample form found on the following page for the Provider's convenience and recommends that this be completed with the Member at intake for all levels of care except emergency inpatient admissions and crisis intervention services. This form should be completed as part of the initial paperwork at the onset of each treatment episode.

Providers may modify the form or create a new one as long as the issue of choice is clearly addressed and documented in the Member's medical record. Signed forms must be maintained in the Member's medical record and should be completed at the onset of each treatment episode.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Assurance of Freedom of Choice Form

This form verifies that I have been informed and understand that I have a choice of Providers available to me.

I have been given freedom of choice in selecting available Providers and realize that I may choose to receive treatment at any agency available through CBHNP. I am aware that I have a right to choose between at least two Providers. If I wish, alternate Providers will be made available to me through CBHNP Member Services Department.

I am also aware that my Provider will discuss with me all treatment options and what the treatment options involve, including advantages and/or disadvantages of each type of treatment.

My family and significant others will be included in treatment if I wish them to be.

Signature _____

Date _____

Witness _____

Date _____

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Cooperation with Consumer Family Satisfaction Team (C/FST) Survey Process

CBHNP Network Providers will accommodate and cooperate with the Consumer Satisfaction Survey Process. This is a HealthChoices requirement which is intended to gather and analyze Member satisfaction with services rendered. The Program is in place to determine whether priority population adult behavioral health service recipients and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families are satisfied with services and to help ensure that problems related to service access, delivery and outcome are identified and resolved in a timely manner. This is primarily accomplished by gathering information through face-to-face discussions with recipients of behavioral health services and the families of child and adolescent service recipients. The information is shared with the County and CBHNP in order to resolve issues and improve services. Provider specific survey results will also be used in the re-credentialing process. Providers must accommodate and cooperate with the surveyors in their conducting Member satisfaction surveys as permitted within the confidentiality standards and the laws. Providers may be asked to respond to survey findings through identified action plans or required corrective actions and to cooperate with follow-up monitoring activities that may be required.

Compliance with the Americans with Disabilities Act

The CBHNP Network Provider's have a responsibility to remove "non-physical" barriers to service and will make available at the request of its clients the following:

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

Section 504 of the Rehabilitation Act of 1973 (Section 504) and Title 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 against 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.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

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 in section 2 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 Member's rights as well as the Provider's responsibilities as defined in Title 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 PA Office for the Deaf and Hard of Hearing for information on additional information on resources that may assist you. It is suggested that you use PA ODHH Main Office number to speak with the Administrative Assistant to reach the appropriate 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 and if there are any communication access or physical access need. 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.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

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 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

1-800-692-7443 (Voice)

1-877-375-7139 (TDD)

Pennsylvania Assistive Technology Lending Library

1-800-204-7424 (Voice)

1-800-750-7428 (TTY)

PA TTY/Assistive Communications

1-800 670-7303 (Voice) or 717-236-2400 (Voice)

1-800-440-0374 (TTY)

717-236-5733 (TTY)

717-236-5733 (Fax)

PA Office for the Deaf and Hard of Hearing

1-800-233-3008 (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

717-703-0073 (Voice)

1-866-895-4206 (TTY)

717-909-5599 (Fax)

Self for Hard of Hearing People

301-657-2248 (Voice)

301-657-2249 (TTY)

301-913-9413 (Fax)

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

National Institute on Deafness and other Communication Disorders Clearing House

1-800-241-1044 (Voice)

1-800-241-1055 (TTY)

301-907-8830 (Fax)

The CBHNP Member Services Department will assist Members with a request for special needs and the CBHNP Provider Relations Department will assist the Provider in meeting this goal when applicable.

For additional information, Providers are encouraged to review OMHSAS Bulletin number OMHSAS-01-06 issued on 10/01/01.

Cultural/Ethnic/Racial Sensitivity

All Providers are expected to be aware of and sensitive to their organizations 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, the organization staff are equipped to handle the request appropriately. CBHNP may monitor this area during Provider profiling, site visits, or other activities.

Confidentiality

CBHNP Providers will ensure that Member clinical information is 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. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides assurance that protected health information (PHI) will remain confidential. The act further defines how PHI is used and shared. Providers should consult their legal counsel with specific questions regarding HIPAA.

Release of Information Forms

HealthChoices 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, CBHNP complies with federal and state regulations governing the release of client information (disclosure of confidential information) and record retention. CBHNP maintains strict policies concerning internal security, review processes, disposal of confidential documents and distribution of statistical information. CBHNP also requires 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, child abuse, elder, etc.).
- 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, so long as the Member is 14 years or older. Drug and Alcohol services require Member consent regardless of age.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- 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.
- CBHNP 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.
- CBHNP 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 CBHNP and a CBHNP network Provider must include a statement regarding the confidentiality of the information exchanged.
- Any CBHNP 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 or 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; Medical Assistance Subsection 1101.51; Health Care Financing Administration, 42 CFR Chapter IV, 10-1-93.

Access Standards

HealthChoices dictates the required Provider responses time for emergent, urgent and routine services as follows:

Emergent

Providers must ensure that CBHNP Members are seen face-to-face within **one hour** of the request for services. Provider is responsible to facilitate access to emergency crisis intervention or the emergency room if a Member presents in an emergency state as defined below.

Emergency Care – A medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could result in:

- Placing the health of the individual in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part

Urgent

Provider must ensure that CBHNP Members are seen face-to-face within **twenty-four (24) hours** of the request for services. Provider is responsible to facilitate and coordinate with CBHNP as necessary

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Urgent Care – Any illness or severe condition that under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) hour period and, if left untreated, could rapidly become a crisis or emergency situation. Additionally, it includes situations such as when a Member's discharge from a hospital will be delayed until services are approved or a Member's ability to avoid hospitalization is dependent upon prompt approval of services.

Routine

Provider must ensure that CBHNP Members be offered an appointment to be seen face-to-face within **seven (7) calendar days** of the request for services.

Routine Care - Members assessed at this level of risk must be seen within seven calendar days of initial contact. Routine risk is determined based upon exclusion of needs consistent with emergent or urgent risk, as reported by the Member and/or family members or Provider calling on behalf of the Member

Under any circumstances, Providers have a responsibility to assist Members to meet needs such as coordination of transportation and securing medication if necessary.

Appointment Availability

Providers are required to maintain hours sufficient to meet the demand of the practice. **CBHNP Members cannot be put on a waiting list.** If a Provider site cannot meet the Member's need within the specified timelines for routine care, as indicated, Providers must inform the Member that they should contact CBHNP 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 with the Provider.

Again, it is critical that Providers notify their Provider Relations Representative immediately if anything has changed which will affect CBHNP's 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" Which is available on the CBHNP website. 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.

Provider Reporting

Measurement of Ability to Meet Access Standards

Ability to meet access standards is measured using data provided to CBHNP by network Providers. Authorization request forms for outpatient services require that Providers include three very important dates, the date the Member first requested services, the date an appointment was first offered and the date the Member was actually seen for the first appointment. If a Member has been in treatment but is requiring a different level of care, it must be treated as if the Member is a new patient. In such a case, you would use the date the Member was recommended to begin the new service as the date first requested.

"First Offered" Date

It is extremely important that dates are reported on the outpatient request form properly. Provider staff should be aware that the date "first offered" is the first available appointment, even if the Member is not able to accept it. Providers are paid a higher rate when they are able to offer an appointment within the access standard, even if the Member is unable to accept that appointment.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Site visits to high volume Providers will include a limited review of Member files to assure accurate reporting of the date a service was first requested by the Member, date first appointment was offered and the date the Member was first seen.

Performance/Outcomes Measurement System (POMS) Data Reporting

CBHNP is required under the HealthChoices contract to participate in and assure the reporting of POMS data to the Department of Public Welfare. As such, the organization has established guidelines to accomplish this task. All CBHNP network Providers will assist in completing the task, as necessary.

Critical Incident Reporting

For all network Providers, it is the policy of CBHNP Capital Area to mirror as closely as possible the reporting requirements and categories outlined in the draft DPW OMHSAS Community Incident Management and Report System. CBHNP Capital Area 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 Providers shall be required to report critical incidents to CBHNP Capital Area within 24 hours of the time at which the Provider becomes aware of their 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.
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 incidents identified by Providers as critical, adverse or unusual.

The completed report form should be submitted to CBHNP Capital Area Quality Improvement Department within 24 hours of the occurrence or discovery of the incident occurrence. Due to the sensitive nature of the information and identification of the Member, Providers will submit the forms to CBHNP Capital Area via first class US Mail or by fax. Forms may not be sent as e-mail attachments.

The form should be completed in its entirety. No spaces should be left blank. Please be sure that the Provider contact person indicated on the form is able to answer questions about the incident should clarification be necessary.

PR-008 regarding Incident Reporting as well as the reporting form is available on the CBHNP Website at www.cbhnp.org. Alternate formats may be accepted with prior approval. Please contact your Provider Relations Representative for more information.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Medical Records Standards

All Providers are required to minimally meet recordkeeping requirements per PA Code Chapter 55 1101.51 (e). The CBHNP Quality Improvement Program provides guidelines for medical record documentation for CBHNP Providers. These guidelines are consistent with the standards of national accrediting organizations. The CBHNP Medical Records standards are as follows:

Accessibility and Availability of Medical Records

Provider contracts include provision to permit CBHNP Quality Improvement staff, and appropriate/required agencies access to the medical records of CBHNP Members. Records may be reviewed to monitor quality, medical necessity, coordination of care, and continuing care planning.

CBHNP Providers are contractually committed to maintaining medical record documentation of each encounter with CBHNP Members.

Record Keeping

CBHNP establishes standards for organization, contents, and readability of the CBHNP Member's medical records. These standards apply equally to Provider records and to internal Member records maintained by the CBHNP Clinical Care Managers. 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.

While all CBHNP Member medical records must contain specific data elements regardless of document, internal CBHNP medical records provide a summary of treatment conveyed by the CBHNP Clinical Care Manager and professional advisor and is based on information provided by the treating Provider(s). Treating Provider medical record documentation is expected to be more detail oriented and specific. **All records must conform to the record documentation standards for the Medical Assistance Manual, Chapter 1101.** Data elements for CBHNP Member medical records include:

- The CBHNP Member's name and/or client number on each page of paper documentation and on every entry of electronic records.
- The CBHNP Member's identifying information and demographics to include:
 - 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 point 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
- Past Medical History/Treatment History to include:
 - Significant Health Events – accidents, operations, hospitalizations

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- 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/substance abuse 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 CBHNP 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 CBHNP Primary Care physician when appropriate
 - Documentation of CBHNP Primary Care Physician referral to CBHNP Provider.
 - Quarterly summary of the CBHNP Member's progress in behavioral health treatment, prepared by the CBHNP Providers for the CBHNP 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 CBHNP 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, delineated treatment intervals through episode of care/illness but at a minimum at termination of treatment for all CBHNP Members.
- Documentation of reason for termination of treatment.
- Documentation of date(s) of family, therapy/intervention/visits for any CBHNP Member under the age of 18.

Communication Requirements and Continuity of Care

- The treating CBHNP Provider is required to make and maintain contact with the CBHNP Member's PCP with proper authorization for disclosure when clinically appropriate and to provide, at a minimum, quarterly treatment summaries to the PCP.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- The treating CBHNP Provider is required to make and maintain contact with other service Providers who are also treating the Member.
- When indicated, the CBHNP Provider refers the Member to the PCP for assessment, evaluation, treatment, and further referral as needed. In those situations in which the CBHNP Member does not know/have a PCP, the CBHNP Provider refers the Member to CBHNP.
- Providers facilitate coordination and continuity of care among the multi-Providers treating a CBHNP Member and communicate regularly with CBHNP.
- Admission and discharge of a CBHNP Member into Inpatient or Partial Hospitalization even if there is a primary insurer must be communicated to the Clinical Care Manager.

Referral for Medically Necessary Care

CBHNP coordinates medically necessary medical-surgical, specialty, secondary, and tertiary service for Members through the CBHNP Clinical Care Managers. They are responsible during the assessment, screening, and referral process to determine whether the Member may be in need of medical-surgical, specialty, secondary, and tertiary services and to facilitate an appropriate referral. Providers should contact a Clinical Care Manager to facilitate referral as necessary.

CBHNP facilitates orientation and education for CBHNP Providers to increase Providers' awareness of the Member's need for medically necessary medical-surgical, specialty, secondary, and tertiary services and to establish the referral process and procedures.

Provision of Emergency Care

CBHNP ensures the provision of emergency services to CBHNP Members. CBHNP ensures CBHNP Members know where and how to obtain medically necessary care in emergency situations.

Referral Requirements

CBHNP specifies referral requirements to Providers and subcontractors and documents records of approved and denied services.

Broken/Missed Appointments and AMA discharge

CBHNP has tasked its contracted network Providers with following up on 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" 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.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

- For Members who “no show” for initial routine care, the Provider will send a letter requesting that the Member contact 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

CBHNP has a 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 X, Clinical Handbook.

Medical Necessity Criteria

The Medical Necessity Criteria for HealthChoices is found in Appendix T of the HealthChoices Program Standards and Requirements and can be accessed on the Department of Public Welfare website at the following address: <http://www.dpw.state.pa.us/omap/rfp/lcbhrfp/lcbht.pdf>. Appendix T can also be accessed via the CBHNP website: <http://www.cbhnp.org/caremanprov.aspx>. A paper copy of all Medical Necessity Criteria for HealthChoices is available to Providers by contacting your Provider Relations Representative. Please refer to Chapter I of this manual for CBHNP phone and address information.

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. 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. CBHNP has identified critical elements that must be addressed in discharge plans and outlines expectations in Chapter IX, Clinical Handbook.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter VII Suspected/Substantiated Fraud and Abuse

CBHNP seeks to ensure the integrity of the HealthChoices program by investigating any suspected fraud and abuse. Provider fraud and abuse can include:

- Physical/verbal abuse to a Member
- Denial of care
- Confidentiality violations
- Fraudulent billing
- Provider staff misrepresenting credentials
- Any other Provider action that places a Member in jeopardy
- Any other Provider action that violates Federal/State or other applicable regulations

CBHNP provides a toll free access line 24 hours a day, 7 days a week to ensure the immediacy of Provider reporting of suspected fraud and abuse. CBHNP will comply with all Department of Public Welfare mandatory or statutory regulatory requirements with respect to fraud and abuse.

In addition, the Department of Public Welfare has established a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is 1-866-DPW-TIPS (1-866-379-8477) and operates between the hours of 8:30 AM and 3:30 PM, Monday through Friday. Voice mail is available at all other times. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Suspected fraud and abuse may also be reported via the website at: <http://www.dpw.state.pa.us/omap> or emailed to omaptips@state.pa.us. Information reported via the website or email can also be done anonymously. The website contains additional information on reporting fraud and abuse.

Some common examples of fraud and abuse are:

Billing or charging Medical Assistance recipients for covered services

Billing more than once for the same service

Dispensing generic drugs and billing for brand name drugs

Falsifying records

Performing inappropriate or unnecessary services

Failure to complete clinical medical record documentation

Falsification or back dating of clinical record entries

All Providers are obligated by the Provider Agreement to notify CBHNP of any suspected fraud or abuse. The designated Corporate Compliance Officer should report such incidents to the CBHNP Corporate Compliance Officer within **72 hours** when learning of a potential incident. CBHNP compliance staff, under the direction of the Corporate Compliance Officer, will work with each Provider to develop a self report audit plan, as well as a follow-up corrective action plan to prevent future occurrence of any confirmed violation.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter VIII PROVIDER INFO'S

Provider Info's should be maintained with the CBHNP Provider Manual to serve as procedure updates and clarifications. The information contained in Provider Info's should be shared with Provider staff to clarify CBHNP expectations and procedures. Provider Info's are available at the website, www.cbhnp.org or by calling Provider Relations at 1-888-700-7370.

Provider Info's are organized into categories so you can easily determine what items are relevant to your organization. The following categories will be used. CBHNP will number the documents according to the structure outlined below for easy reference.

Categories:

- a. AD – Administrative Update (Includes administrative procedures or expectations pertaining to all levels of care. EXCLUDES authorization procedures)
- b. BHRS - BHRS Update (Includes authorization procedures)
- c. D&A – Drug and Alcohol all LOC Update (includes authorization procedures)
- d. MH – Mental Health all LOC Updates (includes authorization procedures)

Example:

AD03 – 001

Category is AD (Administrative); Year issued is 2003; 001 indicates it is the first publication of the year.

As information changes, we will rescind previous Info's containing incorrect information. Please remember to maintain the Provider Info's with your Provider Manual and distribute the information widely among staff responsible for carrying out the activities.

In lieu of a Provider Info, CBHNP Policies and Procedures may also be distributed from time to time. Please see the CBHNP website for a full list of documents that have been distributed to date or contact your Provider Relations Representative for copies.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter IX CLINICAL HANDBOOK

Definitions:

MSS – Member Services Staff

CCM – Clinical Care Manager

MNC – Medical Necessity Criteria

ICM – Intensive Case Management/Manager

RC – Resource Coordination/Coordinator

CRR – Community Residential Rehabilitation

RTF – Residential Treatment Facility

FBMH – Family Based Mental Health

SA – Substance Abuse

MH – Mental Health

BHRS – Behavioral Health Rehabilitation Services

PCPC – Pa Client Placement Criteria

CI – Crisis Intervention

ASAM – American Society of Addiction Medicine

PHP – Partial Hospitalization Program

PAC – Provider Advisory Committee

Non-Incentive Statement Regarding CBHNP Staff

CBHNP and its staff will not arbitrarily deny or reduce the amount, duration or scope of a required service because of any contractual or financial incentive. UM decisions are based solely on established medical necessity criteria. CBHNP does not provide incentives to its employees who conduct utilization management activities for denying, limiting or discontinuing medically necessary services.

- UM decision-making is based only on appropriateness of care and service and enrollment in HealthChoices
- CBHNP does not reward practitioners or other individuals for issuing denials of coverage or service
- Financial incentives for UM decision-makers are never linked to decisions that result in under-utilization or utilization of specific services

Member Services Staff (MSS)

Member Services Staff is a great resource for Providers 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 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:

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Authorizations

Questions regarding status of approval, authorization numbers, etc. for NON-BHRS related services. BHRS authorization questions will be forwarded to the appropriate Clinical Associate.

Clinical Care Manager Case Assignment

MSS can tell you who is assigned to manage a particular Member's care.

Eligibility Questions

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 CBHNP 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 provision and ensure insurance eligibility for all services provided.

Locating Providers

MSS can help Members/family members find a selection of outpatient Providers that are convenient to where the Member lives or works.

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

MH Outpatient Services Registration

a. Initial Request

MH outpatient services should be requested within five (5) business days from the time a Provider sees a Member using the Outpatient Treatment Request form for MH services. These routine services, (individual, family, group therapy; psychiatric evaluations, medication management; medication training and support, clozaril and clozapine), do not need to be pre-certified. Initial service authorizations would include up to 24 therapy units (individual, family, and group) per six months and/or 18 medication checks in one year. Psychological and Neuropsychological testing must be pre-certified.

b. Ongoing Services/ Reauthorization Requests

Authorizations are limited by the number of sessions and/or the authorization expiration date. Reauthorization requests are needed when **either** the number of authorized sessions has been exhausted prior to the expiration date OR the authorization expiration date has been reached. Authorizations **cannot** be extended. Reauthorization should be requested using the Outpatient Treatment Request form for MH services, which is the same form used for initial authorization requests.

Please refer to the most recent mental health outpatient authorization request forms and instructions.

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

SA Outpatient Service Registration

- a. **Initial Request:** Initial SA outpatient services should be requested within five (5) business days from the time a Provider sees a Member using the Outpatient Treatment Request Form for

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

substance abuse services or the Substance Abuse Intensive Case Management request form. Drug and alcohol Intensive Outpatient Program, Partial Hospitalization Program and Rehabilitation must be pre-certified by contacting CBHNP by phone prior to initiating services.

- b. **Ongoing Services:** Reauthorization of SA outpatient services should be requested on the same form used to request the initial authorization. Continued authorization is based on Member meeting Pennsylvania Client Placement Criteria (PCPC) or American Society of Addiction Medicine (ASAM).

Crisis Intervention Services Registration

Crisis Intervention (CI) services do not require prior authorization, however the CI Provider must notify CBHNP of billable services that have been provided using the following process:

- a. The CI Encounter Form must be submitted to CBHNP within a maximum period of one month **from** the date of the initial Member contact for the current event so that an authorization number can be assigned. CI Encounter Forms can be submitted more frequently to expedite authorization entry, but must be submitted prior to the claim submission.
- b. Make sure to submit all contacts at the same time for services delivered to the same Member on the same date of service to avoid potential authorization errors.
- c. The Provider must receive the authorization number prior to billing a claim.
- d. Per our current policy, claims are required to be submitted within 60 days from the date of service and an authorization number is required with the claims submission. Therefore, if a claim is received prior to the receipt of the encounter form, the claim cannot be processed since there will be no valid authorization to process the claim.
- e. MSS will contact the Provider for any discrepancy with regard to Member eligibility, duplicated contacts, and unclear or illegible information presented on form.

Please refer to the current Crisis Intervention Services Provider Info available on the CBHNP website.

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 CCM.
- c. If a Member has a primary insurance, CBHNP pre-certification is not required, however, CBHNP must be notified upon admission and discharge.

SA Partial Hospitalization

- a. **Initial Request:** Must be pre-certified by contacting CBHNP by phone prior to initiating services. Approval is based on Member meeting PCPC or ASAM.
- b. **Ongoing Services:** Continued authorizations are based on Member meeting PCPC or ASAM received during a live continued stay review with a CBHNP CCM.
- c. If a Member has a primary insurance, CBHNP pre-certification is not required, however, CBHNP must be notified upon admission and discharge.

SA Intensive Outpatient Services

- a. **Initial Request:** Must be pre-certified by contacting CBHNP by phone prior to initiating services. Approval is based on Member meeting PCPC/ASAM.
- b. **Ongoing Services:** Continued authorizations are based on Member meeting PCPC or ASAM received during a live continued stay review with a CBHNP CCM.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

MH Behavior Health Rehabilitation Services, BHRS

- a. **Initial Request for BHRS services:** Requires a current psychological evaluation recommending the service, an Interagency Service Planning Team (ISPT) meeting agreement or disagreement form with signatures, a completed plan of care and a treatment plan. The ISPT meeting will be coordinated by an ICM/RC, if involved, or coordinated by CBHNP when there is no ICM/RC involved with the Member. CBHNP will review the documentation to see if the requested services meet MNC. CBHNP will notify the family and if involved, CASSP Coordinator, the ICM/ RC, Children and Youth Services and Juvenile Probation of the initial MNC outcome.
- b. **Ongoing BHRS services:** Require a current psychological evaluation recommending the services, an ISPT meeting as stipulated by Mental Health bulletin, 01-01-05, and an ISPT input signature page, a completed plan of care and a treatment plan with team signatures. The ISPT meeting will be coordinated by ICM/RC, if involved, or by the Provider currently providing the BHRS service. CBHNP will review the documentation to see if the requested services meet MNC. CBHNP will notify the family and current Provider of the MNC outcome.

MH Family Based Mental Health Services, (FBMH)

- a. **Initial request:** Requires a team agreement for a referral to an evaluation or prescriber to recommend FBMH if it is appropriate. The evaluation or prescriber making the recommendation to FBMH must be a medical doctor, licensed psychologist, or licensed psychiatrist. The recommendation can be in the form of an evaluation or a recommendation/prescription without an evaluation. Supporting information from the treatment team, family and prescriber or evaluator is required to show that Member meets MNC. CBHNP will review all the documentation to see if the requested services meet MNC. CBHNP will notify the family and if involved, CASSP Coordinator, the ICM/ RC, Children and Youth Services and Juvenile Probation of the initial MNC outcome. A current psychological evaluation must be in the Member's record as part of the initial assessment and will need completed within the first 30 days of treatment if a current psychological is not available. This is required to continue the service.
- b. **Ongoing Services:** Requires completed treatment plan, current crisis plan, discharge plan and discharge criteria and evidence of a interagency team meeting sent to CBHNP for review.

Residential Treatment Facility, (RTF)

- a. **Initial Request:** Requires a psychiatric evaluation, ISPT meeting, which the active ICM/RC will facilitate with CBHNP participating and signatures, POC and treatment plan with signatures. CBHNP will review for MNC and family, CASSP Coordinator, Children and Youth Services, Juvenile Probation and ICM/RC will be notified of outcome.
- b. **Ongoing Services:** Requires a psychiatric evaluation, ISPT meeting with CBHNP participation and signatures, POC and treatment plan with signatures. CBHNP will review for MNC and family, CASSP Coordinator and ICM/RC will be notified of outcome. CBHNP will inform Provider of the continued stay review date at the time of the authorization.

SA Non Hospital Residential

- a. **Initial Requests:** Must be precertified by contacting CBHNP by phone prior to initiating services.
- b. **Ongoing Services:** Continued authorizations are based on Member meeting PCPC or ASAM criteria received during a live continued stay review with a CBHNP CCM.
- c. If a Member has a primary insurance, CBHNP pre-certification is not required however, a CCM must be notified upon admission and discharge.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

MH Inpatient

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

- a. **Initial Request:** Must be precertified by contacting CBHNP 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 CCM. CBHNP typically authorizes continued stay in four day increments but this may vary depending on specific medical needs.
- c. If a Member has a primary insurance, CBHNP pre-certification is not required however, a CCM must be notified upon admission and discharge.

SA Hospital Based Rehab

- a. **Initial Request:** Must be precertified by contacting CBHNP by phone prior to initiating services.
- b. **Ongoing Services:** Continued authorizations are based on Member meeting PCPC or ASAM criteria received during a live continued stay review with a CBHNP CCM.
- c. If a Member has a primary insurance, CBHNP pre-certification is not required however, a CCM 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 Members 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 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, and is part of the reauthorization request for BHRS and FBMH.

CBHNP will conduct live discharge reviews with all network Providers for inpatient and Partial Hospitalization. The following information must be included in the **discharge review** with the CBHNP CCM.

- 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 CBHNP funded service.** Documents may

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

be submitted via U.S. Mail or Fax. *The discharge plan is considered part of the service CBHNP has purchased from you, therefore, in accordance with the Provider Agreement, lack of receipt of the discharge plan by CBHNP may delay payment for services rendered. This becomes especially important when the discharge summary recommends other levels of care, especially BHRS which has a 60 day expiration date and RTF which has a 30 day expiration date.*

Outpatient Discharge

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.

- Plans must include background information
- Presenting problems

- All five (5) Axis Diagnosis 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.

Role of the ICM/RC in Discharge Planning

ICM/RC is a critical and effective resource and will be valuable in assuring continuity of care across the service continuum. CBHNP has developed a means of tracking and notifying the ICM/RC of hospitalizations to enable the ICM/RC to become involved in discharge planning.

In instances where no ICM/RC is assigned, a CBHNP Follow-Up Specialist will contact the Providers to determine if appointments are kept as scheduled. Both the CBHNP Follow-Up Specialist and CCM will be involved in providing outreach to the Members who do not keep scheduled appointments.

AMA and Discharge Plans

If a Member leaves treatment against medical advice and there are no grounds for commitment, CBHNP requires that the Provider notify the CCM in a timely fashion so that outreach efforts by CBHNP and ICM/RC Providers, if authorized, can be initiated quickly.

Medical Necessity Denial

A MNC denial is defined as a determination made by a CBHNP Medical Director or Licensed Physician 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 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.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Denial notices are printed and reviewed by the CCM prior to mailing the notice to check the content while ensuring the notice is mailed to the Member within two (2) business days of the decision. CBHNP will ensure the Member receives the notice by the 21st day after the request is received by CBHNP.

Denial notices follow the format as approved by DPW. Advanced notice will be given to the Member for filing a complaint/grievance. For continued stay inpatient denials, the inpatient facility is contacted by telephone and the notice is faxed, consistent with HIPAA guidelines, rather than mailed to the inpatient facility, and the notice is to be hand delivered to the Member by that facility. CBHNP is responsible for ensuring the Member and Provider receive the denial notice.

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 1-888-722-8646, 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 appeal 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 IV of this Provider Manual for a full discussion of Complaint and Grievance Procedures.

Priority Populations

HealthChoices defines Priority Populations as: Members with serious mental illness and/or addictive disease, and children and adolescent Members with or at risk of serious emotional disturbance and/or who abuse substances and who, in the absence of effective behavioral health treatment and rehabilitation services, care coordination and management are at risk of separation from their families through placement in long term treatment facilities, homelessness, or incarceration, and/or present a risk of serious harm to self or others.

Drug and alcohol priority populations include child and adolescent substance abusers and persons with addictive diseases including pregnant women and women with dependent children, intravenous drug users and persons with HIV/AIDS who abuse substances.

Providers participating in CBHNP's HealthChoices program will be required to identify all Members seeking services who meet criteria for Priority Populations.

CBHNP will offer all in-plan and identified supplemental services to the populations referenced by the Department as Priority populations.

Special Needs Populations

In addition, CBHNP has developed coordination of care agreements with all three PH-MCOs in an effort to provide collaboration and coordination of assessment and treatment of CBHNP Capital Area HealthChoices Members. Coordination and communication among behavioral health Providers, Members, and other care Providers is critical for efficient and effective care, especially for persons with co-existing physical impairments and/or diseases. Because multiple treatment Providers are often involved with an individual, especially in the case of persons with co-existing disorders, shared communication requires the identification of a designated clinician to coordinate an individual's care. The CBHNP CCM will be accountable for facilitating this assignment for all cases and will monitor appropriate performance based on established standards of practice.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Coordination of care for children and adolescents requires an additional focus that is not found with adults. Many children who have a serious emotional disturbance and/or an addictive disease are involved with multiple child serving agencies. Coordination of care by CBHNP will be critical in the delivery of treatment with the School District, the Intermediate Unit, Children and Youth Services and Juvenile Probation and Parole.

CBHNP will offer all in-plan and identified supplemental services to the populations referenced by the Department as Special Needs populations.

Child/Adolescent Services System Program (CASSP Principles) as defined by OMHSAS:

1. **Child-centered:** Services meet the individual needs of the child, consider the child's family and community contexts, and are developmentally appropriate, strengths-based and child-specific.
2. **Family-focused:** Services recognize that the family is the primary support system for the child and participates as a full partner in all stages of the decision-making and treatment planning process.
3. **Community-based:** Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community.
4. **Multi-system:** Services are planned in collaboration with all the child-serving systems involved in the child's life.
5. **Culturally competent:** Services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of the child's and family's ethnic group.
6. **Least restrictive/least intrusive:** Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

The CCM and, when appropriate, the targeted case manager will actively participate in interagency team meetings and assure that all child serving agencies are working together for the achievement of outcomes as developed by the child, parent and interagency team and in coordination with CASSP Principles.

Community Integration

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

Whole Person Focus

Outcome research demonstrates the significant interplay of psychological concerns and medical health issues. CBHNP's CCM will strive to address all Member needs, using a bio-psycho-social approach to treatment. CBHNP will be responsible for ensuring a thorough evaluation and assessment of medical issues and developing a system to facilitate communication between medical and psychological health Providers.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

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. CBHNP 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. CBHNP has developed and monitors standards of care, providing research and training on outcomes proven treatment technologies along with implementation of the Department's Performance Outcome Measurement Service (POMS) as discussed in the Provider reporting section of this manual. The development of outcomes that include a focused assessment of how well treatment addresses the needs of priority and special needs populations is critical.

Cultural Competence

Providers must strive to eliminate barriers to treatment caused by failures to understand or address issues of cultural differences. CBHNP stresses the importance of providing clinical assessment, which addresses the developmental, cultural and linguistic needs of Members. CBHNP does not make assumptions regarding cultural preferences but asks Members directly which type of Provider they would prefer. 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

The CBHNP 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 CBHNP expectations when providing services to Members. The Provider Advisory Committee (PAC) of CBHNP 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 six (6) clinical practice guidelines:

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

Attention Deficit Hyperactivity Disorder. Adopted the American Academy of Pediatrics Clinical Practice Guideline: "Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactivity Disorder" (Pediatrics 105:1158-1170, 2000). Available on-line at: <http://www.aap.org/policy/ac0002.html>

Attention Deficit Hyperactivity Disorder. Adopted the American Academy of Pediatrics Clinical Practice Guideline: "Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder (Pediatrics 108:1033-1044, 2001). Available on-line at: <http://www.aap.org/policy/s0120.html>

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

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

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

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

Clinical Practice Guidelines are available directly at the source using links provided above or through our website at www.cbhnp.org. Documents are copyrighted however, Clinicians are permitted to print one copy for his/her own use. Contact your Provider Relations Representative at 717-671-6500 if you need assistance to get a paper copy of these guidelines.

Community Support Program (CSP) Principles defined by OMHSAS

1. Consumer-Centered/Consumer-Empowered -
Services are based upon the needs of the individual and incorporate self-help and other approaches that allow consumers to retain the greatest possible control over their own lives.
2. Culturally Competent -
Services are sensitive and responsive to racial, ethnic, and religious and gender differences of consumers and families.
3. Designed to Meet Special Needs -
Services are designed to meet the needs of persons with mental illness who are also affected by such factors as old age, substance abuse, physical illness or disability, mental retardation, homelessness or involvement with the criminal justice system.
4. Community-Based/Natural Supports -
Services are provided in the least coercive manner and in the most natural settings possible. Consumers are encouraged to use the natural supports in the community and to integrate into the living, working, learning and leisure activities of the community.
5. Flexible -
Services are designed to allow people to move in and out of the system and within the system as needed.
6. Coordinated -
Treatment services and supports are coordinated on both the local system level and on an individual consumer basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Coordination includes linkages with consumers, families, advocates and professionals at every level of the system of care.
7. Accountable -
Service Providers are accountable to the users of services and include consumers and families in planning, development, implementation, and monitoring and evaluating services.
8. Strengths Based -
Services build upon the assets and strengths of consumers and help people maintain a sense of identity, self-esteem and dignity.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

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

1. Initial Assessment – Pre-certification for Inpatient/Partial Hospitalization

Providers should be prepared to provide information as follows:

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.

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, volunteers 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

2. Continued Stay Review

Providers should be prepared to provide information as follows:

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: 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.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

3. 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 calls. 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.

Again, Discharge plans are critical in documenting progress and planning for ongoing services. Discharge **plans must be provided within 2 weeks after discharge from any CBHNP funded service.** Documents may be submitted via U.S. Mail or Fax. *The discharge plan is considered part of the service CBHNP has purchased from you, therefore, in accordance with the Provider Agreement, lack of receipt of the discharge plan by CBHNP may delay payment for services rendered. This becomes especially important when the discharge summary recommends other levels of care, especially BHRS which has a 60 day expiration date and RTF which has a 30 day expiration date.*

Preventative Behavioral Health Programs and Community Education

CBHNP is committed to providing community education and prevention programs for CHBNP Members. Community education and prevention services are intended to assist Members and their families to learn about specific behavioral health issues, wellness, and prevention models. CBHNP will design or select preventive health programs to prevent or detect the incidence, emergence, or worsening of behavioral health disorders. CBHNP considers such factors as age, sex, socioeconomic status, ethnic background, family support systems, cultural identity and practices, clinical needs, and risk characteristics to ensure that our programs are relevant and significant to enrollees. The development,

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

oversight and implementation of prevention programs are the responsibility of the CBHNP Quality Improvement Committee. CBHNP has implemented two preventive behavioral health programs:

Early Identification of Attention Deficit Hyperactivity Disorder.

The goal of the program is early identification and appropriate treatment. Information is sent to parents of all identified CBHNP Members who reach age six. Despite the ready availability of information on child development, many parents are not able to differentiate between normative, but “difficult”, behavior and ADHD. This program educates parents about the differences, provides a quick screening tool, and information on where to turn for more help.

Improving Treatment Compliance for Adults with Depression.

The goal for this program is secondary prevention. For an individual patient, the aim is a reduction in the length of the symptomatic period through compliance with treatment (especially medication). For the CBHNP population, the aim is a reduction in the prevalence of Major Depressive Disorder.

For further information on preventive behavioral health programs, please refer to the CBHNP website.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter X Claims Handbook

CBHNP is committed to helping adults with serious mental illnesses and co-occurring disorders live successfully in the community utilizing the CSP Principles.

This section provides an overview of the claims process for CBHNP. The CBHNP claims payment process was designed to ensure prompt and accurate payment for services provided to Members of the CBHNP Capital Area HealthChoices program. This section describes the billing process.

Our goal is to make billing and claims payment as simple for Providers as possible. In this spirit, CBHNP has developed a Claims Help Desk. This service is available at 1-888-700-7370, Monday through Friday from 8:30 AM to 4:30 PM, to assist Provider staff with claims questions.

Completing & Submitting Claims Forms

CBHNP will accept the two existing claims forms, the UB-92 for inpatient or other services billed with a revenue code and the CMS-1500 for all services billed with a procedure code (ambulatory and non-hospital D&A services).

Providers of inpatient service will use a UB-92 claim form. Providers of Ambulatory Services will use the CMS 1500 for billing. UB-92 claims forms will not be accepted for billing ambulatory services. **All invoices must be received within 60 days of the date of service to be considered for payment.** Cases involving third party liability have 60 days from the EOB date to submit the claim. The EOB from the primary insurance MUST be submitted with the claim.

Authorization Number

All claim forms must reflect the appropriate authorization number. The authorization number should be written clearly in the space indicated on the form. Claims that are missing the appropriate authorization number may be subject to delay to allow for proper matching of service to payment.

Electronic Billing

CBHNP has created a generic email account for Providers interested in electronic billing (edi@cbhnp.org). Providers can use this email address for all electronic billing questions. All questions should be initiated with an email, rather than a phone call. Once we know the nature of the question, we can then have the best person respond. Additional current information about electronic billing can be found on the CBHNP website. **Please do not attempt to submit claims electronically until a trading partner agreement is in place.**

More information such as companion guides and standard code set information is available on the CBHNP Website at <http://www.cbhnp.org/hcclaims.aspx>.

Paper Claim Submission

Paper claims should be mailed to:

**CBHNP
Claims Department
P.O. Box 6600
Harrisburg, PA 17112**

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

CMS 1500 Form and UB 92 Form

Each claim form must indicate the patient’s diagnosis using ICD-9-CM diagnosis codes and the procedures that you performed. When billing for professional services, there will be a procedure code associated with the service. When billing for inpatient stays, there will be a DRG or a Revenue code as appropriate. Current CPT and HCPCS procedure codes will be used for billing. Reimbursement will be based on the CBHNP fee schedule provided through the contracting process. The following section provides instruction for completion of each accepted form. Should any questions arise regarding the completion of these forms, please contact the CBHNP Claims Help Desk for assistance.

CMS 1500 Claim Form Completion Guidelines

BLOCK #	REQUIRED (R) NOT REQUIRED (N)	INSTRUCTIONS
1	N	Check Applicable Program
1a	R	Recipient Medicaid ID Number
2	R	Patient’s Name <i>(last name, first name, middle initial)</i>
3	R	Patient’s Birth Date (MMDDCCYY) and Sex <i>(check the box)</i>
4	N	Enrollee Name <i>(last name, first name, middle initial)</i>
5	R	Patient’s Address
6	N	Enrollee’s Relationship to Insured <i>(check box for self, spouse, child, other)</i>
7	N	Enrollee Address <i>(number, apartment number, street, city, code, telephone number with area code)</i>
8	N	Enrollee’s Status <i>(check boxes for single, married, other, employed, full-time student, part-time student)</i>
9	N	Other Enrollee Name <i>(last name, first name, middle initial)</i>
9a	N	Other Enrollee Policy or Group
9b	N	Other Enrollee Date of Birth (MMDDCCYY) and Sex
9c	N	Employer’s name or School Name
9d	N	Insurance Plan Name or Program Name
10a-c	N	Enrollee’s Condition Related to Employment, auto accident and other accident
10d	N	N/A
11	R	Insured policy, Group or FECA Number (if applicable)
11a	R	Insured Date of Birth
11b	N	Employer’s name or School
11c	R	Insurance Plan Name or Program Name (if applicable)
11d	N	Is there another health benefit plan? <i>(check block Yes or No)</i>
12	R	Patient’s or Authorized Person’s Signature All invoices must have either the Recipient’s signature or the words “Signature Exceptions” or “Signature on File.”

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

BLOCK #	REQUIRED (R) NOT REQUIRED (N)	INSTRUCTIONS
13	N	Insured or Authorized Person's Signature
14	N	Date of Current Illness
15	N	Date of Same or Similar Illness
16	N	Date Client Unable to Work in Current Occupation
17	R	Name of Referring Physician or Other Source (if applicable)
17a	R	Identification Number of Referring Physician <i>Enter the complete license number of the practitioner noted in block 17. This number contains a prefix consisting of two alpha characters, the certification number composed of six digits, and a one alpha suffix. Sometimes, the MPI number of the referring/attending physician is required rather than the license number.</i>
18	R	Hospitalization Dates Related to Current Services
19	R	Reserved for local (<i>Provider Type and Provider Medical Assistance Number</i>).
21	R	Diagnosis or Nature of Illness or Injury (<i>ICD-9-CM Diagnosis Code</i>)
22	N	Medicaid Resubmission Code/Original Referral Number
23	R	Prior Authorization Number
24a	R	Dates of Service (<i>Note the begin and end date - use one line per service per day</i>)
24b	R	Place of Service (<i>See PROMISE Chart</i>)
24c	R	Type of Service (<i>See CBHNP's Fee Schedule</i>)
24d	R	Procedures, Service, or Supplies <i>Enter the applicable procedure codes and modifiers from CBHNP's Fee schedule.</i>
24e	R	Diagnosis Code <i>Enter the diagnosis reference number as shown in block 21 to correlate the diagnosis code to the procedure or service performed.</i>
24f	R	\$ Charges
24g	R	Days or Units
24h	R	EPSDT Family Plan (if applicable)
24j	R	Coordination of Benefits information (COB) (if applicable) Enter the one digit resource code, which is found on the PROMISE chart, if the recipient has another resource available to pay for the service.
24k	R	Other Insurance Paid (if applicable) Portion of the bill that was paid by another insurance company.
25	R	Federal Tax ID Number
26	N	Patient's Account Number
27	N	Accept Assignment
28	R	Total Charges Enter the total sum of 24f lines 1-4 in dollars and cents.
29	R	Amount Paid by Other Insurance (if applicable) Enter the total sum of 24k lines 1-4 in dollars and cents.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

BLOCK #	REQUIRED (R) NOT REQUIRED (N)	INSTRUCTIONS
30	R	<i>Balance Due</i>
31	R	Signature of Physician / Supplier of Service and Invoice Date
32	R	Name and Address of Facility where services were provided (If other than Home or Office.)
33	R	Physician's/Supplier's Name, Address, Zip Code, phone Enter your Medical Assistance Provider Number.

UB92 Claim Form Completion Guidelines

BLOCK #	REQUIRED (R) NOT REQUIRED (N)	INSTRUCTIONS
1	R	Provider Name, Address, Telephone Number
2	N	Unlabeled Field
3	R	Patient Control Number
4	R	Type of Bill (<i>See UB-92 PROMISe Chart</i>)
5	R	Federal Tax Number
6	R	Statement Covers Period (<i>Note a beginning and end date</i>)
7	R	Covered Days
8	R	Non-covered Days (if applicable)
9	R	Coinsurance Days (if applicable)
10	R	Life Time Reserve Days (if applicable)
11	N	Unlabeled Field
12	R	Patient's Name
13	R	Patient's Address
14	R	Patient's Birth Date (<i>MMDDCCYY</i>)
15	R	Patient's Sex
16	N	Patient's Marital Status
17	R	Admission Date (<i>MMDDYY</i>)
18	R	Admission Hour (<i>See UB-92 PROMISe Chart</i>)
19	R	Admission Type (<i>See UB-92 PROMISe Chart</i>)
20	N	Admission Source
21	R	Discharge Hour (<i>See UB-92 PROMISe Chart</i>)
22	R	Patient Status (<i>See UB-92 PROMISe Chart</i>)
23	R	Medical Record Number
24-30	N	Condition Codes
31	N	Unlabeled Field
32-35	N	Occurrence Codes and Dates
36	N	Occurrence Span Codes and Dates
37	N	Internal Control Number/Document Control Number
38	N	Responsible Party Name and Address
39-41	R	Value Codes and Amounts (if applicable)
42	R	Revenue Code (<i>See CBHNP's Fee Schedule</i>)
43	R	Revenue Code Description
44	N	HCPCS/Rate (<i>If applicable, enter CBHNP's Procedure Code.</i>)

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

BLOCK #	REQUIRED (R) NOT REQUIRED (N)	INSTRUCTIONS
45	N	Service Date
46	R	Service Units
47	R	Total Charges
48	N	Non-Covered Charges
49	N	Unlabeled Field
50	R	Payer Identification <i>Enter the name of each payer organization from which you may anticipate payment.</i>
51	R	Provider Medical Assistance ID Number <i>Enter the seven digit Provider Medical Assistance ID Number.</i>
52	N	Release of Information Certification Indicator
53	N	Assignment of Benefits Certification Indicator
54	R	Prior Payments – Amount paid by other insurance (if applicable)
55	N	Assignment Amount Due
56	N	Unlabeled Field
57	N	Unlabeled Field
58	R	Insured's Name (if applicable)
59	N	Patient's Relationship to Insured
60	R	Patient Recipient Number (<i>10 digit Medical Assistance Number</i>)
61	R	Group Name (if applicable)
62	R	Insurance Group Number (if applicable)
63	R	Treatment Authorization Number
64	R	Employment Status Code
65	N	Employer Name
66	N	Employer Location
67	R	Principal Diagnosis Code (<i>ICD-9-CM Diagnosis Code</i>)
68-75	R	Other Diagnosis Code – Secondary Diagnosis (if applicable) (<i>ICD-9-CM Diagnosis Code</i>)
76	R	Admission Diagnosis Code (<i>ICD-9-CM Diagnosis Code</i>)
77	N	E-Codes
78	N	Unlabeled Field
79	N	Procedure Coding
80	N	Principal Procedure Code and Date
81	N	Other Procedure Codes and Date
82	R	Attending Physician License Number <i>Enter the complete license number of the attending physician. This number contains a prefix consisting of two alpha characters, the certification number composed of a six digit and one alpha character.</i>
83	R	Other Physician Identification (if applicable)
84	R	Remarks <i>Enter your Medical Assistance Provider Number.</i>
85	R	Provider Representative Signature
86	R	Date Bill Submitted

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Claim Payment Disagreements

All claims payments will include an explanation of benefits (EOB). The EOB provides you with a detailed explanation of the amount of each claim paid and the reason for any amount of the claim that was denied. If you have questions about a denial or disagree with a claim payment for any reason, contact CBHNP's Claims HelpDesk at 1-888-700-7370. A Customer Service Representative can help to facilitate a review of the claims payment in question. Please be prepared to provide the Authorization number, Provider/facility name, the Member's name and ID number.

If the claim is denied as a result of a Provider error that can be corrected, the Customer Service Representative will assist you to understand the required corrections so that you can re-submit the invoice.

If after reviewing the denial with the Customer Service Representative you continue to believe that a claim was denied in error, you have the right to request a formal review in writing using the Administrative Denial Appeal process as discussed in this manual. Your assigned Provider Relations Representative can assist should you have questions about the process. CBHNP will complete the review within thirty (30) business days. You will receive a written response to your request outlining the findings of the formal review. Include all necessary information with your request since the decision of the reviewing committee is final.

Claim Re-submission

Resubmission of Corrected Claims

Corrected claims may be resubmitted when the Provider finds that they billed for an incorrect number of units. In cases where the resubmission serves to correct a claim that has already been paid, the claim must be clearly identified as a "resubmitted Corrected Claim" and resubmitted within 60 days of the remittance notice date relative to the original batch claims submission.

If no payment has been made for a claim because the claim was returned to you as incomplete or with a code error, the claim must be clearly identified as a "resubmitted corrected claim" and resubmitted within 60 days of the return date.

Resubmission for Coordination of Benefits (COB) Request

When you receive denial with a COB requesting additional information, you may resubmit the claim with the additional information included. If you are instructed to resubmit the claim, you should follow the same procedures as in the initial submission. Mail the claim with any supporting materials to:

**CBHNP
Claims Department
P.O. Box 6600
Harrisburg, PA 17112**

TPL Submission

When submitting claims to CBHNP as a secondary payer, the EOB (Explanation of Benefit) from the primary insurer must be attached to the claim. **Claims with attached EOB must be submitted within 60 days of your notification of payment or denial by the other insurance company.**

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Some claims will require an adjustment due to over or under payment of a prior claim. If an adjustment is required, the COB will give a detailed explanation and include a description of the process for the adjustment. In most cases, CBHNP will make the adjustment to a future payment.

Expectations for CBHNP Response to Claims Submission

CBHNP's turnaround time for claims is averaging approximately eighteen (18) days. CBHNP pays all "clean" claims (claims that are accurate and complete) within forty-five (45) days. Our goal is to provide payment as quickly as possible and to pay most claims within thirty (30) days of receipt of a clean claim.

If you have not heard from CBHNP within 30 days after you sent the claim in, please contact the Claims Help Desk at 1-888-700-7370 to inquire as to the status of the claim as this may indicate the claim was not received. If CBHNP indicates the claim was not received, Providers will be asked to fax or mail the claim immediately. It is imperative that Providers closely monitor their claims submissions to identify potential issues quickly. Every call received at the claims help desk is logged for future reference.

Checking on the Status of a Claim

You may check the status of a claim at any time by calling 1-888-700-7370. To make an inquiry, you will need to provide the Authorization number, Provider/facility name, Member's name and identification number, the procedure code(s) and the date(s) of service for which you are billing. **Again, if you have not heard from CBHNP on a claim within 30 days of the date you believe it was submitted, contact CBHNP immediately as this may indicate that the claim was not received. If CBHNP indicates the claim was not received, Providers will be asked to fax or mail the claim immediately.**

Claims Appeals

Claims appeals are subject to the Administrative Appeal Process (Review of Administrative Denial) described in Chapter V Provider Relations Services.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Chapter XI FREQUENTLY ASKED QUESTIONS

Provider Enrollment and Related Questions

HOW CAN I BECOME A CBHNP NETWORK PROVIDER?

All Providers go through the credentialing process which begins by completing a Provider application. Providers may obtain an application package by contacting a Credentialing Specialist at 1-888-700-7370 or on the website at www.cbhnp.org. All Providers must be licensed and enrolled in the Pennsylvania Medical Assistance Program.

HOW DO I ENROLL WITH THE PENNSYLVANIA MEDICAL ASSISTANCE PROGRAM?

All CBHNP HealthChoices Providers must be enrolled in the PA Medical Assistance Program. You may visit DPW's Website at www.dpw.state.pa.us or call them at 717-772-6456 24 hours per day, 7 days per week. To check the status of your application to be a Medical Assistance Provider call 717-772-6140 Monday through Friday 8:30 – 12:00 or 1:00 – 5:00 pm.

WHAT IF I CANNOT ACCEPT ANY NEW REFERRALS OR OTHER CHANGES OCCUR THAT AFFECTS MY ABILITY TO SEE MEMBERS?

It is important that you tell your Provider Relations Representative any new information that affects referrals so Providers and Members will not be inconvenienced. Please be sure to notify us of phone number and address changes as well. CBHNP will need the information in written form via fax (717-671-6522) or mail. A "Provider Data Update Form" may be used and is available on the website. Temporary inability to accept referrals will not jeopardize network status.

WHO DO I NOTIFY WHEN A SITE MOVES OR A PRACTITIONER LEAVES/STARTS EMPLOYMENT?

This information should be reported to your Provider Relations Representative in writing using the "Provider Data Update Form." Up to date information prevents inconvenience for Members as well as Providers.

If you are structured as a group practice, each new practitioner must complete an Individual Application for Enrollment which is available on the website. If you are credentialed as an organization it is not necessary to complete the Individual Application for Enrollment for new hires however, you must let us know if you have a new prescribing practitioner. Failure to notify CBHNP of new prescribing psychiatrists may lead to problems when Members get prescriptions filled.

Clinical Operations and Authorization Questions

HOW DO I REQUEST AUTHORIZATION?

All services except psychiatric evaluation, medication management, family, individual and, group therapy which are outpatient services and hospital detoxification services require prior authorization. The Outpatient Authorization Request Form for psychiatric evaluation, medication management,

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

Clozaril/Clozapine Support, family, individual, and group therapy must be submitted within ten (10) business days of the INITIAL appointment. Up to 48 therapy sessions over a twelve month period will be authorized. CBHNP will authorize using CPT Code 90806 which reflects a 45 to 50 minute hour. Medication management is authorized for 18 visits over a one year period of time. Please be sure to pay attention to the number of sessions authorized as well as the expiration date of the authorization.

CBHNP has two (2) business days after the date of receipt to approve the request. Please allow three (3) business days after the date the request if you choose to call for an authorization number.

Current authorization request forms as well as instructions for completing the form can be found on the website. Inpatient hospitalization and partial hospitalization require a phone call to CBHNP. You will have access to a live person 24 hours per day, 7 days per week if you have questions or need to discuss a case.

WHEN WILL I GET THE AUTHORIZATION?

Hard copies of authorizations will be mailed to you. You should receive a copy in approximately five (5) business days, depending on mail service. If you have questions about the status of your authorization request, you may contact Member Services using the phone number identified for the Members County of residence in Chapter I of this Manual. Please allow three days after the date the faxed request was submitted before calling. If you do not receive the hard copy authorization, please call. In any circumstance, never hold your claims because you have not received hard copies of authorizations.

SHOULD WE STOP SERVICES UNTIL WE GET AN AUTHORIZATION EVEN THOUGH WE SENT IN THE AUTHORIZATION REQUEST LATE?

Professional standards would indicate that services should not be discontinued based on late authorizations. The Provider should work directly with the Clinical Care Manager to decide how to proceed. Providers should assure that all authorization requests are submitted per CBHNP requirements so that there is minimal impact to the Member's treatment.

HOW SHOULD WE CONTINUE TO PROVIDE SERVICES IN THE HOME AND COMMUNITY WHEN THE MEMBER GOES INTO INPATIENT OR PARTIAL HOSPITALIZATION?

The lead clinician should contact Member's assigned Clinical Care Manager to discuss treatment concerns when Members are in Partial Hospitalization or Inpatient. Continuation of services should be part of that discussion.

HOW DO I KNOW WHO IS THE ASSIGNED CLINICAL CARE MANAGER?

Member Services Specialist Staff can provide this information via phone inquires.

WHY DO MEMBER SERVICES STAFF ASK SO MANY QUESTIONS FOR EVERY CALL?

Our Member Services Specialist Staff need to obtain as much information as possible from callers in order to determine how to handle each call. They are responsible for completing an initial assessment for each incoming call. Please refer to [CBHNP PROVIDER INFO #AD 03-004 Regarding Member Services](#). This document along with all Provider Info's is available on the CBHNP website (www.CBHNP.org) - Care Management /Member Services.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

WHAT DO I DO IF A MEMBER WANTS TO GO TO A DIFFERENT PROVIDER?

As a Provider, you would be responsible for providing the Member with other Provider options and/or referring the Member to CBHNP if they require additional information or experience any problems with transferring Providers.

Please refer to [CBHNP PROVIDER INFO #02-002 - Care Management/Member Services Process Clarifications](#) on CBHNP website www.CBHNP.org Care Management /Member Services

WHAT MUST BE SUBMITTED IN AN AUTHORIZATION / RE-AUTHORIZATION PACKET FOR BHRS SERVICES?

Refer to [CBHNP PROVIDER INFO #02-015](#) on CBHNP website (www.CBHNP.org) Care Management /Member Services

WHAT IF I DO NOT AGREE WITH AN ADMINISTRATIVE DENIAL FOR AUTHORIZATION OR CLAIMS PAYMENT?

If your authorization request or claim was denied due to administrative or procedural errors, you may request that CBHNP reconsider the decision. Reversal of administrative 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 valid special circumstances as determined by CBHNP. An example of a valid special circumstance would be a conflict with EVS regarding an individual's eligibility which can be proven by the Provider in the form of EVS documentation. Failure to follow guidelines outlined in the revised Mental Health Outpatient Authorization Request Form Instructions and detailed in this Provider Manual will result in administrative denial.

All requests for review of administrative denial must be submitted in writing within 60 days of the authorization request denial or date of service.

Providers requesting review of administrative denial will be instructed to send a letter to the attention of PROVIDER RELATIONS, ADMINISTRATIVE DENIAL REVIEW stating the following:

1. Member name and dates of service
2. Explanation of circumstances
3. Steps taken to correct and prevent future occurrences
4. Documentation of Members seen/dates services provided and billable amount(s)
5. Desired action from CBHNP
6. Documentation relevant to the request (ie... EVS slip verifying that EVS was checked for eligibility and wrongly indicated enrollment status, fax confirmation page, etc...)

Refer to Provider Info AD03-007R for more information. CBHNP will make a decision about your request within 30 days of receipt of the appeal.

HOW WILL I KNOW ABOUT CHANGES IN AUTHORIZATION PROCESSES AND OTHER PROCEDURES AT CBHNP?

CBHNP will share this information with Providers through Provider News briefs and Provider Info's. Provider Info's should be regarded as supplements and clarifications to the CBHNP Provider Manual. All such communication can be found on the website and are available for download.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

WHAT DO I DO IF A MEMBER NEEDS EMERGENCY SERVICES?

CBHNP expects the Provider to take immediate action to ensure the safety of the Member and others. CBHNP should be contacted for service authorization using the Member Services number for the Members County of residence located in Chapter I of this Manual after the situation is stabilized.

Emergencies should be considered as incidents/behaviors when Member is a direct threat to self and/or others and is in need of a higher level of care due to safety. **Emergency Care** is defined as: A medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could place the health of the individual in serious jeopardy; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.

The Lead Clinician: FBMHS Team, MT, BSC, or Outpatient Therapist should be consulted first for an acute exacerbation of target behaviors that do not result in risk to self and/or others but still require immediate interventions for stabilization.

The Lead Clinician should contact the Member's assigned Clinical Care Manager within one business day to discuss the case. A team meeting may need to be convened to discuss any changes to current treatment interventions.

Claims and Eligibility Questions

HOW DO I SUBMIT A CLAIM FOR PAYMENT?

Claims must be submitted within **60 days** of the date of service.

Depending on the service you provided, one of two (2) claim forms may be used. The CMS 1500 is used for ambulatory services or services billed with a procedure code. The UB 92 should be used for inpatient or other services that are billed with a revenue code. Forms can be obtained at most office supply stores as they are standard in the industry. Claims may be submitted to the following address:

CBHNP
Attention: Claims Department
P.O. Box 6600
Harrisburg, PA 17112

WHEN WILL I GET PAID?

A minimum of ninety percent (90%) of all clean claims are paid within 30 days. All clean claims are paid within 45 days. A clean claim includes all of the information necessary to process your claim. Necessary information is listed in Chapter X of the CBHNP Provider Manual. If you have not heard from CBHNP within 30 days of the date you believe you submitted the claims, call the HelpDesk immediately at 1-888-700-7370 as this may be an indicator that CBHNP has not received your claim.

Community Behavioral HealthCare Network of PA (CBHNP) Provider Manual 2007

WHAT IF I HAVE A QUESTION ABOUT MY CLAIM?

CBHNP has a Claims Helpdesk that is staffed from 8:00 am to 5:00 pm each weekday. The phone number is 1-888-700-7370.

HOW DO I CHECK MEMBER ELIGIBILITY?

CBHNP is responsible for behavioral health services for HealthChoices Members residing in Bedford, Blair, Clinton, Franklin, Fulton, Lycoming and Somerset Counties.

Due to volatility of membership, we *strongly* recommend that Providers check eligibility frequently. We recommend that eligibility checks occur at a minimum every two weeks but ideally before each appointment. CBHNP has no involvement with determining eligibility. Member Files are downloaded to CBHNP on a daily basis from DPW. Further, authorization is not a guarantee of payment. The Provider must verify that the Member continues to be eligible prior to rendering the service.

Providers should check the Member's eligibility by using the State's Electronic Verification System at **1-800-766-5387** at no cost to you. When calling EVS, be prepared to supply your Provider MA ID, the Member's identification number and date of birth. You can check eligibility 24 hours per day, 7 days per week using this phone number.

If you are interested in obtaining PROMISe ready eligibility verification devices, two vendors are available, Insurance Benefit Spot Check, 1-800-233-7768 and TES at 1-800-843-5237 ext 5604. PROMISe ready Provider Electronic Solutions Software is also available at the DPW website or by calling the Provider Assistance Center at 1-800-248-2152.