# HealthChoices Provider Manual

Updated February 2023

**pa.performcare.org**

PerformCARE®

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## Definitions

ACT — Assertive community treatment

ADA — Americans with Disabilities Act

ALD — Assistive listening devices

AMA — Against medical advice

APA — American Psychological Association

ASAM — American Society of Addiction Medicine

BH-MCO — Behavioral health managed care organization

BHT — Behavioral health technician

BPI — Bureau of Program Integrity

BSC — Behavioral specialist consultant

CABHC — Community Area Behavioral Health Collaborative

CAP — Corrective action plan

CAQH — Council for Affordable Quality Healthcare, Inc.

CARF — Commission on Accreditation of Rehabilitation Facilities

CART — Computer-assisted real-time transcription

CASSP — Child and Adolescent Service System Program

CC — Care Connector

CCISC — Comprehensive Continuous Integrated System of Care

CCM — Clinical care manager

CHBA — Council for Higher Education Accreditation

CHC — Community HealthChoices

CI — Crisis intervention

COA — Council on Accreditation

COB — Coordination of benefits

COD — Co-occurring disorders

CPT — Current Procedural Terminology

CRE — Certified review entity

CRR HH — Community residential rehabilitation host home

CSP — Community support program

CTT — Community treatment team

CVO — Credentials verification organization

CYS — Children and Youth Services

D&A — Drug and alcohol

D&A NH — Drug and alcohol non-hospital

DCN — Document control number

DDAP — Department of Drug and Alcohol Programs

DHS — Department of Human Services

DOH — Department of Health

DOI — Department of Insurance

DRG — Diagnosis-related group

DSM — Diagnostic and Statistical Manual of Mental Disorders

EFT — Electronic funds transfer

EOB — Explanation of benefits

ER — Emergency room

ERA — Electronic remittance advice

EVS — Electronic verification system

FBA — Functional behavioral assessment

FBMHS — Family-based mental health services

FERA — Fraud Enforcement and Recovery Act

FFS — Fee-for-service

FSS — Family support services

HCAC — Health care-acquired condition

HCPCS — Healthcare Common Procedure Coding System

HIPAA — Health Insurance Portability and Accountability Act of 1996

IBHS — Intensive behavioral health services

ICM — Intensive case management

ISPT — Interagency service planning team

JCAHO — Joint Commission on Accreditation of Healthcare Organizations

JPO — Juvenile probation officer

LCSW — Licensed clinical social worker

LMFT — Licensed marriage and family therapist

LPC — Licensed professional counselor

MA — Medical Assistance

MA ID — Medical Assistance identification

MAT — Medication-assisted treatment

MCO — Managed care organization

MH — Mental health

MH IP — Mental health inpatient

MNG — Medical necessity guidelines

MSS — Member Services staff

MST — Multi-systemic therapy

MT — Mobile therapy

NCQA — National Committee for Quality Assurance

NPDB — National Practitioner Data Bank

OMHSAS — Office of Mental Health and Substance Abuse Services

OP — Outpatient

OPPC — Other provider-preventable conditions

PAC — Provider Advisory Committee

PA ODHH — Pennsylvania Office of Deaf and Hard of Hearing

PCP — Primary care provider

PH-MCO — Physical health managed care organization

PHP — Partial hospitalization program

POMS — Performance outcome measurement system

PSS — Peer support services

QI — Quality improvement

RC — Resource coordination

RFP — Request for proposal

RTF — Residential treatment facility

SU — Substance use

SIU — Special Investigations Unit

SS — Social Security

TCM — Targeted case management

TRR — Treatment record review

USDE — United States Department of Education

WRAP — Wellness recovery action plan

# Chapter I
# INTRODUCTION AND SUMMARY OF CHANGES

## About PerformCare

For over 20 years, PerformCare has been working with valued county and community partners to improve the quality of life for the more than 250,000 members we serve across Pennsylvania. We remain committed to a mission-driven philosophy of care — providing quality, reliable, and cost-effective behavioral health management services to members 24 hours a day, 365 days per year.

PerformCare, part of the AmeriHealth Caritas℠ Family of Companies, is a full-service managed behavioral health care organization that supports members and providers through specialized behavioral health and human services programs in both the public and private sector. For more information about PerformCare, please visit **pa.performcare.org** or contact Provider Relations at **1-888-700-7370**.

PerformCare Clinical Care Managers are master's-level, licensed, and experienced clinicians with advanced training in mental health and substance use disorders. They are trained to appropriately assess the clinical needs of the member, monitor services, and work with network providers to offer clinically appropriate and empirically based treatment services in a managed care delivery model. PerformCare Clinical Care Managers and Member Services Specialist staff are available 24 hours a day, seven days a week, to address family and caregiver needs, as well as the needs of our members.

We are happy that you have chosen to be part of our provider network. Please do not hesitate to call us if you need assistance or have recommendations for improvement. Our Provider Relations staff can be reached by calling **1-888-700-7370**.

This Provider Manual provides 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.

## Summary of Changes

This Provider Manual revision is updated to reflect the changes from behavioral health rehabilitation services (BHRS) to IBHS, incorporating Community HealthChoices, updating our terminology to reflect diversity, equity, and inclusion instead of cultural competence, changes in provider payments through ECHO and claims submission options through Change Healthcare and reformatting to remove specific forms or contents that may change over time, which have been replaced with links to forms and content.

This document is current at the date of printing. Be alert for provider notices and other form changes. Please check the website frequently: **pa.performcare.org**. Please be sure to register for iContact and you will automatically receive email alerts when items that may interest you are posted to the website.

**Please be sure to review the entire Provider Manual, as most chapters have been edited and updated since the last revision in 2019.**

## Chapter II
## CONTACT INFORMATION

The Operations Center, located in Harrisburg at the Clover Hill office, houses functional areas that serve all HealthChoices contracts including claims, credentialing, administration and contracts, care management, and Member Services.

Mailing address:
PerformCare
8040 Carlson Road
Harrisburg, PA 17112

PerformCare also has a regional office for Franklin and Fulton counties. **Note:** No service authorization requests should be mailed or faxed to the regional office. All service requests must be submitted to the Operations Center in Harrisburg.

### PerformCare Facilities

| Facility | Address | Phone and fax |
|---|---|---|
| Operation Center, Clover Hill | 8040 Carlson Road<br>Harrisburg, PA 17112 | Phone: **1-717-671-6500**<br>Fax: **1-717-671-6521** |
| Franklin/Fulton office | 417 Phoenix Drive, Unit A<br>Chambersburg, PA 17201 | Phone: **1-717-263-8723**<br>Fax: **1-717-264-8727** |

### Main Numbers and Toll-Free Numbers

| Region/department | Number |
|---|---|
| Provider Line (all provider calls) and Claims Help Desk | **1-888-700-7370** |
| Operations Center, Clover Hill | **1-717-671-6500** |
| Franklin/Fulton office | **1-717-263-8723** |
| Member Services, Capital Area | **1-888-722-8646** |
| Member Services, Franklin/Fulton | **1-866-773-7917** |

### Fax Numbers

| Region/department | Number |
|---|---|
| Administration | **1-717-671-6521** |
| Claims | **1-717-671-6522** |
| Provider Relations | **1-717-671-6522** |
| Clinical Operations — toll-free for all HealthChoices counties | **1-888-987-5828 (Outpatient Authorization submissions)**<br>**1-855-707-5823 (children's services)** |
| Franklin/Fulton office | **1-717-264-8727** |
| Member Services/Outpatient Services — all HealthChoices counties | **1-717-671-6565** |
| Quality Improvement (incident reporting) | **1-717-671-6571** |

## Physical Health Care

Through physical health managed care organizations (PH-MCOs), recipients receive quality medical care and timely access to all appropriate physical health services, whether the services are delivered on an inpatient or outpatient basis. The Pennsylvania Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) oversees the physical health component of the HealthChoices program ("HealthChoices").

HealthChoices currently serves approximately 3.2 million recipients in the following zones:

- **Southeast Zone** — Bucks, Chester, Delaware, Montgomery, and Philadelphia counties
- **Southwest Zone** — Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland counties
- **Lehigh/Capital Zone** — Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York counties
- **Northwest Zone** — Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, and Warren counties
- **Northeast Zone** — Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming counties

The HealthChoices program has three goals that guide DHS in its implementation efforts. These goals are:

- To improve access to health care services for Medical Assistance (MA) recipients
- To improve the quality of health care available to MA recipients
- To stabilize Pennsylvania's MA spending

Enrollees have an option to choose one of the HealthChoices PH-MCOs in their respective zone. See the list below for physical health plan options for enrollees in counties managed by PerformCare (Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, and Perry).

| HealthChoices managed care physical health plan options | Number | Special Needs Unit (SNU) |
|---|---|---|
| Highmark Wholecare | **1-800-392-1147** | **1-800-642-3550** |
| AmeriHealth Caritas Pennsylvania | **1-888-991-7200** | **1-800-684-5503** |
| UPMC For You | **1-800-286-4242** | **1-866-463-1462** |
| Health Partners Plans | **1-800-553-0784** | **1-866-500-4571** |
| Geisinger Health Plan | **1-855-227-1302** | **1-855-214-8100** |

## Community HealthChoices

Community HealthChoices (CHC) is the Pennsylvania DHS program serving older Pennsylvanians and individuals with physical disabilities to help individuals remain in their homes. The program is for people age 21 or older who have both Medicare and Medicaid or receive long-term services and supports (LTSS) through Medicaid. PerformCare collaborates with all CHC physical health plans to arrange and deliver behavioral health services for members receiving LTSS, including members who are dual-eligible and/or living in nursing facilities.

Enrollees have an option to choose one of the CHC PH-MCOs. See the list below for CHC plan options for enrollees in counties managed by PerformCare (Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, and Perry).

| Community HealthChoices physical health plan options | Number |
|---|---|
| AmeriHealth Caritas Pennsylvania CHC | **1-855-235-5115 (TTY 1-800-235-5112**) |
| PA Health and Wellness | **1-844-626-6813 (TTY 1-844-349-8916**) |
| UPMC Community HealthChoices | **1-844-833-0523 (TTY 711)** |

## HealthChoices Behavioral Health Program Oversight

Through behavioral health managed care organizations (BH-MCOs) such as PerformCare, recipients receive quality medical care and timely access to appropriate mental health and/or drug and alcohol services. This component is overseen by the DHS Office of Mental Health and Substance Abuse Services (OMHSAS) and HealthChoices primary contractors. Note that in many cases the primary contractor counties have delegated administration of their behavioral health services to consortium or collaborative organizations. The following organizations work closely with both the counties and PerformCare.

### Capital Area Behavioral Health Collaborative (CABHC)

CABHC oversees Cumberland, Dauphin, Lancaster, Lebanon, and Perry counties HealthChoices programs:
2300 Vartan Way, Suite 206
Harrisburg, PA 17110
**1-717-671-7190**
**www.cabhc.org**

### Tuscarora Managed Care Alliance (TMCA)

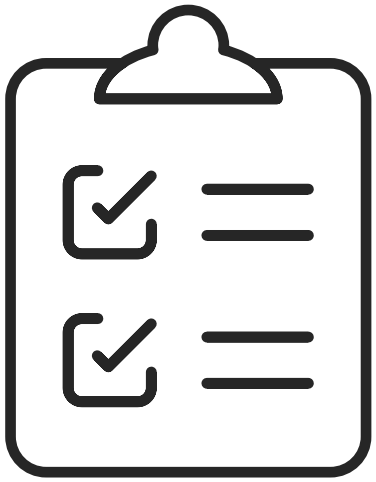
TMCA oversees Franklin and Fulton counties:
218 N. Second Street
P.O. Box 867
Chambersburg, PA 17201
**1-866-646-1060**
**www.bhc-tmca.com**

## MA Transportation Programs

Cumberland County: **1-800-632-9063**
Dauphin County: **1-717-232-7009** or **1-800-309-8905**
Franklin County: **1-800-632-9063**
Fulton County: **1-717-485-4899** or **1-800-999-0478**
Lancaster County: **1-717-291-1243** or **1-800-892-1122**
Lebanon County: **1-717-273-9328**
Perry County: **1-717-567-2490** or **1-877-800-7433**
Somerset County: **1-814-445-9628** or **1-800-452-0148**

Please refer to the PerformCare website (**pa.performcare.org**) for medical necessity guidelines (MNG), provider search tools, and other useful information. You can register for NaviNet and get instant access to check the status of authorizations and claims. Register for our email notification system, iContact, to receive authorization request forms, provider notices, and email notices of new postings.

## Chapter III
## QUALITY IMPROVEMENT



We are committed to providing the highest quality of behavioral health care services possible to our 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, and 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
- Services provided by qualified/credentialed professionals demonstrating a high level of clinical proficiency

PerformCare is committed to actively pursuing continuous efforts to develop an effective Continuous Quality Improvement (QI) Program. This program coordinates activities designed to monitor and ensure high quality administrative and clinical services provided to PerformCare HealthChoices members. To achieve this goal, the 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

PerformCare systematically monitors and evaluates the quality and effectiveness of systems, services, and member treatment. The following Continuous QI Program goals provide the focus for all QI activities:

- **Access** — the degree to which appropriate care and services are accessible and obtainable to meet the member's needs.
- **Appropriateness** — the degree to which the care and services provided are relevant to the member's clinical needs, given the current state of knowledge and available resources.
- **Competency** — the degree to which providers and PerformCare staff adhere to professional and/or organizational standards of care and practice.
- **Consumer and family involvement** — the degree to which HealthChoices members and families of members have an active role in PerformCare.
- **Continuity and care coordination** — the degree to which needed health care services for a member or specified population are coordinated across levels of care, across organizations, or across care of physical health and behavioral health.
- **Diversity and cultural competency** — the degree to which providers and PerformCare staff understand and demonstrate respect for differences among groups.
- **Outcomes and efficacy** — the degree to which a treatment or service improves health status.

- **Prevention and community outreach** — the degree to which PerformCare services promote health, prevent deterioration of conditions, and educate the community.
- **Safety** — the degree to which risks of adverse outcome are reduced for the member and others, including the health care provider.
- **Service excellence** — the degree to which PerformCare meets established service standards and produces provider and member satisfaction.

## Scope

The Director of Quality Management (QM) has the authority and responsibility to ensure all QI findings, conclusions, recommendations, actions taken, and results are documented and reported to appropriate PerformCare individuals, including the Medical Director, senior management, and other supervisory staff. This information is incorporated in daily operations and used to ensure a focus on quality operations throughout the organization. Within PerformCare programs and operations, the Director of QM ensures that information generated through QI activities is used to improve quality, including:

- Access to care, screening, assessment, and referral
- 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 PH-MCOs
- Feedback to providers regarding quality profiling and improved practice standards
- Billing and claims processing

## Quality Indicators for Monitoring

Within each of the following areas, quality indicators for monitoring and evaluation are identified and the methodology, time frames, and performance standards by which indicators are measured are outlined. Quality indicators help monitor service provision and allow a review of a full range of demographic groups, treatment settings, and types of services. Quality indicators are customized to each initiative and/or level of care and may include medical necessity guidelines, readmission and follow-up rates, statistical data, administrative standards, and outcomes. 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
- Nontraditional behavioral health services governed by the program
- Member Services
- Screening, assessment, authorization, and referral
- Utilization management
- Network/Provider Services

### Administrative services

- Access to treatment
- Availability and accessibility of care/provider
- Coordination and integration of care
- Continuity of care

## 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 PerformCare operations.

Performance improvement projects are identified by external entities to achieve, through ongoing measurements and interventions, sustained significant improvement in clinical and non-clinical care areas that are developed to have a favorable effect on health outcomes and member satisfaction. The projects include quality planning, QI, and quality control/measurement activities focused on:

- Measuring performance, using objective quality indicators, to be monitored, with an emphasis on indicators that provide efficient, accurate, and reliable means of monitoring quality of services and treatment within targeted areas
- Implementing system interventions to achieve improvement in quality
- Evaluating and initiating activities for increasing and sustaining improvement
- Developing appropriate data collection methods, including scheduled on-site audits, focused studies (e.g., studies by population, diagnostic group, or service type), standardized measurement of outcomes, and routine analysis of treatment-generated data
- Identifying research methodology, reporting mechanisms, and time frames for data collection for each indicator
- Comparing PerformCare performance data with benchmarking data, professional standards, and internal baseline data to establish performance thresholds and guidelines
- Using routine assessment of member satisfaction data to ensure services are responsive to the needs of members
- Developing and implementing system interventions to achieve QI and implement through remedial/corrective actions
- Evaluating improvement activities to ensure identified problem areas are effectively addressed
- Initiating activities to increase and sustain improvement throughout the network

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

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

## Objectives

PerformCare has established the following continuous QI Program objectives. These objectives are intended to guide the development of the annual Quality Improvement/Utilization Management (QI/UM) Work Plan and to allow PerformCare to reach its QI /UM goals. Strategies to achieve these objectives may vary according to specific details of the current year QI/UM Work Plan:

- Indicators related to administrative and clinical services are outlined in the QI/UM 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.
- Medical necessity guidelines are utilized in determinations for behavioral health services. Appendix S and Appendix T of the contract between the county and DHS are the established medical necessity guidelines for behavioral health services. Medical necessity guidelines are established for services other than those covered by Appendix S and T and approved by DHS. In all cases, PerformCare uses medical necessity guidelines in determining the appropriate need for and level of behavioral health services. Inter-rater reliability and internal audits are performed to ensure consistent application of medical necessity guidelines.
- 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 provider profiling protocols are initiated for PerformCare network providers. Provider profiling is completed semiannually for specific levels of care, including:
- Intensive Behavioral Health Services (IBHS)
- Mental Health Inpatient Program (MH IP)
- Mental Health Outpatient Services (MH OP)
  - Outpatient Therapy
  - Psychiatric Evaluations
  - Medication Management
- Community-Based Mental Health Services
  - Peer Support Services
  - Psychiatric Rehabilitation Services
  - Targeted Case Management
- Family-Based Mental Health Services (FBMHS)
- Residential Treatment Facility (RTF)
- Substance Use Services
  - Medically Managed Intensive Inpatient Withdrawal Management
  - Medically Monitored Inpatient Withdrawal Management
  - Medically Managed Intensive Inpatient Services
  - Medically Monitored Intensive Inpatient Services
  - Clinically Managed High-Intensity Residential Services
  - Clinically Managed Low-Intensity Residential Services
  - Substance Use Outpatient Therapy (SU OP)
  - Substance Use Intensive Outpatient Program (SU IOP)
  - Substance Use Partial Hospitalization Program (SU PHP)
- Measures vary among reports but may include measures for length of stay/duration of services/number of unique members served, readmission rates, follow-up rates, access data, utilization data, Consumer/Family Satisfaction Team data, and any other agreed upon measures, as determined appropriate by level

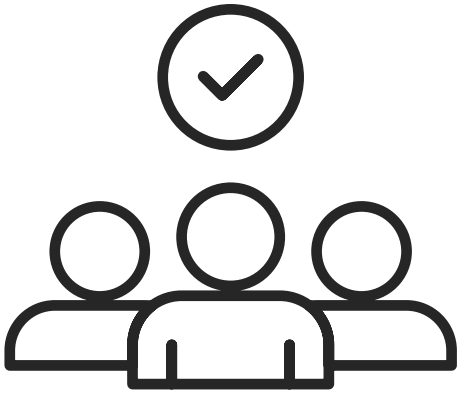
of care. Results are made public on the PerformCare website. Data is analyzed and aggregated and, when appropriate, PerformCare reaches out to providers to request plans for areas that need improvement. Opportunities for clinical care improvement are identified and documented. Appropriate actions for 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 PerformCare and its network providers.
- Services related to claims payment are monitored regularly to ensure 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 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 QI/UM Program activities are monitored and modifications to the QI/UM Plan and/or Work Plan are made as needed to ensure that QI activities are consistent with the changing needs of the organization and its members.

You may receive a copy of the PerformCare QI/UM Work Plan, Service Description, and Annual Evaluation upon request by contacting your Account Executive.

## Chapter IV
## MEMBER COMPLAINTS AND GRIEVANCES

PerformCare has a well-defined and specific process for filing member complaints and grievances at no cost, including fair hearings and expedited reviews. Members may ask providers to file on their behalf if 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 PerformCare Provider Relations Department at **1-888-700-7370**. The Authorization for Representation and Expedited Certification forms that are needed for the provider to file on the member's behalf are available on the PerformCare website in the **Forms** section.



Some key highlights within the complaint and grievance policy and procedure are listed below. It is important to note that this information is not comprehensive and provides a snapshot of main points, not complete processes. A more comprehensive description of each process can be found on the PerformCare website at **pa.performcare.org/members/resources/complaints.aspx**. The process can also be explained over the phone by a Coordinator in PerformCare's Complaints and Grievances Department.

## Complaints

A complaint can be filed by a member or their representative anytime they are dissatisfied with any part of treatment received.

- The member may file a complaint either orally or in writing. PerformCare will document the complaint concerns and forward them to the provider. The provider will then be expected to return a written response including any supporting documentation.
- Members have the right to request a next-level review if they are unhappy with the first-level review. Depending on the type of complaint, the options for next-level review may differ. A C&G Coordinator will explain these options to the member when they relay the outcome of their first-level complaint. Options for next steps may include one or more of the following:
- Second-level complaint
- External review
- Fair hearing
- More information regarding each option is available on the PerformCare website at **pa.performcare.org/members/resources/complaints-grievances-fair-hearings.aspx**.
- More information can be obtained by contacting the PerformCare C&G department.

PerformCare retains the right in accordance with your contract to request part or all the medical record to fully address the member's concern. PerformCare also obtains a health disclosure form from members at the time the complaint is filed. This form can be found on the PerformCare website at **pa.performcare.org/members/resources/complaints.aspx**.

## Grievances

A grievance in the HealthChoices program is an appeal of a medical necessity decision made by PerformCare. PerformCare 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. The member will be given 60 calendar days from the date of the written denial notice to file a grievance. If the member wants to continue receiving services that are being reduced, changed, or denied, the grievance must be filed within 10 calendar days of the denial notification, or within one calendar day for denials related to inpatient hospitalization.

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 Authorization for Representation form is located on the PerformCare website under **Forms**. Providers may elect to use their own form; however, it must contain the same information as the PerformCare form. The written consent will include all the following elements:

- 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 BH-MCO to which the grievance will be submitted

- An explanation of the specific service for which coverage was provided or denied to the member to which the consent will apply
- The following statement: "The member or the member's representative may not 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."
- The following statement: "The consent of the member or the member's representative shall be automatically rescinded if the provider fails to file a grievance or fails to continue to prosecute the grievance through the review process."
- The following statement: "The member or member's representative, if the member is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The member or the member's representative understands the information in the member's consent."
- The dated signature of the member or the member's representative, and the dated signature of a witness

Upon conclusion of the review, a written notification will be sent out to the member and other applicable parties to relay the outcome of the review. This will include the final decision, the rationale for that decision, and next-level review options available. If any of the requested services continue to be denied, options for next-level review include:

- External review
- Fair hearing

More information related to these options can be found on the PerformCare website or by calling and speaking with a C&G Coordinator.

### Expedited Complaint and Grievance Process

- PerformCare will provide the opportunity for an expedited review of a complaint or grievance if a member or member's representative provides PerformCare with a written certification from the member's 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 process. This certification is necessary even when the member's request for the expedited complaint or grievance is made orally. The certification must include the physician's signature.
- A request for an expedited review may be filed either in writing or orally. If the provider certification is not included with the request, PerformCare will inform the member that the provider must submit a provider certification as to the reason why the expedited review is needed. PerformCare will make a reasonable effort to obtain the certification from the provider. If the provider certification is not received within 72 hours of the member's request, PerformCare will decide the complaint or grievance within the standard time frames.
- PerformCare will make all reasonable efforts to give the member prompt oral notice denying the request for an expedited review and will send a written notice that the complaint or grievance will be processed within the standard time frames.

## External Grievance Reviews

Requests for filing an external review may be filed upon conclusion of the internal complaint or grievance reviews.

When a provider is filing an external review, instead of or on behalf of the member, there may be a cost to the provider, which cannot be passed on to the member. An additional form is required to acknowledge their understanding for fulfilling any financial liabilities. This form can be found on PerformCare's website. When a provider is filing an external grievance, 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 member or the member'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 must file a complaint or grievance with PerformCare, and receive a decision on that complaint or grievance, prior to filing a request for a fair hearing.
- A member or their representative must make this request in writing to the Department of Human Services (DHS). PerformCare then receives notification of this request from DHS. These requests can be mailed or faxed to:

Department of Human Services
Office of Mental Health and Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17105-2675
Fax: **1-717-772-7827**

- A member or the member's representative may request a fair hearing within 120 days of the date on the written notice of decision for a grievance, or for a complaint that is related to one the following:
  - The denial of a requested service because the service is not a covered service
  - The failure of PerformCare to meet the required time frames for providing a service
  - The failure of PerformCare to decide a complaint or grievance within the specified time frames
  - The denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance program
  - The denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the member
  - The denial of a member's request to dispute a financial liability, including cost sharing copayments, premiums, deductibles, coinsurance, and other member financial liabilities

### Expedited Fair Hearing

- A request for an expedited fair hearing may be filed with DHS either in writing or orally.
- A member must first complete all internal processes 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 DHS 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.

### Provider Participation and Billing

There are times when members will request staff to participate in grievance reviews to help better explain the need for services that have been denied. As specified by Appendix H of the HealthChoices Program Standards and Requirements, the meeting time and those invited to attend the grievance meeting is controlled by the member filing the grievance. If a member requests staff participation, providers are encouraged to accommodate the member and his or her family. However, please note that staff time spent in the grievance meeting should not replace authorized service delivery time, nor should it be submitted to PerformCare for reimbursement. PerformCare recognizes the efforts providers make to attend grievance meetings and thanks providers for supporting members as they engage in the grievance process.

For complaints, providers against whom the complaint was filed may participate in the review meeting to further clarify or answer questions about the concerns raised. The provider's participation is contingent on member consent. If a member is receiving services from multiple providers, the member has the option to invite other providers to help explain the concerns raised or speak to what they might have observed. In these cases, this time spent in the meeting should not replace authorized service delivery time, nor should it be submitted for reimbursement. PerformCare recognizes the efforts providers make to attend grievance meetings and thanks providers for supporting members as they engage in the complaint process.

## Chapter V
## PROVIDER COMPLAINTS

PerformCare is a managed care organization that relies on collaboration and cooperation with providers to ensure excellent customer service for our membership. While PerformCare personnel and the network of providers are all professionals, and it is important to focus on customer service and a positive member experience, we recognize that disagreements and differences in opinion will occur.

PerformCare expects that providers will work together and make every attempt to resolve concerns and issues privately. When all efforts have been exhausted, PerformCare can offer assistance and additional support to resolve the concern.

### How to Submit a Provider Complaint

Complaints should be directed to the Complaints and Grievances department. You can access the Complaints and Grievances department by calling the Provider Line at **1-888-700-7370** and selecting **option 4**. The Complaints and Grievances staff will obtain information from you and can explain the process that will be followed. Complaints can also be submitted to PerformCare in writing to:

PerformCare
Complaints and Grievances Department
8040 Carlson Road
Harrisburg, PA 17112

PerformCare tracks all provider complaints in a database for analysis to identify trends that need to be addressed by PerformCare for improving our performance and the performance of our network providers. This type of analysis is also reviewed by the Quality Improvement/Utilization Management (QI/UM) Committee. It is imperative that providers adhere to time frames indicated in written communication for submitting records and providing responses as requested. Failure to respond may result in referral to the Credentialing Committee. Please see Policy QI-045: Provider Complaint Process for additional information.

### Provider and Member Satisfaction Surveys

Two network satisfaction surveys are conducted annually by PerformCare.

The provider satisfaction survey is sent to providers by PerformCare and offers the opportunity for providers to give PerformCare 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. Additional provider satisfaction surveys may be performed directly by the county primary contractors.

The member satisfaction survey is sent to members by a PerformCare contracted survey vendor to measure member satisfaction with PerformCare and the services received through PerformCare network providers. The survey data is used to identify areas of strength and opportunity and can lead to improvements in services to our members and the community. Additional member surveys are conducted by the Consumer and Family Satisfaction Teams (C/FSTs) in each contract through face-to-face interviews with members. The purpose of these surveys is to determine whether PerformCare members and their families are satisfied with PerformCare and with the services they received. They also help ensure that problems related to service access, delivery, outcomes, recovery, and resiliency are resolved in a timely manner.

## Chapter VI
## CREDENTIALING AND PROVIDER RELATIONS SERVICES

### Credentialing/Re-credentialing

PerformCare has an established network of behavioral health care providers and strives to offer the full scope of care and service resources with the highest level of quality within established standards of access and choice. All network providers are credentialed and re-credentialed to provide behavioral health clinical care and services. PerformCare has formally assigned responsibility for the credentialing and re-credentialing review function, including the review of behavioral health provider credentials and additional information to make recommendations for approval or disapproval of the entities, to the PerformCare Credentialing Committee. The Credentialing

Committee includes representation from our established network of behavioral health care providers as well as our county partners and oversights. The full credentialing/re-credentialing policy and procedure is available by going to the PerformCare website, **pa.performcare.org**.

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

- Intensive Behavioral Health Services (IBHS)
- Community Residential Rehabilitative Host Home (CRR-HH)
- Family-Based Mental Health Services (FBMHS)
- Licensed physician practitioners who are psychiatrists or certified in addiction medicine
- Non-physician practitioners, such as:
  - Licensed Psychologists
  - Licensed Clinical Social Workers (LCSW)
  - Licensed Professional Counselors (LPC)
  - Licensed Marriage and Family Therapists (LMFT)
  - Certified Registered Nurse Practitioners (CRNP)
- Peer Support Services
- Residential Treatment Facility (RTF)
- Substance Use and/or Mental Health Outpatient
- Substance Use and/or Mental Health Inpatient
- Substance Use and/or Mental Health Partial Hospitalization
- Substance Use and/or Mental Health Intensive Case Management and Resource Coordination
- Substance Use Medically Monitored Inpatient Withdrawal Management, Clinically Managed High-Intensity Residential Services, or Clinically Managed Low-Intensity Residential Services
- Substance Use Medically Managed Intensive Inpatient Withdrawal Management or Medically Managed Intensive Inpatient Services

## 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 PerformCare 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 the information that 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 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 Technician who is able to provide all information about the status of the application such as that it was received, sent to the CVO for primary source verification, and scheduled to be presented to Credentialing Committee.

### Right to independent professional judgment

Nothing in this Provider Manual shall be deemed to change or alter any relationship which exists, or which may come to exist between provider and any member. Providers have the right and responsibility to exercise independent professional judgment consistent with accepted standards of care. Providers and individual behavioral health practitioners may freely communicate with members about their treatment, regardless of benefit coverage limitations.

## Application Process

When providers are interested in adding new/additional sites/services, they must first contact their assigned Account Executive to obtain an in-plan application (see AD 11 108: Expansion Request Process for In Plan Service for Providers (Policy and Procedure PR 029)).

### Individual provider application

The application process for individual behavioral health practitioners requires submission of a complete application as well as supporting documentation such as copies of resumes, licenses, insurance riders, documentation of privileges, etc. Applications can be requested by contacting an Account Executive at **1-888-700-7370**.

If you are a participant with CAQH, the CVO will pull the application from CAQH. Through CAQH, each provider determines what entity is eligible to receive his or her credentialing information. Providers who have elected "universal" status do not need to do anything for PerformCare to receive file information. If you do not have broad distribution permissions, providers must select **AmeriHealth Caritas/Keystone First** for PerformCare to receive your application. Providers that do not participate with CAQH will receive a Pennsylvania Standard Application emailed from AmeriHealth Caritas/Keystone First, which acts as our CVO. Upon completion, it will be returned to AmeriHealth Caritas/Keystone First for review and primary source verification of information included in the application. Following the primary source verification process, the application and supporting documentation is reviewed by PerformCare's Credentialing Committee for an approval/disapproval determination regarding the individual's PerformCare 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 requested by calling **1-888-700-7370** and speaking to an Account Executive.

## Credentialing Site Visit

Following receipt and review of the facility application, PerformCare will determine if a site visit is necessary. 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 (but is not limited to):

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

A minimum score of 80% on the site visit is required to be eligible for approval for the network. The Account Executive will assist the provider to the extent practical and appropriate relative to improvement. The Account Executive will provide a report with recommendations for improvement to the provider and will revisit the site within six months to assess progress. Assistance will be documented in the provider file and will include dates and assistance that was provided. This will continue until the provider meets standards.

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

## Credentialing Committee Decision

PerformCare does not make credentialing or 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. In developing its network, PerformCare strives to meet the cultural and special needs of members.

Applicants are notified of their initial credentialing approval within seven business days of the Committee meeting. Should the PerformCare 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 reverification of clinical credentials of PerformCare network providers. The PerformCare Credentialing Department maintains an active file of all PerformCare credentialing decisions. A reminder system ensures each facility and individual behavioral health provider is re-credentialed as scheduled. As part of this process, PerformCare periodically reviews provider information from the NPDB as well as the Office of Inspector General list of individuals who have been excluded from participation in Medicare and Medical Assistance Programs. Providers are required to disclose at the time of discovery any criminal convictions related to the delivery of medical care or services under the Medicare, Medicaid, or Title XX Social Service programs by any staff. Such information must also be reported at the time of application for or renewal of network participation (credentialing and re-credentialing). Providers are also obligated to provide such information to PerformCare at any time upon request.

At a minimum the re-credentialing process occurs every three years. The Credentialing Committee will meet on a monthly basis to credential and re-credential providers. For providers who are undergoing re-credentialing during a particular month, the Credentialing, Provider Relations, and QI departments will report the following measures and statistical data since the previous credentialing date (if applicable but not limited to):

- Reverification of licensure standing
- Credentialing Committee disciplinary actions, including applicable suspensions of referrals
- Site visit dates and scores, if applicable
- Treatment record review scores and applicable quality improvement plans, as available
- Quality of Care Council referrals — with particular attention to non-routine site visits, as available
- Complaints and grievances — with particular attention to substantiated complaints, as available
- Administrative appeals, including those rejected or denied, as available

## Adding a New Site or Service

When a high-volume provider relocates or opens a new site, PerformCare 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 PerformCare members, so please plan accordingly. While the definition may vary from time to time, currently PerformCare considers a high-volume provider to be one who sees 200 or more unique members in a 12-month period. Except for supplemental services, anytime there is a change, providers are required to notify DHS.

Providers who are adding a new service or site should contact their Account Executive to determine the process. The Account Executive will notify you if a site visit is necessary.

## Address Changes

Providers are contractually bound to report changes that affect referrals. When a decision has been made to relocate the office site, several things must occur. The site must be listed in the entity license (if applicable), the site must be properly enrolled in the Pennsylvania Medical Assistance program, and, if the site is considered high-volume, it will require a site visit from PerformCare. The new site must be properly enrolled in the Pennsylvania Medical Assistance program to receive payment for services. Therefore, plan carefully and provide enough time for all necessary activities to be completed. Providers must contact their Account Executive prior to any changes.

## Contracting and Rate Notices

### Contracts

PerformCare uses a standard Provider Agreement that has been approved by the DOH and OMHSAS. DOH and OMHSAS must approve the agreement to ensure that it includes all required language per the HealthChoices program and rules and regulations around managed care services.

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 Medical Assistance enrollment or if there is a change in payment methodology such as value-based purchasing arrangements. Rate notices are used to document rate or per diem changes to existing services.

### Rate notices and fee schedules

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 calendar days' notice of rate changes. Providers who do not accept the terms of the rate notice may terminate the agreement upon 30 days' written notice. Please review explanation of benefits (EOB) documents closely to ensure that you begin receiving the new rates for services delivered on or after the date indicated on notice of an updated fee schedule. It is the provider's responsibility to monitor payment received. In the event of a discrepancy, contact your Account Executive immediately. PerformCare strongly suggests that providers bill their usual and customary charges rather than the rate indicated on the rate notice. In the event of a system or data entry error, this practice will help you avoid the need to resubmit corrected claims when the issue is resolved. Please be aware that rate schedules are approved by PerformCare's primary contractor and may differ according to the member's county of residence.

### Requests for rate adjustments

Residential and inpatient services are not included on the fee schedule and are negotiated rates. Providers of inpatient and residential services may request rate increases every two years or more frequently with an acceptable justification. Requests should be submitted in writing to the PerformCare Contracting Manager at 8040 Carlson Road, Harrisburg, PA, 17112. PerformCare will consider the request and respond accordingly. Providers will be asked to provide evidence to support the request in the form of budgets, audits, and possible additional information. Quality data is also very important in considering rate requests. For existing providers requesting a rate increase, PerformCare Clinical and Quality departments are consulted relative to the provider's performance. Part of the analysis by contracting staff is to include a review of quality-of-care concerns reported and administrative compliance.

A provider will not necessarily lose the opportunity for a rate increase if a quality or compliance issue has been identified, but in these cases, the increase could be reduced or contingent upon improvement. At a minimum, criteria considered include:

- Most current provider profiling results
- Most current quality audit results
- Consumer/Family Satisfaction Team survey results/responsiveness
- OP — requires services within seven days for routine requests
- Number of member complaints
- Administrative compliance concerns reported
- Quality of care concerns
- Credentialing referrals and disposition
- Average length of stay (RTF and inpatient [IP])
- Readmission rates (RTF, IP, Substance Use Non-Hospital [SU NH] programs)

Providers who have a service that is significantly different than other providers delivering the same level of care, or costs more to operate, may be granted an exception, and be paid at a program-specific rate. Please know that rate adjustments will not be made retroactively. PerformCare and its county partners make every effort to keep rate payment consistent between county and BH-MCO funding, but this is not a guarantee. This process is driven by Policy and Procedure PR-026: Provider Rate Setting, which is available on the PerformCare website.

## Provider Quality and Progressive Discipline

PerformCare recognizes that its QI Program is dependent upon 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. The Credentialing Committee reviews the information and trends results, as well as recommends corrective action when necessary. Network providers who consistently fail to meet standards will be placed on probationary status pending corrective action and are in jeopardy of contract termination. This process is driven by Policy and Procedure QI-CR-003: Credentialing Progressive Disciplinary Actions for Providers, which is available on the PerformCare website.

## Individual Outcome Measures

The Credentialing Committee will meet on a monthly basis to credential and re-credential providers. Provider indicators and standards are integrated into the re-credentialing decision process. For providers who are undergoing re-credentialing during a particular month, the Credentialing, Provider Relations, and QI departments will report the measures for those providers. This report gives a detailed review that allows the Credentialing Committee to have an overall picture of the provider's performance since the previous credentialing date. 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 PerformCare access standards for emergent, urgent, and routine care.
- **Medical record completeness and accuracy:** PerformCare will conduct medical record reviews with properly signed release of information forms or use redacted charts to review documentation for completeness of information, accuracy, appropriate signatures, current treatment plan and supporting documentation, and discharge planning. The medical record is also sometimes called a "treatment record."
- **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 and licensure requirements as designated by the Department of Human Services for participation in the Pennsylvania Medicaid program.
- **Compliance with PerformCare Requirements:** Providers are rated on standards that measure compliance with administrative requirements of the PerformCare 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 Complaints and Grievances department. The database will be queried monthly for information regarding providers who are due to be re-credentialed. Complaint information will be used in the re-credentialing decision. It is imperative that providers adhere to time frames indicated in written communication for submitting records and providing responses as requested. Failure to respond may result in a referral to the credentialing committee.

## Resolution of Quality of Care Concerns

When PerformCare becomes aware of a member safety concern through any venue, including incident reports, member complaints, county staff concerns, or PerformCare staff concerns, and follow-up is required, a referral will be made to the Quality of Care Council.

- The Medical Director or designee will send a letter of notification to the network provider. The letter will describe the member safety concerns and actions will be recommended for correction of the problem. The network provider is afforded a specified, reasonable period of time appropriate to the nature of the problem, in which the network provider must make corrections.
- Repeated nonconforming behavior will subject the network provider to progressive discipline. In addition, referrals and/or admissions may be frozen while the issue is investigated and monitored.
- Failure to conform thereafter is considered grounds for initiation of the formal sanctioning process.

## Credentialing Committee Actions

The Credentialing Committee includes the use of peer review to make recommendations regarding initial credentialing and re-credentialing decisions as well as disciplinary actions for credentialed providers.

The Committee may include representation from the full range of participating practitioners, including psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists and/or certified addictions counselors in the Plans' network. Participants will have understanding of and experience with prescribing and/or recommending in-plan services. The Credentialing Committee also includes HealthChoices primary contractor representative(s).

For all applications, the Credentialing Committee may make one of the following determinations:

- Application approved
- Application pended for additional information
- Application denied

The Credentialing Committee is also responsible for ensuring appropriate handling of all quality issues identified relative to any provider that are not resolved via other areas in PerformCare (i.e., QOCC, Clinical, Network Operations) and applying appropriate disciplinary actions as needed. This process is driven by Policy and Procedure QI-CR-003: Credentialing Progressive Disciplinary Actions for Providers, which is available on the PerformCare website.

The Credentialing Committee may make one or more of the following recommendations based on the provider not reaching acceptable levels of performance:

- Written warning
- Corrective action plan
- Suspension of referrals
- Other requirements such as mandating reports or submission of records
- Termination

The Credentialing Committee provides written notification of disciplinary action to the affected providers. The written notice states the circumstances warranting the adjustment and specifies a reasonable period within which the provider may remedy the failure to perform according to standards. The provider is 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, PerformCare follows established guidelines of reporting to the appropriate authorities.

### Provider appeal process

The provider organizations, facilities, and/or individual behavioral health providers may appeal the decision to reduce, suspend, or terminate clinical privileges or change provider status by formally requesting a review within 30 days of the verbal notification of the decision. Notice of 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 provider must formally file an appeal in writing with the PerformCare Director of Operations and PerformCare Director of QM or designee within 30 days of the verbal notification of the decision. The request for appeal is logged and the issue is tracked in the log until resolution.
- Written acknowledgment of the request to appeal is sent within three business days of receipt of the appeal by the PerformCare Director of Operations and the PerformCare Director of QM or designee.
- The initial review regarding the network status change appeals process is conducted by the PerformCare Medical Director or designee, who makes a determination within 10 business days.
- Notification of disposition of appeal is sent to the provider, by the PerformCare Director of Operations or the PerformCare Director of QM or designee.
- If the provider is dissatisfied with the decision, the provider may request a second and final internal level of appeal within 30 days of the receipt of the written notification of the decision. The request is made in writing to the PerformCare Executive Director or designee.
  - The provider appeal is presented to a panel not to exceed five members who will be chosen by the PerformCare Executive Management team. The panel may include but is not limited to PerformCare staff, county representatives, and/or provider representatives. Panel members:
    - Will have not previously been involved in the decision to change the provider's network status
    - Will not be located in the county in which the appealing provider is located
    - Will have no conflict of or vested interest in the outcome of the decision
  - The provider is afforded the opportunity to present supporting statements and documentation. All supporting statements and documentation from the provider and PerformCare must be submitted to the opposing party one week prior to the panel review meeting.
  - The panel renders a decision within 15 calendar days of the meeting and advises PerformCare of the final decision in writing. The panel has the option to uphold or overturn the original decision with or without conditions. Additional conditions suggested by the panel will be reviewed by PerformCare executive management to ensure compliance with PerformCare policies and procedures. The decision of the panel will be reported to the Credentialing Committee. The Committee will monitor the completion of any conditions imposed by the panel. The Credentialing Committee may also elect to require additional actions of the provider. PerformCare sends a copy of the final decision to the provider.
- 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.

## Medical Assistance (MA) Enrollment

All providers must be enrolled in the Pennsylvania Medical Assistance Program in order to participate as a PerformCare network Provider. In addition, Ordering, Referring, and Prescribing Providers must also be MA enrolled. (Please refer to Provider Notice AD 17 104 for detail).

PerformCare credentials and utilizes the following Pennsylvania Medical Assistance provider types and specialties (Excerpted from OMHSAS HealthChoices Behavioral Health Services Reporting Classification Chart):

| Service | Provider type | Provider specialty |
|---|---|---|
| Inpatient Psychiatric Services | 01 – Inpatient Facility | 010 – Acute Care Hospital |
| Inpatient Psychiatric Services | 01 – Inpatient Facility | 011 – Private Psychiatric Hospital or |
| | | 022 – Private Psychiatric Unit |
| Inpatient Psychiatric Services | 01 – Inpatient Facility | 018 – Extended Acute Psych Inpatient |
| | | |
| Inpatient Drug & Alcohol Withdrawal Management | 01 – Inpatient Facility | 010 – Acute Care Hospital |
| Inpatient Drug & Alcohol Withdrawal Management | 01 – Inpatient Facility | 019 – D&A Rehab Hosp or<br>441 – D&A Rehab Unit |
| Inpatient Drug & Alcohol Rehab | 01 – Inpatient Facility | 010 – Acute Care Hospital |
| Inpatient Drug & Alcohol Rehab | 01 – Inpatient Facility | 019 – D&A Rehab Hosp or<br>441 – D&A Rehab Unit |
| | | |
| Non-Hospital Residential, Detoxification, Rehabilitation, Halfway House Services for D&A Dependence/Addiction | 11 – Mental Health / Substance Abuse | 131 – D&A Halfway House |
| | | 132 – D&A Medically Monitored Detox |
| | | 185 – D&A Non-Hosp Residential Clinically Managed |
| | | 186 – D&A Non-Hosp Residential Medically Monitored |
| | | |
| Psychiatric Outpatient Clinic Services | 08 – Clinic | 110 – Psychiatric Outpatient |
| | 01 – Inpatient | 183 – Hospital Based Med Clinic |
| Psychiatric Outpatient Mobile Services | 08 – Clinic | 074 – Mobile Mental Health Trtmt |
| Psychiatric Outpatient Services | 11 – Mental Health / Substance Abuse | 113 – Partial Psych Hosp Children or |
| | | 114 – Partial Psych Hosp Adult |
| Psychiatric Outpatient Clinic Services | 08 – Clinic | 080 – FQHC or<br>081 – RHC |
| Psychiatric Outpatient Services | 19 – Psychologist | 190 – General Psychologist |
| | 31 – Physician | 339 – Psychiatry |
| | 31 – Physician | 315 – Emergency Medicine |
| | | 316 – Family Practice |
| | | 322 – Internal Medicine |
| | | 345 – Pediatrics |
| | | |

| Service | Provider type | Provider specialty |
|---|---|---|
| Residential Treatment Facilities (RTF) for Children & Adolescents — JCAHO | 01 – Inpatient | 013 – RTF (JCAHO certified) Hospital |
| | | |
| Residential Treatment Facilities (RTF) for | 56 – RTF | 560 – RTF (Non-JCAHO certified) |
| Children & Adolescents — Non-JCAHO | 52 – CRR | 520 – C&Y Lic Group Home w/ MH Treatment Component |
| | | |
| Outpatient Drug & Alcohol | 08 – Clinic | 184 – D&A Outpatient |
| | 08 – Clinic | 084 – Methadone Maintenance |
| Outpatient Drug & Alcohol | 08 – Clinic | 080 – FQHC or 081 – RHC |
| | | |
| Laboratory Studies/Diagnostic Radiology/ | 01 – Inpatient Facility | 183 – Hospital Based Med Clinic |
| Medical Diagnostic Ordered by BH | 28 – Laboratory | 280 – Independent Laboratory |
| Physicians | | |
| Laboratory Studies/Diagnostic Radiology/Medical Diagnostic Ordered by BH Physicians | 31 – Physician | 339 – Psychiatry |
| Clozapine | 01 – Inpatient Facility | 010 – Acute Care Hospital |
| Clozapine Support Services | 31 – Physician | 339 – Psychiatry |
| | 08 – Clinic | 110 – Psychiatric Outpatient |
| | 11 – Mental Health/ Substance Abuse | 113 – Partial Psych Hosp Children or |
| | | 114 – Partial Psych Hosp Adult |
| | | |
| Crisis Intervention | 11 – Mental Health/ Substance Abuse | 118 – MH Crisis Intervention |
| Family Based Services for Children & Adolescents | 11 – Mental Health/ Substance Abuse | 115 – Family Based MH |
| Targeted MH Case Management — Intensive Case Management | 21 – Case Manager | 222 – MH TCM, Intensive |
| Targeted MH Case Management — Blended Case Management | 21 – Case Manager | 222 – MH TCM, Intensive |
| Targeted MH Case Management — Resource Coordination | 21 – Case Manager | 221 – MH TCM, Resource Coordination |
| Peer Support Services | 11 – Mental Health/ Substance Abuse | 076 – Peer Specialist |
| | | |

| Service | Provider type | Provider specialty |
|---|---|---|
| Rehabilitative Services | 11 – Mental Health/ Substance Abuse | 123 – Psychiatric Rehab |
| Mental Health General | 11 – Mental Health/ Substance Abuse | 110 – Psychiatric Outpatient |
| Residential & Housing Support Services | 11 – Mental Health/SA | 110 – Psychiatric Outpatient |
| Integrated Community Wellness Center | 08 – Clinic | 111 – Community Mental Health |
| Mental Health General | 11 – Mental Health/ Substance Abuse | 111 – Community Mental Health |
| | | |
| Outpatient Drug & Alcohol | 11 – Mental Health/ Substance Abuse | 084 – Methadone Maintenance |
| | | 129 – D&A Partial Hospitalization |
| | | 184 – Outpatient D&A |
| | 21 – Case Manager | 138 – D&A Targeted Case Mgmt |
| Outpatient Drug & Alcohol | 11 – Mental Health/ Substance Abuse | 128 – D&A Intensive Outpatient |
| | | |
| Mental Health General | 11 – Mental Health/ Substance Abuse | 112 – OP Practitioner - MH |
| | | 119 – MH - OMHSAS |
| | | 110 – Psychiatric Outpatient |
| Outpatient Drug & Alcohol | 11 – Mental Health/ | 127 – D&A OP |
| | Substance Abuse | 184 – Outpatient D&A |
| | | |
| Case Management Services | 21 – Case Manager | 212 – MA Case Management for under 21 years of age |
| | | |
| Outpatient Behavioral Health | 17 – Therapist | 171 – Occupational Therapist |
| Tobacco Cessation | 01 – Inpatient Facility | 370 – Tobacco Cessation |
| | 05 – Home Health | |
| | 08 – Clinic | |
| | 09 – CRNP | |
| | 19 – Psychologist | |
| | 27 – Dentist | |
| | 31 – Physician | |
| | 37 – Tobacco Cessation | |
| | | |
| Ancillary Services | 31 – Physician | 339 – Psychiatry |

| Service | Provider type | Provider specialty |
|---|---|---|
| Other — Outpatient | 31 – Physician | 339 – Psychiatry |
| | 19 – Psychologist | 190 – General Psychologist |
| | 01 – Inpatient Facility | 010 – Acute Care Hospital |
| | 01 – Inpatient Facility | 011 – Private Psych Hosp or |
| | | 022 – Private Psych Unit |
| | 08 – Clinic | 080 – FQHC or 081 – RHC |
| | 08 – Clinic | 110 – Psychiatric Outpatient |
| | 08 – Clinic | 110 – Psychiatric Outpatient |
| | 08 – Clinic | 110 – Psychiatric Outpatient |
| | 09 – CRNP | 103 – Family & Adult Psychiatric Mental Health |
| | 11 – Mental Health/ Substance Abuse | 113 – Partial Psych Hosp Child |
| | | 114 – Partial Psych Hosp Adult |
| Opioid Use Disorder Centers of | 01 – Inpatient Facility | 232 – Opioid COE |
| Excellence | 08 – Clinic | |
| | 11 – Mental Health/ Substance Abuse | |
| | 19 – Psychologist | |
| | 21 – Case Manager | |
| | 31 – Physician | |
| | | |
| IBHS | 11 – Mental Health/ Substance Abuse | 590 – Individual IBHS |
| | | 591 – Group IBHS |
| | | 592 – Applied Behavior Analysis — IBHS |
| IBHS for Children & Adolescent with ID | 11 – Mental Health/ Substance Abuse | 590 – Individual IBHS |
| | | 591 – Group IBHS |
| | | 592 – Applied Behavior Analysis — IBHS |
| IBHS | 11 – Mental Health/ Substance Abuse | 590 – Individual IBHS |
| | | |
| EPSDT | 17 – Therapist | 174 – Art Therapist |
| | 17 – Therapist | 175 – Music Therapist |
| | 19 – Psychologist | 190 – General Psychologist |
| | 52 – CRR | 523 – Host Home/Children |

Medical Assistance sets standards for enrollment of all providers. Providers are required to be licensed (in those cases where applicable) to be enrolled. All provider addresses where service will be delivered must be included on the DHS enrollment file with the appropriate provider type and specialty for the services being delivered. Effective in 2008, the DHS OMAP no longer separately enrolls any address that appears on a license as a satellite site for licensed mental health outpatient clinics and partial psychiatric service providers. Drug and alcohol service providers are required to enroll each services site. For fast access to enrollment information and forms, visit **www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx**.

Providers can also visit DHS' website at **www.dhs.pa.gov** or call the OMAP enrollment toll-free inquiry line at **1-800-537-8862**, **option 1** for more information on fee-for-service enrollments. To check the status of your application to be a Medical Assistance provider, call **1-800-537-8862**, **option 1**. Please note that OMAP does not handle all types of enrollments. OMHSAS enrolls Targeted Case Management, Family-Based Mental Health and Crisis Intervention Services. For those enrollments, contact the behavioral health services line at **1-800-433-4459**.

PerformCare's Provider Relations department assists with supplemental service enrollment when appropriate. These services include those provided by group or independently practicing licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), and licensed marriage and family therapists (LMFTs) as well as substance use partial, intensive outpatient, non-hospital residential, and any other unique service for adults.

### Licensed Clinician MA Enrollment

LCSWs, LPCs, and LMFTs are enrolled in the PerformCare network as a supplemental provider (11/112) at the option of Medical Assistance. If Medical Assistance enrollment is completed, the enrollment is only applicable for HealthChoices. The enrollment (11/112) does not permit billing the Medical Assistance fee-for-service program in the event coverage under HealthChoices is lost. Limits may apply to the types of services that can be provided. This type of enrollment will only be permitted by PerformCare if a person in your care becomes a PerformCare member during treatment or if the clinician's participation provides choice to members in areas without appropriate member choice. PerformCare will assist with this enrollment as part of the credentialing process if the practitioner meets one of the standards to permit entry to the network. MA enrollment is not a guarantee that a practitioner will be accepted to the network. Supplemental providers do not have the option to enroll in MA without the support of the BH-MCO whose network they will participate in.

As the process for MA enrollment and credentialing with PerformCare can change, please refer to the above paragraph for information on enrolling in MA and call PerformCare Provider Relations at **1-888-700-7370** for current information relative to the enrollment of these types of practitioners.

### MA Provider Reenrollment/Revalidation Process

On March 7, 2014, OMAP issued Bulletin 99-14-06 to outline the requirements associated with the reenrollment (revalidation) requirements for continued participation in the MA program for currently enrolled providers.

On August 1, 2014, OMHSAS, which is responsible for enrolling providers of community support services, issued a similar communication, Bulletin 14-03.

DHS, through OMAP or OMHSAS depending on the provider type, must revalidate the enrollment of all providers, regardless of provider type, at least every five years. This new requirement comes out of the Affordable Care Act and applies to all Medicaid-enrolled providers.

OMHSAS enrolls intensive case management, resource coordination, blended case management, family-based mental health services, mental health crisis intervention services, peer support services, and HealthChoices supplemental services providers (independently enrolled LCSW/LPC/LMFT, and any supplemental service). OMHSAS 14-03 is the reference bulletin for providers of any of the types listed. All other provider types are enrolled through OMAP, thus the OMAP Bulletin 99-14-06 should be referenced.

DHS requires all providers to reenroll at least every five years by submitting a fully completed Pennsylvania PROMISe provider enrollment application, and any required additional documentation/information based on provider type, for every active and current service location.

Providers will have to subsequently reenroll by submitting a complete, up-to-date enrollment application for each service location at least every five years. If a provider does not complete the reenrollment process within five years of the most recent reenrollment, the provider's enrollment will expire. Providers can determine their next reenrollment deadline by logging in to the provider portal for each service location. The reenrollment/revalidation date will be displayed in the masthead of the provider portal for each service location. The date identified is the expiration date for that specific service location based on the most recent application on file with DHS and OMHSAS.

### Additional Guidance for OMHSAS-Enrolled Provider Types

OMHSAS completes enrollment for certain types of services. OMHSAS enrolls community support services (CSS), which include intensive case management, resource coordination, blended case management, family-based mental health services, mental health crisis intervention services, and peer support services, as well as HealthChoices "in lieu of" or non-state plan services and independently enrolled LCSW/LPC/LMFT.

Providers of CSS must complete the latest version of the PROMISe Provider Enrollment Application, including all required accompanying requirements and documentation. Providers of CSS services will obtain their enrollment application and review requirements by accessing the following link: **www.dhs.pa.gov/providers/Providers/Pages/Provider-Enrollment-Docs.aspx**.

Questions about CSS provider enrollment should be directed to the behavioral health services toll-free inquiry line per the bulletin at **1-800-433-4459**.

The process for reenrollment for in lieu of services providers is different. Providers of HealthChoices in lieu of services, enrolled through the BH-MCO, will need to meet the requirements of the contracted county/BH-MCO. These services include those provided by group or independently practicing LCSWs/ LPCs/LMFTs as well as substance use partial, intensive outpatient, non-hospital residential, and any other service not included in the state plan for adults. If the provider continues to meet the contracted county/BH-MCO requirements, a new application with an updated service description will be completed by the provider with PerformCare technical assistance and submitted by PerformCare to OMHSAS for reenrollment every five years. PerformCare will assist by tracking due dates and sending a reminder of the need for a new application.

Questions about in lieu of services enrollment should be directed to your assigned Account Executive.

## Psychiatrist/Psychologist Supervision and MA Enrollment

All licensed practitioners, including psychiatrists and psychologists, must be appropriately enrolled in the Pennsylvania Medical Assistance program and credentialed by PerformCare if they are in private practice. Psychiatrists and licensed psychologists can visit DHS' website at **www.dhs.pa.gov** or call the office at **1-800-537-8862** for more information on Medical Assistance enrollment.

All licensed practitioners not employed by and/or clinically supervised by a licensed MA enrolled psychiatrist, psychologist, licensed inpatient, or outpatient facility must be credentialed by PerformCare individually and appropriately enrolled in the Pennsylvania MA program. A licensed psychologist may supervise three full-time equivalent staff who have graduate training in psychology but are not licensed, not preparing for licensure, or considered to be qualified members of other recognized professions and bill those services to PerformCare using the licensed clinician's own MA identification number (MAID). Effective October 2005, PerformCare did not require formal credentialing of these practitioners; however, the supervising, licensed MA-enrolled clinician must submit an attestation form to notify PerformCare that the clinician is practicing under their supervision. An attestation form and resume should be submitted for each person working under the licensed practitioner. The psychiatrist attestation form can be found here: **pa.performcare.org/assets/pdf/providers/resources-information/form-licensed-psychiatrist-attestation.pdf**

If a PerformCare credentialed, MA-enrolled psychologist intends to use an LSW, LCSW, LPC, LMFT, or unlicensed practitioner to see members, PerformCare must be notified immediately upon hire by submitting the attestation form (with resume attached). Please note the MA-enrolled, credentialed clinician takes full responsibility for all services provided by the practitioner under their supervision. PerformCare requires that primary source verification be completed on the employee's highest level of education and requires providers to verify and maintain documentation that there are no Medicare/Medicaid sanctions against the practitioner.

PA Code, Chapter 41.58, State Board of Psychology, specifies the requirements for supervision and 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." *The definition of graduate training in psychology was amended by the State Board of Psychology, at its April 24, 2013, meeting. The Pennsylvania Board of Psychology confirmed that it will continue to interpret the definition of "graduate training in psychology" contained in 41 Pa. Code 41.1 consistent with its statement in The Pennsylvania Bulletin on June 5, 2010 (Vol. 40, Number 23, p. 2947), which provides that the board will "interpret this provision as including graduate coursework which could apply to a doctoral degree, including coursework from terminal master's degree programs." The board's interpretation of "graduate training in psychology" does not require enrollment in a doctoral degree program.

When billing Medical Assistance or PerformCare, licensed MA-enrolled psychologists are permitted to supervise no more than three full-time equivalents (FTEs) at a time.

Please keep in mind that this practice is not intended to circumvent the process of becoming a licensed outpatient clinic. Large group practice providers will be asked to become licensed if possible.

The attestation form can be found at **pa.performcare.org/assets/pdf/providers/resources-information/form-licensed-psychologist-attestation.pdf**. Please contact your Account Executive or check the PerformCare website for the most current version of this form, or if you have questions about this process.

## In Lieu of Services

In lieu of services are alternative treatment services that are discretionary, cost-effective alternatives to state plan services. Supplemental services are useful for meeting the specialized needs of members and provide economical ways to address treatment needs that are in addition to or in lieu of traditional, state plan services. They are services that the BH-MCO provides above and beyond state Medicaid plan services. They are services that cannot be provided under any existing service delivery model or provider type. Periodically, PerformCare will request proposals from providers for new and creative services. Proposals are jointly reviewed by HealthChoices primary contractors, county representatives, and PerformCare. Please see your Account Executive about how to submit a proposal as each county is unique in how this is managed. In lieu of services must also be approved by OMHSAS.

## Program Exception Attestation for Approved Services

OMHSAS is tasked with responsibility for approving service descriptions. Part of the review at the state level is to ensure that the service description meets requirements as a Medicaid service and conforms to Centers for Medicare & Medicaid Services (CMS) requirements. Changes to the service descriptions, including the counties served, must first be approved by the county/BH-MCO then by OMHSAS prior to implementation.

Program descriptions should be kept up to date and properly reflect what is occurring in the program to avoid problems with referrals and payment.

PerformCare has developed a tool to assist providers in regular annual review of exception services. The Program Exception Attestation form can be found at **https://pa.performcare.org/assets/pdf/providers/resources-information/program-exception-attestation-form.pdf**. This form is to be completed annually (by January 1 of each year) and submitted to Provider Relations for each program with a unique, approved service description. Submit completed forms via fax at **1-717-671-6522** or electronically to your Account Executive.

This process will raise awareness and prevent issues that may result from failure to follow the approved service description.

## Administrative Appeals (Administrative Claims Denials)

Providers must follow all authorization and billing requirements as defined in the Provider Manual and provider notices. This policy is intended to apply to claims denials that are not approved because they do not meet contractual or administrative requirements. Administrative denials are **not** denied based on medical necessity guidelines.

Before submitting an administrative appeal, a claim must be billed, and a denial notification must be received by the provider. All appeal requests must include the claim numbers for all dates of service involved. All requests for review of an administrative denial must be submitted in writing and received within 60 days of receiving the administrative denial notification. No claims 365 days old or older will be considered for payment regardless of the circumstances. Providers must have an internal auditing system to ensure claims and administrative appeal requests are submitted timely.

An appeal that is valued at less than $10,000 and received within 365 days of the dates of service will be reviewed by the Administrative Appeal Committee and will be decided within 30 days of the receipt of the appeal submission. The committee is comprised of representatives from each department who research and review each request.

An appeal that is valued at $10,000 or more and/or has dates of service that are older than 365 days will be reviewed by executive management and will be decided within 30 days of the receipt of the appeal submission.

Providers requesting review of an administrative denial must submit a completed Administrative Appeal Request Form, in which the following information must be provided:

- Member name
- Provider name
- Contact name
- Contact's mailing address
- Claim number(s)
- Service/CPT code with modifier
- Date(s) of service
- Explanation of circumstances
- Steps taken to correct and prevent future occurrences
- Value of the expected reimbursement
- For IBHS, FBMHS, or RTF/CRR requests, all clinical notes for the month requested as well as the treatment plan and prescription/order/evaluation must be submitted.
- For MH IP requests, admitting and discharge evaluation and progress notes are required.
- For SU residential, ASAM level of care determination is required.
- Whenever a service requiring pre-certification was provided without a medical necessity review, the medical record must be submitted with the request.
- Documentation relevant to the request:
  - Eligibility verification system (EVS) documentation verifying that eligibility was checked and wrongly indicated enrollment status
  - An explanation of benefits (EOB) must be included in cases where the member has other insurance in addition to PerformCare coverage

Reasons for approval (reversal of the original claims denial) may include but are not limited to:

1. Documentation of eligibility verification issues beyond the control of the provider
2. Documentation of processing errors by PerformCare
3. Documentation of continued stay review issues beyond the control of the provider
4. Unavoidable delay caused by another provider

Reasons to uphold the original claims denial may include but are not limited to:

1. Failure in authorization management by the provider
2. Failure in claims or billing management by provider
3. Failure to check a member's eligibility prior to service delivery
4. Submission of the request was beyond 60 days of the original claim's denial notice.
5. Untimely filing — claims that are 365 days or more beyond the dates of service will not be considered for payment.

Reasons for rejection of an appeal request (which reserves the opportunity for the provider to resubmit the appeal) include:

1. A claim was not billed, and a denial notice was not received before the administrative appeal request was submitted to PerformCare.
2. The claim number(s) was missing.
3. Incorrect or insufficient information was submitted.
4. The requested dates of service have already been paid.

**All relevant information must be submitted with the appeal request. The decision of the review process is final.**

**Please submit all administrative appeal requests by postal mail to:**

**PerformCare Admin Appeals**
**P.O. Box 7301**
**London, KY 40742**

## ADMINISTRATIVE APPEAL REQUEST

| | |
|---|---|
| Date: | |
| **Member information** | |
| Member name: | |
| Social Security number: | |
| County of residence: | MA ID: |
| Primary insurance: | |
| Secondary insurance: | |
| **Provider information** | |
| Provider name: | |
| Provider site address: | |
| Contact person's name: | |
| Contact person's address: | |
| Phone number: | |
| **Appeal information:** | |
| Date(s) of service to be reviewed: | |
| Type of service: | CPT code: |
| Modifier: | |
| Authorization number: | Claim number: |
| Total $ amount requested | |
| Provider's requested action: | |
| Reason for denial: | |
| Steps taken to correct and prevent future occurrences (if applicable): | |
| **Additional information:** | |
| Please submit additional documentation of services rendered, such as EVS verification or any other documentation that will support the request. Please include a typed narrative of additional supporting documentation to justify the request. | |
| **TO BE COMPLETED BY PERFORMCARE** | |
| Log number: | Committee review date: |
| Eligibility: | Pended to: |
| Pended date: | Due date: |
| Notes: | |
| Outcome: ☐ Approve ☐ Deny ☐ Reject | |
| Final decision date: | |
| Reason: | |

## Availability of PerformCare Policies and Procedures

PerformCare makes all policies and procedures relevant to providers available upon request. Contact your Account Executive for additional information or check the PerformCare website under **Resources and Information**.

## NaviNet

NaviNet is a web-based application which allows credentialed, contracted providers within the PerformCare network to have access to:

- Eligibility and Benefits Inquiry
- Claim Status Inquiry
- Claim Submission (connection to Change Healthcare's ConnectCenter).
- Report Inquiry (reserved for later use)
- Provider Directory (connection to PerformCare's online Provider Directory).
- Pre-Authorization Management (connection to PerformCare's Jiva care management system).
- Forms and Dashboards (includes IBHS and Family-Based Provider Capacity entry).

This application is a secure web-based application that enables users to access real-time information 24 hours a day, seven days a week. Providers will find that this resource will save them valuable time when managing their authorizations and claims.

Provider agencies must register to use NaviNet. In addition, each individual user within the agency must be registered and passwords should never be shared. Information regarding NaviNet, such as registration forms and agreements, can be found at **pa.performcare.org** in the **Providers** section of the website.

A security officer must be identified within each agency. Those individuals will handle the registration of new NaviNet users within each provider agency.

Watch the PerformCare website for additions to the system and complete your registration forms today!

## Provider Email Alerts and Notifications

PerformCare's *Network News* online information service, also known as iContact, is a free email alert service for PerformCare providers. We strongly encourage all providers to use this service. You can sign up by visiting the **Providers** page on the PerformCare website, and clicking on **Sign up for *Network News* email** at the bottom of the page. Please distribute this information to those within your organization who rely on updates to stay current with PerformCare news.

The iContact service is a quick and efficient form of communication between PerformCare and all credentialed providers. Some of the items you will receive notifications on include:

- All forms, policies, procedures, and events
- When pertinent forms, policies, and procedures are revised, an email notification of the new posting with a link is sent to registered users. This information will be easily communicated to PerformCare providers.
- Events and training notifications, including recorded trainings

## Chapter VII
## PROVIDER RESPONSIBILITIES

### Commitment to Recovery Principles

In May 2021, an update to the November 2005 publication "A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults" was published and distributed by OMHSAS. This update is titled "A Call for Change: 15 Years of Progress in HealthChoices Behavioral Health." It was noted that progress has been made with regards to promoting recovery and resiliency since the original "A Call for Change" report was issued. It calls upon all stakeholders, including providers, to implement more recovery-oriented service system. As PerformCare continues to implement a recovery-oriented system of care, we encourage providers to also take an active role and participate in learning opportunities. Peer Support Services and Certified Recovery Specialists have become integral components of the array of services offered to individuals and the utilization of these services has increased over time. Access to Psychiatric Rehabilitation Services has also been expanded.

Phase II will now focus on the following areas: addressing workforce issues, increasing the availability of EBPs and training for provider staff on EBPs, expanding access to telehealth services, enhancing quality services for youth, improving the crisis system, and enhancing integrated care.

Recovery is a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices, and opportunities that promote people reaching their full potential as individuals and community members.

People with serious mental illnesses do, in fact, recover and can become symptom-free with time. Others move on a rich journey known as the recovery process. It is through this process people discover wellness tools and symptoms interfere less and less with their ability to live a self-identified full and meaningful life. The amalgamation of these voices has created what is now known as the "recovery movement" in mental health. One of the basic premises of this movement is that the role of a mental health service system is not to "do for" or to "do to," but to "do with."

Recovery is defined as the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

**The 10 Fundamental Components of Recovery* include:**

- **Self-direction:** Individuals lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and person-centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

- **Empowerment:** Individuals have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives, and are educated and supported in so doing. They have the ability to join with other individuals to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of their own destiny and influences the organizational and societal structures in their life.
- **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services (such as recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for individual access to these supports.
- **Non-linear:** Recovery is not a step-by step process, but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the individual to move on to fully engage in the work of recovery.
- **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, individuals leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer support:** Mutual support — including the sharing of experiential knowledge and skills and social learning — plays an invaluable role in recovery. Individuals encourage and engage other individuals in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect:** Community, systems, and societal acceptance and appreciation of individuals — including protecting their rights and eliminating discrimination and stigma — are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of individuals in all aspects of their lives.
- **Responsibility:** Individuals have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Individuals must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope:** Recovery provides the essential and motivating message of a better future — that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

The New Freedom Commission full report can be located at **https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm#:~:text=The%20President's%20New%20Freedom%20Commission,fall%20through%20the%20system's%20cracks**.

*Please note that we have made slight changes to the wording to reflect the voices of Pennsylvania's Recovery Champions. It is through these collected voices that we have chosen to change the word "consumer" to "person," "peer," and "individual."

Providers should be committed to the following to support recovery and resiliency principles:

- In all interactions, individuals using behavioral health services should be considered and treated as equal partners in the treatment process.
- A nonjudgmental atmosphere should be promoted by all employees. Avoid and correct "us/them" attitudes.
- Educate staff in recovery principles and concepts.
- Promote full and meaningful participation by members and family in the treatment planning process.

SAMHSA provider assistance to improve delivery of recovery-oriented services, supports, and treatment can be found at **www.samhsa.gov/recovery-to-practice** or **1-800-789-2647**.

### Commitment to Resiliency

Resilience is a term that has been borrowed from the sciences and adopted by psychology. When used by psychologists, it refers to the ability to cope successfully or adapt to trauma or crisis. Provider organizations are expected to provide staff with training and education to help them foster resiliency in each person through their own expectations and appropriate therapeutic interventions.

In the article "Fostering Resilience: A Strengths-Based Approach to Mental Health" by Douglas Coatsworth, PhD, and Larissa Duncan, resilience is described as "…the process of adapting well in the face of adversity, tragedy, or high levels of stress." The article goes on to describe that resilience has also been used to refer to the processes by which children, youth, and adults withstand those sources of challenge, and manage adversity and trauma. Resilience is not to be interpreted as a specific trait. The article notes "resilience is not a single characteristic of the individual such as eye color or height, or some trait that individuals may possess more or less of, such as intelligence or thoughtfulness" and that "this kind of conceptualization of resilience is an inappropriate labeling of the person that attributes too much to the person and not enough to the person's social environment, in much the same way that the opposite label of 'at-risk youth' does. It also implies a more permanent view of resilience than is warranted. A person's ability to be resilient may change over time as his/her resources to cope increase or decrease."

Finally, it is critical to understand that we can help improve resilience. Resources include personal characteristics, as well as social and environmental factors. This means we can help build resilience by strengthening family and community ties, easing financial burdens, finding housing, friends, mentors, after school programs, and other available supports.

The American Psychological Association (APA) also provides excellent resources to share with staff and families. Articles and brochures are available through the APA Psychology Help Center at **www.apa.org/topics/resilience**.

### Commitment to Clinically Appropriate Services for LGBTQIA+ Members

Every provider in the PerformCare network is expected to provide the best possible service. This includes considerations related to ensuring that LGBTQIA+ members receive competent services. Please see OMHSAS Bulletin 11-01: Non-Discrimination Toward Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex People for more information and suggestions: **pa.performcare.org/assets/pdf/providers/resources-information/policies/dhs-2011/010711-omhsas-non-discrimination-lgbtqi.pdf**. PerformCare may provide additional information or instruction on this issue in the future.

### Policy on conversion therapies

Conversion therapy is not a supported treatment approach among behavioral health professionals. In addition, PerformCare does not recognize lesbian, gay, and bisexual orientations as a mental illness. PerformCare currently funds therapy associated with presenting symptomatology (e.g., sexual orientation issues; managing cultural issues associated with sexual identity; addressing stigma; healthy integration of sexual identity) as defined by the *Diagnostic and Statistical Manual Fifth Edition* (DSM-5) (e.g., gender dysphoria ). PerformCare will not endorse, authorize, or fund any therapy or any other treatment designed to change a client's sexual orientation, or modify a client's gender identity or gender expression from those with which the client identifies or which clients claim as their own. All therapies that are promoted for an LGBTQIA+ member must be developed in conjunction with the individual receiving treatment.

## Commitment to Child/Adolescent Services System Program (CASSP Principles)

CASSP is based on a well-defined set of principles for mental health services for children and adolescents with severe emotional disorders or at risk of developing severe emotional disorders and their families. These principles are summarized in six core statements:

**Child-centered:** Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

**Family-focused:** The family is the primary support system for the child and it is important to help empower the family to advocate for themselves. The family participates as a full partner in all stages of the decision-making and treatment planning process including implementation, monitoring, and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents, other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

**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. Community resources include not only mental health professionals and provider agencies, but also social, religious, and cultural organizations and other natural community support networks.

**Multisystem:** Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

**Culturally competent:** Culture determines our worldview and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of a particular group of people.

**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 ensure 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. See **www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/CASSP.aspx** for more information on CASSP principles.

### Commitment to Community Support Program (CSP) Principles

- **Individual-centered/individual-empowered:** Services are based upon the needs of the individual and incorporate self-help and other approaches that allow individuals to retain the greatest possible control over their own lives.
- **Culturally competent:** Services are sensitive and responsive to racial, ethnic, religious, and gender differences of individuals and families.
- **Designed to meet special needs:** Services are designed to meet the needs of people with mental illness who are also affected by such factors as age, substance use, physical illness or disability, intellectual disability, homelessness, or involvement with the criminal justice system.
- **Community-based/natural supports:** Services are provided in the least intrusive manner and in the most natural settings possible. Individuals are encouraged to use the natural supports in the community and to integrate into the living, working, learning, and leisure activities of the community.
- **Flexible:** Services are designed to allow people to move in and out of the system and within the system as needed.
- **Coordinated:** Treatment services and supports are coordinated on both the local system level and on an individual basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Coordination includes linkages with members, families, advocates, and professionals at every level of the system of care.
- **Accountable:** Service providers are accountable to the participants of services and include members and families in planning, development, implementation, monitoring, and evaluating services.
- **Strengths-based:** Services build upon the assets and strengths of individuals and help people maintain a sense of identity, self-esteem, and dignity.

### Commitment to Community Integration

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

### Commitment to Whole-Person Focus

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

### Commitment to Improvement of Quality of Life

Services and supports for members will focus on recovery through self-discovery and education. Services will support members to define, choose, and achieve a self-identified and fulfilling life. PerformCare will promote this philosophy though education and development of appropriate resources as well as monitor fidelity standards when applicable. These activities will help to ensure that all people receiving services have the opportunity to improve their lives and become active community citizens.

### Commitment to Outcome Focus

Systems of care and provider services are guided by defined outcomes, measurable goals, and research-supported best-practice approaches to treatment. PerformCare has developed and monitors standards of care, providing research and training on outcomes-proven treatment technologies along with implementation of the DHS' 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 neurodiverse or neurodivergent and mental health needs populations is critical.

### Commitment to Diversity, Equity, and Inclusion

Providers must strive to eliminate barriers to treatment caused by failures to understand or address issues of cultural differences. PerformCare stresses the importance of providing clinical assessment, which addresses the cultural and linguistic needs of members. PerformCare has contracts with treatment providers in the community that are capable of addressing cultural, linguistic, and developmental needs to provide direct assessments and ongoing care.

All PerformCare providers are expected to be aware of and sensitive to their organization's Diversity, Equity, and Inclusion (DEI) needs by creating an environment whereby the cultural, and linguistic needs of members are taken into consideration. Provider staff should practice ongoing cultural humility and awareness. Training should be provided to ensure effective treatment to members from a diverse background. Providers must have policies and procedures to ensure the organization's staff is equipped to handle requests initiated by non-English speaking members appropriately. Providers may not decline a referral based on the member's linguistic needs for non-English speaking members or the need for an interpreter for language, hearing, or visual needs. PerformCare may monitor this area during site visits, re-credentialing activities, and surveys of provider service sites. PerformCare encourages all providers to establish a mechanism to ensure that cultural humility and awareness trainings are provided to staff upon hiring and throughout their employment.

### Nondiscrimination Policy

Providers must not discriminate against staff, agents, or members receiving services regardless of their race, color, national origin, ethnicity, actual or perceived sexual orientation, age, gender identity, gender expression, or disability. Providers must ensure their complaint procedures include acceptance of complaints from members for any alleged violation of this policy in keeping with current HealthChoices and DHS complaint and grievance processes. In addition, PerformCare strongly encourages all network providers to have a complaint procedure that affords an employee the opportunity to report any alleged violation of this policy.

### Compliance With Law and Regulation

PerformCare and its provider subcontractors must comply with all applicable federal and state laws, rules, regulations, and requirements of the Pennsylvania MA program, Department of Health, DHS, CMS, and any other applicable entity, including but not limited to:

Title VI and VII of the Civil Rights Act of 1964 (42 U.S.C. Section 2000 d. et seq. and 2000 e. et seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. Section 701 et seq.); The Age Discrimination Act of 1975 (42 U.S.C. Section 6101 et seq.); the Americans with Disabilities Act of 1990 as amended (42 U.S.C. Section 12101 et seq.) the Pennsylvania Human Relations Act of 1955 (71 P.S. Section 941 et seq.); The Pennsylvania Managed Care Consumer Protection Act (Act 68) of 1998 (Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2101 et seq.); as amended and Title IX of the Education Amendment of 1972 (regarding education programs and activities), 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information) and 45 CFR Part 74, Appendix A and section 1557 of the Patient Protection and Affordable Care Act; the Medical Practice Act of 1985, 63 P.S. §422.1 et seq. and its regulations in Title 49 Pa. Code; Title 28 Pa. Code, Chapter 9; and Title 55 Pa. Code §§1101 et seq., insofar as they are applicable to provider responsibilities under their Agreement with PerformCare.

Providers are obligated to comply with all the rules and regulations that apply to the fee-for-service MA program. These program requirements can be found in Appendix BB of the HealthChoices RFP and the Behavioral HealthChoices Program Standards and Requirements (PSR).

HealthChoices Program Standards and Requirements and Appendices are available at **www.dhs.pa.gov/HealthChoices/HC-Services/Pages/BehavioralHealth-Publications.aspx**.

At a minimum, Chapter 1101 (MA Manual) and 1150 (MA Program Payment Provisions) apply to all MA-enrolled providers. In addition, MA has specific rules and regulations by provider type that can be found online at **www.pacode.com**. As well, there are a series of DHS bulletins applicable to providers. Bulletins can be searched by year, department, or provider type at **www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx**.

Applicable licensing regulations set forth by DHS must also be followed. Regulations can be found at **www.pacode.com**.

Providers are strongly encouraged to have a self-audit mechanism to ensure they are compliant with all applicable rules and regulations as well as a mechanism to self-report instances of potential fraud or abuse to PerformCare within 72 hours of the finding.

## Corporate Compliance Activities and Self-Audit

Providers must have quality, effective compliance protocols to ensure they are meeting all required applicable laws relative to the program as well as MA billing. One of the best resources is MA Bulletin 99-02-13, issued on December 2, 2002, titled "The Bureau of Program Integrity and the Medical Assistance Provider Self-Audit Protocol." Additional information about the provider self-audit protocol and all MA bulletins applicable to Program Integrity can be found on DHS' website at **www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx**.

It is very important to keep in mind that policy decisions that come out of licensing do not necessarily translate to an ability to bill Medical Assistance funds. Licensing rules are separate from MA payment rules; thus, it is very important to be aware of provisions in the Pennsylvania MA Manual Chapter 1101 and Chapter 1150 as well as specific chapters according to services you provide.

DHS has established a hotline to report suspected fraud, waste, and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is **1-866-DHS-TIPS (1-844-347-8477)** and is available between the hours of 8:30 a.m. and 3:30 p.m., Monday through Friday. Voicemail is available at all other times. Callers do not have to give their name and may call after hours and leave a voicemail if they prefer.

Some common examples of fraud, waste, 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

Suspected fraud, waste, and abuse may also be reported via the website at **www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx**.

You do not have to give your name if you use the website or email to report fraud, waste, or abuse. The website contains additional information on reporting fraud, waste, and abuse.

BH-MCOs are obligated to make all reasonable efforts to prevent and detect fraud, waste, and abuse in partnership with their provider network to ensure that members receive the best care. BH-MCOs are responsible for reporting their efforts and findings to the Bureau of Program Integrity (BPI) each quarter. Providers may be randomly selected for review based on complaints, referrals, tips, and information received by the OMAP Fraud and Abuse Hotline or the BH-MCO directly, or through the use of fraud and abuse detection technology. All providers are subject to review.

All MA providers, regardless of the delivery system (FFS or HealthChoices) are required to comply and be knowledgeable about the relevant regulatory requirements for the services provided. This includes not only Medicaid regulations but also OMHSAS and DDAP bulletins. Providers found to be out of compliance with MA rules and payment protocols may be subject to BPI or BH-MCO actions that could include:

- Educational letters
- Recovery of improperly paid funds
- Termination of a provider's provider agreement and preclusion of a provider's direct and indirect participation in the MA program (BPI)
- Referring the case to the Attorney General's Medicaid Fraud Control Section or other appropriate criminal law enforcement agency (BPI)
- Referring a case to an appropriate civil agency (e.g., licensing bodies)
- Seeking a civil monetary penalty amounting to twice the overpaid amount plus interest (BPI)
- Recommending corrective action plans (CAPs) that inform the provider about making internal policy changes to improve or clarify program standards

**PerformCare supports BPI's recommendations and requires all providers to ensure compliance with the**

**Pennsylvania MA program through regular and deliberate self-audits.**

1. Providers must be aware of billing requirements and compensable services under the MA program. These rules are separate from licensing regulations. All MA-enrolled providers are subject to the provisions of the Pennsylvania Medical Assistance Manual Chapter 1101 and Chapter 1150. Additionally, there are chapters for most services reimbursed under the Pennsylvania Medical Assistance program including, Drug and Alcohol Outpatient, Mental Health Outpatient, Inpatient, and more. A quick link to the Pennsylvania Code online is included below for easy reference. **www.pacode.com/secure/data/055/partIIItoc.html**

2. Providers will adopt and implement compliance plans to ensure that they remain in compliance with MA regulations.

3. As part of a compliance plan, providers will periodically conduct self-audits to ensure compliance with MA regulations.

4. To the extent that overpayments are identified, providers will utilize the MA provider self-audit protocol to facilitate the return of overpayments.

Again, providers are required to have a self-audit and other quality mechanism to ensure 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 PerformCare within 72 hours of the finding.

## Provider Screening of Employees and Contractors for Exclusion

Provider screening of all employees and contractors (both individuals and entities) must be conducted at the time of hire or contracting, and thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in federal health care programs. For specific explanation and the full requirements, please refer to MA Bulletin 99-11-05: Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation. All DHS bulletins can be searched and obtained at **www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx**.

Providers must check against the National Plan and Provider Enumeration System (NPPES) (effective for rating periods starting on or after July 1, 2017), the System for Award Management (SAM) at **www.sam.gov**; the U.S. Department of Health & Human Services Office of Inspector General (HHS-OIG) and the Medicheck databases for screening to determine exclusion status at the time of hire or contracting and thereafter on an ongoing monthly basis.

Providers must screen all employees, contractors, and those individuals or entities having ownership or controlling interest in the provider and report any criminal convictions related to federal health care programs to PerformCare.

In addition, federal regulations as outlined in the Deficit Reduction Act of 2006 and the Federal False Claims Act, as amended May 2009, apply to all providers.

## Provider Preventable or Acquired Conditions

PerformCare must have a policy regarding preventable and acquired conditions to comply with federal regulations to implement section 2702 of the Patient Protection and Affordable Care Act as outlined in the Federal Register/Vol. 76 No. 108, final rule published June 6, 2011. To that end, PerformCare has implemented Policy and Procedure CC-006: Payment Adjustments for Provider-Preventable Conditions including Health Care-Acquired Conditions.

### Provider-preventable conditions (PPCs)

PPC is an umbrella term for hospital and non-hospital-acquired conditions and is defined as two distinct categories, health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

### HCACs

HCACs apply to all Medicaid inpatient hospital settings only and are defined as the full list of Medicare's hospital-acquired conditions (HAC), with certain exceptions that are unrelated to behavioral health services. See the CMS Final Rule or PerformCare Policy and Procedure CC-006 Attachment 3 for a full listing of HCACs. HCAC identification is accomplished by PerformCare through review of present on admissions (POA) indicators, which are required to be submitted on all inpatient claims. Provider responsibility for proper HCAC identification is simply to accurately include POA indicators on all inpatient claims. Data analysis and potential identification of HCACs from those claims is then conducted by PerformCare. There may be follow-up treatment record requests made of providers as needed.

### OPPCs

OPPCs apply broadly to Medicaid inpatient and outpatient health care settings where these "never events" may occur. OPPCs are defined to include at a minimum, the three Medicare National Coverage Determinations (NCDs). Under these NCDs, CMS does not cover a particular surgical or other invasive procedure when the practitioner erroneously performs:

- A different procedure altogether
- The correct procedure on the wrong body part
- The correct procedure but on the wrong patient (also known as surgery/procedure on the wrong patient, wrong surgery/procedure on a patient, and wrong site surgery/procedure)

An example of an OPPC that could occur in a behavioral health service would be an ECT procedure conducted on the wrong patient. The PerformCare Critical Incident Report form and process has been revised to include the required reporting of any OPPC identified by providers. All OPPCs identified by providers should be reported immediately to the assigned PerformCare Clinical Care Manager via phone call and also submitted on the PerformCare Critical Incident Report form. (Also see the section below entitled "Critical Incident Reporting" under "Provider Reporting" below).

Please see the policy for additional information. This policy is available on the PerformCare website or by contacting an Account Executive.

## Review of Authorizations and Payment

Providers will review authorizations received to ensure they properly reflect member information and services authorized. Similarly, please review EOB statements closely to ensure that you are receiving proper payment. Report known issues or concerns via the provider toll-free line or to your Account Executive promptly.

Adjustments will not be made retroactively. PerformCare strongly suggests that providers bill their usual and customary charges rather than the rate indicated on the rate notice. In the event of a system or data entry error, this practice will help you avoid the need to resubmit corrected claims when the issue is resolved.

## Telehealth

Per OMHSAS-22-02 Guidelines for the Delivery of Behavioral Health Services Through Telehealth 7.1.221, behavioral health services may be delivered via visual and audio, or audio only for providers that meet the requirements outlined in the bulletin. PerformCare requires providers to complete an attestation that the provider has the required policies and procedures in place to bill PerformCare for telehealth services. The attestation verifying that the provider has OMHSAS-required policies and procedures in place is also required as part PerformCare's provider re-credentialing process.

## New Service Development and Expansion

We appreciate providers' efforts to meet needs in the communities we serve through use of evidence-based and promising practices which are empirically based and cost effective. We recognize providers are often the first to identify a trend or need. PerformCare and the counties are supportive of your efforts and wish to be as active in planning and development as possible. Please see Provider Notice AD 11 108: Expansion Request Process for In Plan Service for Providers for more detail.

### Expansion of existing state Medicaid plan services

To ensure that the counties and PerformCare can adequately plan for service expansion and ensure there is support for the expansion, please be sure to contact us immediately if you think there is a need to expand services. Each county has a unique way of monitoring network development so make your Account Executive aware as soon as possible before moving forward with any plans.

### Initiation of new state Medicaid plan services in a county

**Please keep in mind that signing a contract with PerformCare is not an invitation to expand services into any additional county or within a county beyond the initial approval and level of care.** When bringing services into a specific county, in addition to approval from the BH-MCO and oversight entity, all DHS rules apply, including the need for a letter of support from the county mental health and/or D&A program. A letter of support from the county, approval by DHS, or approval by the MCO alone is not sufficient and does not suggest a provider may begin providing services and billing the HealthChoices program. Please contact your Account Executive to determine next steps.

### Supplemental services

Each county has a unique way of managing requests from providers to offer unique services. Please contact your Account Executive to discuss next steps in offering new in lieu of services. Please keep in mind that all such programs must demonstrate real cost effectiveness and outcomes and should be evidence-based.

### Requests for county letters of support

If changes are needed to an existing service description, providers are instructed to contact their assigned Account Executive. Before any letter of support will be issued by a county there must be full review of the service description by PerformCare and the county. Changes must be submitted in a **redlined Word version**. When PerformCare and the county/HealthChoices Oversight are satisfied, the service description is submitted to DHS. Requests for letters of support will be coordinated by the assigned Account Executive.

## 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, PerformCare verifies 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 provider's license is in good standing (for Pennsylvania state licensed Providers, search **www.licensepa.pa.gov**).
2. Verification that there are no sanctions on a provider's license (for Pennsylvania state licensed providers, search **https://exclusions.oig.hhs.gov/**).
3. Primary source verification for the highest level of education for all employees.
4. Verification that the employee has not been terminated, suspended, precluded, or excluded from the MA program. Such practitioners or employees are not permitted to provide service for any Medicaid-funded program, including HealthChoices.

(See **www.humanservices.state.pa.us/Medchk/MedchkSearch/Index, http://exclusions.oig.hhs.gov,** and **https://sam.gov/content/home**.)

Additional guidance is provided through Medical Assistance Bulletin 99-11-05, which was effective August 2011, regarding "Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation." This bulletin mandates that providers check certain sources as frequently as monthly staff to ensure continued compliance. Evidence of regular checks should be available upon request and may be reviewed at credentialing and re-credentialing site visits.

Providers are responsible to ensure that staff meet minimum regulatory requirements. Compensation received for service provided by staff who do not meet regulatory requirements will be subject to repayment.

## Education Requirements for Clinical Staff

Education provides the foundation for solid treatment delivery and as such, providers must be diligent in assuring that each employee received their education from a valid, recognized entity.

The United States Department of Education (USDE) and the Council for Higher Education Accreditation (CHEA) recognize accreditation agencies that ensure their accredited schools "meet acceptable standards of quality" and "maintain standards requisite for its graduates to gain admission to other reputable institutions of higher learning or to achieve credentials for professional practice" (**www.ed.gov**). A CHEA- and USDE-recognized accrediting organization is considered a "reliable authority as to the quality of postsecondary education within the meaning of the U.S. Federal Higher Education Act of 1965" (**www.chea.org**).

PerformCare expects providers to ensure that education requirements for clinical staff are met through accredited entities.

## Reporting Criminal Convictions

It is important that you, as a provider, disclose at the time of discovery any criminal convictions related to the delivery of medical care or services under the Medicare, Medicaid, or Title XX Social Service programs by any staff. Such information must also be reported at the time of application for or renewal of network participation (credentialing and re-credentialing). Providers are also obligated to provide such information to PerformCare at any time upon request.

## Member Choice and Freedom of Choice

Per HealthChoices requirements, MA requirements, and PerformCare provider agreements, all PerformCare network providers are required to ensure that members are aware that they have a right to choose the provider they wish to work with. PerformCare must be able to verify that choice was offered to each member entering service.

The Freedom of Choice format on the following page is applicable to every service except IBHS or Family-Based Mental Health Services because there are already formats specific to those services.

To ensure that the member understands this right, PerformCare will be looking for documentation by the provider confirming that members were informed they have the right to select from at least two providers for the service authorized by PerformCare. Validation that providers are documenting this requirement will occur at the time of re-credentialing. PerformCare offers a sample form on the following page for the provider's convenience and recommends that this information 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 be completed at the onset of each treatment episode.

## Assurance of Freedom of Choice Form

Date:_____

Member name:_____

MAID #:_____

Per Medical Assistance Bulletin 01-00-16, 29-00-05, 33-00-04, 41-00-03, 48-00-02, 49-00-06, 50-00-04

ISSUE DATE: December 29, 2000, EFFECTIVE DATE: December 29, 2000
**www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/d_004910.pdf**

Federal and state regulations drive the provider's responsibilities regarding Medical Assistance (MA) recipients' freedom of choice when selecting providers and services. The Social Security Act, § 1902(a)(23), requires MA programs to provide any individual eligible for MA the ability to secure services from any institution, agency or practitioner qualified to perform the services. This freedom of choice provision allows MA recipients the same opportunities to choose from among available providers of covered health care as are normally offered to the general public. For individuals enrolled in mandatory managed care (MC) programs, the freedom of choice provision is limited to providers enrolled in the MC network. In addition, 55 PA Code, § 1101.51(a), addresses the recipient's freedom of choice of providers. It states, "A recipient may obtain services from any person or organization that is approved by the Department to provide them and enrolled in the MC network. The provider must not make any direct or indirect referral arrangements between practitioners and other providers of medical services or supplies but may recommend the service of another provider or practitioner.

All members must have the freedom to choose from among the types of medically necessary services compensable through the MA program and contracted with the network. Providers must comply with all federal and state regulations regarding an MA recipient's freedom of choice and should in no way attempt to alter or to influence the recipient's decision and choices.

This form verifies that I have been informed and understand that I have a choice of providers and services available to me through the PerformCare network.

If I wish, alternate providers or services will be made available to me through PerformCare Member Services department or the PerformCare Preferred Provider forms. PerformCare Member Services can be reached at the following phone numbers:

Franklin/Fulton: **1-866-773-7917**

Capital Region — Cumberland, Dauphin, Lebanon, Lancaster, and Perry: **1-888-722-8646**

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: _____

This form should remain in the member file but need not be submitted to PerformCare.

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

PerformCare network providers will accommodate and cooperate with the C/FST survey process. This is a HealthChoices requirement that 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 use disorders and their families are satisfied with services and to help ensure 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 and/or telephonic discussions with recipients of behavioral health services and the families of child and adolescent service recipients. Members are chosen at random and should understand that their identity and specific circumstances will remain confidential. The information about the general treatment experience is shared with the county oversight entity and PerformCare 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 conducting member satisfaction surveys as permitted within the confidentiality standards and the laws. C/FST surveyors must be allowed access to members for on-site face-to-face surveying and provided with a private space to do so. 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.

The following grid provides information about the C/FST contractor for each county:

| | | |
|---|---|---|
| Consumer Satisfaction Services Inc. (CSS) | **1-717-651–1070** | Cumberland, Dauphin, Lancaster, Lebanon and Perry counties |
| Mental Health Association of Franklin and Fulton Counties | **1-717-264-4301** | Franklin and Fulton counties |

## Compliance with the Americans with Disabilities Act (ADA)

PerformCare expects network providers to comply with all provisions of the Americans with Disabilities Act applicable to the provision of care to HealthChoices members.

Title III of the ADA mandates that public accommodations, such as a provider's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs or activities of a public entity
- Denial of the benefits of services, programs or activities of a public entity
- Discrimination by any such entity

PerformCare network providers should ensure that their offices are as accessible as possible to persons with disabilities. They should also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. We offer sign language and over-the-phone interpreter services at no cost to the provider or member.

For more information, you can go to the Department of Justice's ADA webpage: **www.ada.gov**.

PerformCare network providers have a responsibility to remove "non-physical" barriers to service and will make available at the request of their clients the following:

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

Section 504 at 45 CFR Part 84 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. Section 1557 of the Affordable Care Act of 2010 prohibits discrimination on the grounds of race, color, national origin, sex, age, or disability in certain health programs and activities. For more information about Section 1557, visit **www.hhs.gov/civil-rights/for-individuals/section-1557/index.html**. Providers should consult their legal counsel with questions or concerns.

All provider staff should be aware of members' 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, Section 1557 of the Affordable Care Act of 2010, Mental Health Procedures Act of 1966 and the Drug and Alcohol Abuse Control Act of 1972. Contact the Pennsylvania Office for the Deaf and Hard of Hearing (PA ODHH) for information on the additional resources that may assist you: **www.dli.pa.gov/Individuals/Disability-Services/odhh/Pages/default.aspx**. We suggest you use the PA ODHH main office number and speak with the administrative assistant to reach the appropriate regional representative.

## Limited English Proficiency

All providers are required to comply with federal laws and regulations related to persons with limited English proficiency and are required to have language services available to people who do not speak or understand English. **A provider may not decline a member for service based on language and/or their need for an interpreter**. All MA providers must give free access to an interpreter to all people that use their office and need an interpreter to access care. OMAP and PerformCare require all providers to comply.

As part of PerformCare's provider reimbursement and rate schedules, PerformCare does provide additional funding to assist providers in offsetting the cost of telephonic and/or in-person interpreter services. However, this was not intended to fully cover all interpreter costs or release providers from their obligations under Title VI of the Civil Rights Act. Under no circumstances should a provider withhold or deny services related to the level of PerformCare's funding of interpreter services.

Please see PerformCare policy PR-027 for information about interpreter costs during service delivery.

### Use of an interpreter

The interpreter's 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 in which they are not an expert.

An accompanying adult may not serve as an interpreter in a clinical setting unless the member displays an "imminent threat" and no qualified interpreter is immediately available or the member requests that the accompanying adult assist the member and the adult member agrees and the use of a non-qualified interpreter is appropriate under the circumstances.

An accompanying child may not act as an interpreter in a clinical setting unless the member displays an "imminent threat" and no qualified interpreter is immediately available.

No staff should act as an interpreter unless the staff:

- Is designated by the agency to provide oral language assistance as part of current, assigned job responsibilities
- Meets definition of "qualified bilingual/multilingual staff" — a member of provider's workforce who is designated to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated that:

- They are proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology, and
- They are able to communicate directly effectively, accurately, and impartially with individuals with limited English proficiency in their primary languages.

Providers should always use certified interpreters with experience or training.

Providers are encouraged to use pre- and post-session meetings between the practitioner and the interpreter and allow for longer sessions when an interpreter is used.

#### Resources for Members and Providers

Disability Rights Pennsylvania
**1-800-692-7443** (voice)
**1-877-375-7139** (TDD)
**1-717-236-8110** (voice)
**1-717-236-0193** (fax)

Pennsylvania Protection & Advocacy
**1-800-692-7443** (voice)
**1-877-375-7139** (TTY)

Pennsylvania Assistive Technology Lending Library
**1-800-204-7428** (voice)
**1-866-268-0579** (TTY)

PA Relay (TTY/assistive communications)
PA Relay Operator (links voice callers to Members who utilize TTY)
**711** or **1-800-654-5984**
For Spanish: **1-844-308-9291**

PA ODHH
**1-800-233-3008** (voice/TTY)
**1-717-783-4912** (voice/TTY)
**1-717-783-4913** (fax)

National Association for the Deaf
**1-301-587-1788** (voice)
**1-301-587-1789** (TTY)
**1-301-587-1791** (fax)

American Society for Deaf Children
**1-800-942-2732** (voice – Toll-free)
**1-866-895-4206** (voice – Toll-free)
**1-717-703-0073** (voice)
**1-717-909-5599** (fax)

Hearing Loss Association of America
**1-301-657-2248** (voice)
**1-301-657-2249** (TTY)
**1-301-913-9413** (fax)

National Institute on Deafness and other Communication Disorders Clearing House
**1-800-241-1044** (voice)
**1-800-241-1055** (TTY)
**1-301-402-0018** (fax)

The PerformCare Member Services department will assist members with a request for special needs and the PerformCare Provider Relations department will assist the provider in meeting this goal when applicable. In addition, please see PerformCare policy PR-027 for information about interpreter costs during service delivery.

For additional information, providers are encouraged to review OMHSAS Bulletin 01-06, issued on October 1, 2001.

## Confidentiality

PerformCare providers will ensure 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 member confidentiality laws and regulations.

### Release of information forms

HealthChoices providers will coordinate care with the member's PCP and other behavioral health care providers as needed. A signed release form must be documented and kept on file. A provider may use an alternate release form for this purpose if it meets all state and federal legal and statutory requirements pertaining to patient confidentiality and release of specific types of protected personal health information. Forms that do not contain all the required information will be rejected. e.g., Federal Regulations 42 CFR, part 2, Pennsylvania statute 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 lV, 10-1-93. To guarantee member confidentiality, PerformCare complies with federal and state regulations governing the release of member information (disclosure of confidential information) and record retention. PerformCare maintains strict policies concerning internal security, review processes, disposal of confidential documents, and distribution of statistical information. PerformCare also requires all providers to adhere to strict confidentiality measures.

## Duty to Warn

The Pennsylvania Supreme Court has ruled that a mental health professional, under certain limited circumstances, owes a duty to warn a third party of threats of harm made by patients. Emerich v. Philadelphia Ctr. For Human Dev., 720 A.2d 1032 (Pa. Sup. Ct. 1998). The court decided a mental health professional has a duty to warn third parties if there was an immediate, known, and serious risk of potentially lethal harm where there is a specific and immediate threat of serious bodily injury that has been communicated to the mental health professional and (2) the threat was made against a specific and readily identifiable victim.

The duty to warn a potential victim of possible harm from a patient must be considered and may override the usual right to confidentiality of the clinical discussion that is typically ensured. In any situation that implies threat of harm to a potential victim, relevant clinical data or history may be released to authorities. If a provider believes a patient represents a threat to self or others, the provider may be required to attempt to protect the patient and to warn the potential victims in a timely manner. Providers should contact the police as well as the intended victim by phone if that is the best way to ensure the potential victim's safety. PerformCare expects providers to be thoroughly familiar with the duty-to-warn rules in Pennsylvania or any state in which they practice. The PerformCare Clinical Care Manager should also be alerted to the situation immediately.

This duty also applies to drug and alcohol providers; however, such providers must be aware that the nature of the services provided may impact the degree of what may be disclosed. Providers should consult state and federal regulations and, if needed, seek legal advice with respect to whether the member may be identified as receiving drug and alcohol services.

## Mandatory Reporting of Abuse

Staff members of agencies that serve children are obligated under the Pennsylvania Child Protective Services law to report suspected incidents of child abuse. For additional details, providers should reference 49 PA Code § 42.42 and/or legal counsel. Incidents of suspected child abuse should be reported to the DHS Childline at **1-800-932-0313**.

Voluntary and certain mandatory reporting is also required under both Pennsylvania's Older Adults Protective Services Act and the Adult Protective Services Act (Act 70 of 2010). The statewide 24-hour hotline for reporting adult and elder abuse is **1-800-490-8505**.

## Access Standards

The HealthChoices Program Standards and Requirements specifies the required provider response time for emergent, urgent, and routine services as follows:

### Emergent

Providers must ensure that PerformCare members are seen face-to-face within one hour of the request for services. **The provider is responsible for facilitating access to emergency crisis intervention or the emergency room (ER) 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 to result in:

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

### Urgent

The provider must ensure that PerformCare members are seen face-to-face within 24 hours of the request for services. The provider is responsible for facilitating and coordinating with PerformCare as necessary.

**Urgent care —** any illness or severe condition that under reasonable standards of medical practice would be diagnosed and treated within a 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

Providers must ensure that PerformCare members be offered an appointment to be seen face-to-face within seven 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. PerformCare 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 they should contact PerformCare Member Services 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 Account Executive immediately if anything has changed which will affect PerformCare's ability to refer members to your organization or practice. Further notification must be provided in writing to avoid any miscommunication. PerformCare makes available a Provider Data Update Form, which is available at **pa.performcare.org/assets/pdf/providers/resources-information/form-provider-data-update.pdf**, to support this communication. Providers are welcome to use the form; however, that specific format is not required. Information can be faxed to Provider Relations at **1-717-671-6522**.

## Provider Reporting

### Measurement of ability to meet access standards

Ability to meet access standards is measured using data provided to PerformCare by network providers. Providers must record the following three very important dates in the member's medical records: 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. Provider staff should be aware the date "first offered" is the first available appointment, even if the member is not able to accept it. For outpatient services, 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. Providers must be certain to use the correct modifier when submitting claims when appointments were offered within standard. Note that records are subject to audit to confirm accuracy. In addition, site visits to high-volume providers will include a limited review of member treatment records to ensure accurate reporting of the date a service was first requested by the member, the date first appointment was offered, and the date the member was first seen.

### Reporting capacity

Providers are expected to report their capacity to accept referrals for IBHS and FBMHS biweekly at a minimum through NaviNet. Providers should direct questions about this to their Account Executive. Submissions are monitored by your Account Executive to ensure reports are submitted at least biweekly.

### Performance Outcome Management System (POMS) data reporting

PerformCare is required under the HealthChoices contract to participate in and ensure the reporting of POMS data to DHS. As such, the organization has established guidelines to accomplish this task. All PerformCare network providers will assist in completing the task, as necessary.

### Critical incident reporting

PerformCare 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 are required to report critical incidents to PerformCare within 24 hours of the time the provider becomes aware of their occurrence. The following incidents that occur during treatment funded by PerformCare must be reported to PerformCare by providers:

- Death of a member
- The actual occurrence of a potentially lethal suicide attempt that requires medical treatment greater than first aid and/or the individual suffers or could have suffered significant injury. All suicide attempts that occur on the provider site, or while the provider is present, should be reported.
- Overdose of prescription, legal, or illegal substances that require treatment greater than first aid or that occur on the provider site or when a provider is present

- Medication error resulting in the need for urgent or emergent medical intervention
- Any member event requiring the fire department or law enforcement agency engagement while member is on the provider site or when a provider is present
- Allegations of abuse
- Consensual sexual contact between peers both under the age of 18 on the provider site or when a provider is present
- Serious injury to member requiring treatment greater than first aid while member is on the provider site or when a provider is present
- Life-threatening illness requiring hospitalization of a member while on the provider site or when a provider is present with member
- A member receiving 24-hour facility care who is out of contact with staff
- Member injury requiring treatment greater than first aid due to restraint or seclusion or improper use of restraint or seclusion
- Any condition that results in a temporary closure of a 24-hour care facility
- Provider-preventable conditions (PPCs)
- Severe physical aggression resulting in damage to property or injury to staff or peers that requires treatment greater than first aid that occurs on the provider site or while a provider is present
- Other occurrence representing actual or potentially serious harm to a member

The completed report form should be submitted to PerformCare QI department via fax at **1-717-671-6571** within 24 hours of the occurrence or discovery of the incident occurrence. While submission via fax is preferred, providers may also choose to submit the forms to PerformCare via first class U.S. Mail. If you are reporting by U.S. Mail, the incident must also be reported telephonically to meet notification guideline of 24 hours. Forms may not be sent as email attachments.

The form should be completed in its entirety. No spaces should be left blank. Please be sure the provider contact person indicated on the form can answer questions about the incident should clarification be necessary.

QI-CIR-001 regarding Incident Reporting as well as the reporting forms are available on the PerformCare website at **pa.performcare.org**. Alternate formats may be accepted with prior approval. Please contact your Account Executive for more information.

### Restraint and seclusion monitoring

PerformCare providers are expected and required to develop written policies and procedures for the use of restraint and seclusion and take strong measures to reduce the use of restraint and seclusion. A Report of Restraint or Seclusion form must be completed for all restraints or seclusions that do not result in member injury requiring treatment greater than first aid for any services that are funded by PerformCare. Restraints or seclusions resulting in injury will follow the CIR process outlined above.

The PerformCare form is required for all submissions. The form should be completed in its entirety. A separate form must be completed for each restraint and/or seclusion episode that occurs.

No spaces should be left blank. Forms are reviewed for completeness and appropriateness and the provider will be notified of incomplete or insufficient submissions and asked to resubmit.

All providers are required to report all restraints and seclusions to PerformCare within 24 hours of the time the provider becomes aware of their occurrence. To submit the form to PerformCare, fax to **1-717-671-6571**.

Information regarding QI-CIR-003 Restraint and Seclusion Monitoring and this process can be found on the PerformCare website.

### Provider Practice Updates

It is critical that providers notify their Account Executive immediately if anything has changed that will affect PerformCare's ability to refer members to your organization or practice or a member's ability to seek services directly. Changes that must be reported include:

- Temporary inability to accept new members into services
- Change in tax identification
- Change in address
- Change in billing address
- Office opening/closure
- Loss or addition of new practitioners that change your clinical specialties or ability to accept referrals
- Mergers/acquisitions
- Phone or fax number change
- Change in contract contact

Communicate all changes in writing to avoid any miscommunication. Please provide change information 60 days in advance whenever possible. County mental health/intellectual disability and/or D&A programs should also be aware of any change in service delivery, so in some cases acknowledgment from the county will be required prior to system changes.

PerformCare has created a Provider Data Update Form, which is available on the PerformCare website at **pa.performcare.org/assets/pdf/providers/resources-information/form-provider-data-update.pdf**. Providers are welcome to use the form; however, that specific format is not required. Information can be faxed to Provider Relations at **1-717-671-6522**.

Through regular reporting, PerformCare can make appropriate member referrals and benefit the member and the provider through timely care.

For services with an approved service description, be aware that OMHSAS is tasked with responsibility for approving final service descriptions as well as revisions. Part of the review at the state level is to ensure that the service description meets requirements as a medical service and conforms to CMS requirements. Changes to the service descriptions, including the counties served, must first be approved by the county/BH-MCO then by OMHSAS prior to implementation.

## Medical Records Standards

All providers are required to minimally meet recordkeeping requirements per PA Code Chapter 55 § 1101.51 (e). The PerformCare QI Program provides guidelines for medical record documentation for PerformCare providers. These guidelines are consistent with the standards of national accrediting organizations. The PerformCare medical records standards are as follows:

### Accessibility and availability of medical records

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

PerformCare providers are contractually committed to maintaining medical record documentation of each encounter with PerformCare members.

### Record keeping

PerformCare establishes standards for organization, content, and readability of PerformCare members' medical records. These standards apply to provider records whether paper-based or electronic. Documentation must be current, detailed, organized, comprehensive, and legible while also promoting effective care and facilitating quality review.

Providers must store treatment records securely, allow access by authorized personnel only, and adhere to all applicable federal and state confidentiality regulations for treatment records. By provider contract, member treatment records must be made available for review by PerformCare for issues related to quality of care, behavioral health outcomes measures, third-party liability, and fraud and abuse. **Providers will maintain medical records of members in accordance with applicable DHS regulations, as set forth in 55 Pa. Code § 1101.53(e), and any other applicable laws and regulations, customary professional medical practice, and in a manner that shall permit timely and effective quality assurance review**. This includes providers posting documentation in a timely manner, as well as making records available for review upon reasonable notice during normal business hours as outlined in the PerformCare Provider Agreement.

The following standards are to be maintained by and apply to all PerformCare providers who create or add to a member's treatment record:

- The member's name and/or MA ID or SS number is on each page of paper documentation and on every entry of electronic records.
- The member's identifying information and demographics include the following:
  - Name
  - Current age and date of birth (DOB)
  - Street address and county of residence
  - Home and work phone numbers and/or method of contact
  - Name and contact information of employer or school
  - Marital status
  - Legal status
  - Parent/guardian name (for children and non-adjudicated adolescents)

- Name and contact information for PCP
- All entries in the member medical record are dated and the author of documentation is identified by name, title, credentials, 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/audit by PerformCare staff.
- Allergies, to include medication allergies and adverse reactions
- All abbreviations are taken from an acceptable list of acronyms.
- Risk factors/risk assessment, including special status situations (e.g., suicide risk, homicide risk, psychosis) and crisis/safety plan
- Medical and psychiatric history
- Developmental history (for children and adolescents)
- Presenting problems
- Mental status exam (when appropriate for service)
- History of behavioral health interventions/treatment, to include dates and duration of services, level of care, information on member compliance with treatment, and treatment success
- DSM-5 diagnosis
- Medication information to include medication name, frequency, dosage, effectiveness of treatment regimen, and any known side effects for:
  - 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
- Name of prescribing physician
- Record of administration of any injection as ordered by physician
- History of and current use of alcohol/substance use to include kind, type, frequency, and amount
- Trauma history
- Consultations, referrals, and specialists' reports, to include laboratory results, psychological evaluations, summaries, screenings, and reviews as applicable
- Coordination with member's PCP to include notification upon admission, change in level of care or treatment, and upon discharge with member's written permission
- Discharge summaries
- Individualized and signed treatment plan, within the required number of days as specified by applicable DHS OMHSAS licensing regulations
- Treatment plan updates completed timely in accordance with regulations for treatment being provided
  - Individualized treatment plan to include:
    - » Measurable goals and objectives

    - » Discharge criteria to move to lesser level of care, with applicable dates
    - » Discharge/aftercare plan
    - » Therapeutic interventions/modalities, preferable empirically based interventions
    - » Target dates for each goal and objective
    - » Response to treatment/progress towards goal achievement
    - » Treatment plan developed, reviewed, and agreed upon by PerformCare member
    - » Documentation of all treatment/interventions provided and results of treatment/interventions
    - » Documentation of efforts related to member strengths, natural and community supports, and focus on recovery/resiliency
- Documentation of team members involved in the multidisciplinary team of PerformCare member needing specialty care and resolution to specialty needs
- Documentation of preventive services/risk screening to include:
    - – Screening for behavioral health conditions that may be affecting physical health
    - – Screening for physical health conditions that may be affecting behavioral health
    - – Screening and referral to PCP when appropriate
- Documentation of PCP referral to PerformCare provider
- Documentation of reason for termination of treatment
- Documentation/progress note of clinical findings for all dates and types of treatment sessions/visits
- Documentation of regular EVS eligibility verification checks
- Authorization requests
- Authorization/denial documentation from PerformCare
- Wellness recovery action plan (WRAP) and advanced directives, if they exist and if not, they have been discussed with the member

In addition, PerformCare has established specific medical records requirements for PerformCare members who are receiving care/services at the IBHS level of care:

- Documentation that IBHS written order was reviewed and comments on findings (e.g., comparison to previous and current evaluations, including diagnostic picture and recommendations)
- Documentation of treatment plan review, including assessment of progress toward treatment goals
- Documentation of team participation in ISPT meeting
- Documentation of efforts to coordinate treatment plan and service delivery with all child-serving systems (school, Children and Youth, Juvenile Probation, Intellectual Disability, etc.)
- Documentation of parental participation in treatment, including meetings and evaluations
- Documentation of treatment delivery review
- Documentation of any parent declining services and reason
- Documentation of BHT, BHT-ABABC, BA, BC-ABA, and MT inability to deliver services

## Treatment Record Review (TRR)

PerformCare conducts treatment record documentation reviews by level of care on a triennial cycle in conjunction with the credentialing schedule. In addition, providers who have scored below the established performance standard may be reviewed more frequently. Some providers may be asked to submit records for desk review. As well, PerformCare may also complete random selected reviews at the request of the county oversight entity or at the discretion of PerformCare. PerformCare will define annually the expectations for review and make these guidelines available to providers via the PerformCare website. TRR tools are created by reviewing OMHSAS bulletins, state, and federal regulations, PerformCare policies and procedures, PerformCare Provider Manual, service descriptions, and best practice documents for each level of care.

Treatment record reviews occurring in accordance with the credentialing schedule will be scheduled in advance. Following the completion of the TRR, the PerformCare reviewer will offer an exit interview with the provider, regardless of whether it is an on-site or desk review. The exit interview is a collaborative discussion between the provider and PerformCare about the results. The reviewer will detail the total score, as well as scores within the individual sections. Additionally, the reviewer may give feedback related to the individual records reviewed. Written notification of results to providers is also completed. Performance Standards are set annually by the PerformCare QI/Utilization Management Committee. Providers will be required to submit a QI Plan if the treatment record review does not meet the established performance standard. Please see Policy QI-049: Documentation Standards for Providers for additional information.

## Communication Requirements and Continuity of Care

- The treating PerformCare provider is required to make and maintain contact with the PerformCare member's PCP with proper authorization for disclosure when clinically appropriate and to provide, at a minimum, quarterly treatment summaries to the PCP.
- The treating PerformCare provider is required to make and maintain contact with other service providers who are also treating the member.
- When indicated, the PerformCare provider refers the member to the PCP for assessment, evaluation, treatment, and further referral as needed. If the PerformCare member does not have a PCP, the PerformCare provider refers the member to their PH-MCO/CHC. In the event that the PerformCare provider is unable to determine the PH-MCO/CHC, they will refer the member to PerformCare.
- Providers facilitate coordination and continuity of care among the multiple providers treating a PerformCare member and communicate regularly with PerformCare.
- Admission of a PerformCare member into a mental health inpatient hospital, even if there is a primary insurer, must be communicated to PerformCare through the Member Services department.

### Referral for medically necessary behavioral health care

PerformCare coordinates medically necessary behavioral health services for members through the PerformCare Clinical Care Managers. Clinical Care Managers are responsible for determining whether the member may need behavioral health services and to ensure services are received by facilitating appropriate referrals when needed for medically necessary behavioral health services.

### Referral to PCP or special needs unit

PerformCare Clinical Care Managers also coordinate referral to the PCP or PH-MCO/CHC special needs unit, with member permission, for assessment of physical health treatment needs. Providers, with member permission, should make referrals directly to the PH-MCO/CHC. In the event they are unable to determine the PH-MCO/CHC, the provider may contact a Clinical Care Manager to facilitate referrals, as necessary.

### Provision of emergency care

PerformCare ensures the provision of emergency services to PerformCare members through county crisis or by contacting PerformCare for assistance in connecting to services. PerformCare members may locate information on where and how to obtain medically necessary care in emergency situations in the PerformCare Member Handbook and on the PerformCare website.

### Referral requirements

PerformCare specifies referral requirements to providers and subcontractors through Care Management interaction and written instruction through provider memos and this manual. PerformCare documents a record of approved and denied services. PerformCare does not require a referral from a PCP or other provider to access medically necessary behavioral health services.

## Missed Appointments and Against Medical Advice Discharge

PerformCare has tasked its contracted network providers with following up on PerformCare members' missed appointments. Providers are expected to contact PerformCare if a member's treatment is compromised or there is a risk of termination of services due to non-participation.

When a member leaves routine care, this is typically not an area of concern. However, "no shows" (members with missed appointments) and discharges against medical advice (AMA) necessitate further follow-up.

The following methods are used for handling "no show" appointments based on the level of care:

- For all missed appointments 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 been discharged from care AMA.
  - Whether telephonically or in writing, offer the member treatment alternatives.
  - Ensure there is member safety, or initiate emergency procedures.
    - » For members who miss appointments 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 ongoing routine treatment appointments, depending on clinical circumstances.
    - » If there is a referring party for a member who misses an appointment, that party will be notified in writing, if permissible.

Neither PerformCare members nor PerformCare may be charged for missed appointments. Providers are encouraged to take all possible steps to work with members to prevent missed appointments.

## Lapse in Authorization

Providers are expected to ensure that authorization for service delivery is in place. Provider policies should ensure that steps required to secure continued authorization occur in a timely manner to accommodate unforeseen circumstances that may impact the timeliness of a reauthorization. Best practice suggests that

services should continue through a lapse in authorization. Providers may use the administrative appeal process to request payment for services delivered without an authorization.

**In the event service delivery is temporarily discontinued for any reason, the provider must notify the Clinical Care Manager immediately so interim needs can be appropriately addressed.**

### Continued Stay Review

PerformCare has a responsibility to review treatment received by members to ensure that the appropriate services are delivered based on established medical necessity guidelines. 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 XI: Covered Services and Authorization Requirements.

### Medical Necessity Guidelines

The medical necessity guidelines for HealthChoices are found in Appendix S and Appendix T of the HealthChoices Program Standards and Requirements, which can be accessed on the DHS website. Appendix S and Appendix T can also be accessed via the PerformCare website at **pa.performcare.org/providers/resources-information/clinical-resources-and-information.aspx**.

PerformCare also developed medical necessity guidelines for some specific services such as Community Residential Rehabilitation Host Home (CRR-HH). OMHSAS approves all medical necessity guidelines used by PerformCare. A copy of all medical necessity guidelines for HealthChoices is available to providers on PerformCare's website or by contacting your Account Executive. Please refer to Chapter I of this manual for phone and address information.

### Discharge Planning

While basic requirements for providers are provided in regulatory and licensing standards, discharge planning is an essential part of treatment and is expected to begin upon admission. PerformCare expects that the discharging provider will ensure 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. A pre-discharge planning meeting should occur with the member and treatment teams to ensure aftercare is in place. Member input and agreement to all after care services, as well as dates and times of appointments, is required.

**It is the expectation that discharging inpatient providers ensure that follow-up appointments are scheduled prior to discharge and occur within seven days of discharge. Members should not be asked to take responsibility for this activity. PerformCare has identified critical elements that must be addressed in discharge plans and outlines expectations in Chapter XI: Covered Services and Authorization Requirements.**

### PerformCare Follow-Up Activities

PerformCare network providers of behavioral health services (both mental health and substance use) have a responsibility to work with PerformCare to ensure coordination of care. To assist, PerformCare has associates whose role is to follow up regularly with members and providers to make assurances about follow-up care.

The goal of this support service is to help ensure members are getting the care they need, particularly after a hospitalization or step down from a higher level of care.

Providers should ensure that staff are aware that if a PerformCare associate calls to confirm an appointment was kept, it is important that the information be provided, and messages be returned promptly. This information is necessary for the ongoing care, treatment, and follow-up of the member. Providers are reminded that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Pennsylvania regulations, this information may be shared among providers and payers for the coordination of care and to support the payment of claims. Both HealthChoices regulations, and provider contracts with PerformCare, specify providers are obligated to present such information upon request. Please be prepared to indicate that:

- The appointment was kept, but the member did not schedule a subsequent appointment.
- The appointment was kept, and the member is accepting ongoing treatment or additional services.
- The member did not show up and did not cancel.
- The member canceled and rescheduled.
- The provider rescheduled.

If the appointment was rescheduled, the new date should be provided with the reason for rescheduling. If the member is accepting additional services (i.e., group therapy, individual therapy, family therapy, etc.), information about the services and the next appointment date should be provided. Providers should also be prepared to report if a member has transportation to the appointment or if assistance was provided to coordinate transportation.

If you are a facility who is providing discharge information (i.e., inpatient, partial hospitalization program [PHP]), please be prepared to provide complete and accurate discharge information to include the following:

- The date of the aftercare appointment
- The time of the aftercare appointment
- Provider name, location, and treatment type
- Provider phone number
- The member's address and phone number where they will be located post-discharge
- When possible, the contact name for the provider who will be providing the aftercare treatment

### Coordination of Benefits

When members have commercial insurance or Medicare, it is expected that care be accessed through the primary insurance first if they are seeking a service that is in the plan's benefit package. If a member with primary insurance seeks care with a provider in PerformCare's network but not in the network of the primary insurance plan, the member should be advised to check with the primary insurance about out-of-network benefits or should be advised to seek care through their primary insurance network. If your organization is not enrolled with Medicare, and you are contacted by a member who also has Medicare for service, please refer the member back to PerformCare Member Services for assistance. The Member Services staff will assist the member to find a Medicare provider. Members may also be reminded that they can contact their Medicare Advantage health plan directly or call Medicare at 1-800-MEDICAR (**1-800-633-4227**) for provider options.

A web-based Medicare provider search for members is also available at **www.medicare.gov/Physician/Search/PhysicianSearch.asp**.

Providers are strongly encouraged to become enrolled in the Medicare program.

Providers are expected to make all reasonable efforts as required per MA enrollment to secure payment from the primary source (§1101.64 MA Manual), including assignment of clinicians that meet the primary insurer's credentialing requirements. PerformCare will not override third-party liability requirement for services provided that would have been paid by the primary payer had it been provided by a clinician who met criteria of the primary payer when the provider has available such credentialed clinicians on staff, because the provider is not in network with the primary payer or because the provider did not follow proper authorization requirements for the primary insurance. This expectation applies to all services rendered at either the primary outpatient clinic site, satellite sites, or any location that is recognized as a place of service by the provider.

Special consideration is given when Medicare is the primary payer and there is documented evidence that there is not a provider of the required service within HealthChoices access standards. Commercial insurance is subject to the same access standards under Pennsylvania Department of Health regulations as PerformCare; thus, the commercial insurer is expected to fulfill its obligation to make payment for services included in their plan.

### Act 62

Act 62 of 2008 (HB 1150) was signed into law on July 9, 2008. Act 62 required that private insurance companies in Pennsylvania provide up to $36,000 per year (adjusted annually) in covered services to children under the age of 21 with an autism spectrum disorder. This coverage was effective beginning July 1, 2009. Expectations are that providers will:

- Follow the existing rules for third-party liability (TPL) (Title 55 § 1101.64. Third-party medical resources).
- Request prior authorization the same way that they always have from both the BH-MCOs and the private insurance companies (if prior authorization is required from the private insurer).
- Recognize that prior authorization is not a guarantee of payment from the BH-MCO. Providers must have documentation of a treatment denial or documentation that a service is not covered before submitting a claim to the BH-MCO.
- Submit a claim to the private insurer (even if they have not yet been contracted with the insurer) and even if they do not think the service is covered, unless there is already written documentation from the private insurer that it is not a covered service.
- PerformCare issued Provider Notice IBHS 21 103 with additional clarifications about provider TPL and Coordination of Benefits and ACT 62 since the implementation of IBHS, which includes ABA services.

### Administrative and Compliance Concerns

Administrative Compliance Concerns (ACC; formerly Administrative and Treatment Quality Concerns) is a tool designed to identify and monitor administrative compliance issues for providers in the PerformCare network. This tool gives providers information on administrative compliance concerns identified by PerformCare associates, to increase provider awareness of compliance expectations and opportunities for improvement.

During the course of daily reviews or interactions with providers, PerformCare associates complete indicators

for ACC as needed. The Quality Performance Specialist (QPS) reviews quarterly ACC reports to identify individual providers who do not meet an established threshold for administrative compliance. A PerformCare associate will outreach to any provider who does not meet the established threshold. Additionally, the QPS reports ACC data to the QI/UM Committee on a semiannual basis.

The ACC process is intended to increase awareness of administrative compliance expectations and opportunities for improvement, with the ultimate goal of improving quality of care for the members we jointly serve.

## Chapter VIII
## MEMBER RIGHTS AND RESPONSIBILITIES

PerformCare providers are encouraged to ask all new members if they have received and understand their written rights and responsibilities. PerformCare providers are expected to review and discuss these rights and responsibilities with the member as necessary and refer the member to a PerformCare Member Services Specialist if there are questions or concerns. Account Executives will review these rights with you at credentialing, re-credentialing, and routine site visits on a regular basis.

**Member Rights**

1. **Be treated with dignity and privacy.** Each member has the right to be treated with respect, recognizing their dignity and need for privacy, by PerformCare staff and network providers.
2. **Receive information.** Each member has the right to get information that they can easily locate and understand about PerformCare, its services, and the providers who treat them when they need it.
3. **Choose their provider.** Each member has the right to pick any PerformCare network providers that they want to treat them. Members may change providers if they are unhappy.
4. **Receive emergency services.** Each member has the right to get emergency services when they need them from any provider without PerformCare's approval.
5. **Receive medical and treatment information.** Each member has the right to get information that members can easily understand from their providers and to be able to talk to providers about their treatment options, without any interference from PerformCare.
6. **Make decisions about their treatment.** Each member has the right to make decisions about their treatment. If a member cannot make treatment decisions by themselves, members have the right to have someone else help them make decisions or to make decisions for them. Members may refuse treatment or services unless they are required to get involuntary treatment under the Mental Health Procedures Act.
7. **Communicate with providers in confidence.** Each member has the right to talk with providers in confidence and to have their information and records kept confidential.
8. **Access their medical records.** Each member has the right to see and get a copy of their medical records and to ask for changes or corrections to their records.
9. **Receive a second opinion.** Each member has the right to ask for a second opinion.

10. **File grievances.** Each member has the right to file a grievance if they disagree with PerformCare's decision that a service is not medically necessary for them.
11. **Voice complaints.** Each member has the right to file a complaint if they are unhappy about the care or treatment they have received.
12. **Request a DHS fair hearing.** Each member has the right to ask for a Department of Human Services fair hearing.
13. **Be free from restraint or seclusion.** Each member has the right to be free from any form of restraint or seclusion used to force members to do something, to discipline them, to make it easier for the provider, or to punish them.
14. **Receive information on all available services.** Each member has the right to get information about services that PerformCare or a provider does not cover because of moral or religious objections and about how to get those services.
15. **Exercise their rights freely.** Each member is free to exercise member rights without it negatively affecting the way the Department of Human Services, PerformCare, or network providers treat them.

**In addition, members of PerformCare also have the following rights and responsibilities:**

1. Provide, to the extent that they can, information needed by their providers.
2. Tell their provider the medicines they are taking. Include over-the-counter medicines, vitamins, and natural remedies.
3. Be involved in decisions about their health care and treatment.
4. Work with their providers to create and carry out their treatment plans.
5. Tell their provider what they want and need.
6. Take their medications as prescribed and tell their provider if there is a problem.
7. Keep their appointments.
8. Learn about PerformCare coverage, including all covered and non-covered benefits and limits.
9. Use only network providers unless PerformCare approves an out-of-network provider.
10. Respect other patients, provider staff, and provider workers.
11. Report fraud and abuse to the Department of Human Services Fraud and Abuse Reporting Hotline.

### Second opinion

A second opinion is advice or a recommendation from a second expert to make sure the advice or recommendation from the first expert is correct. All PerformCare members have a right to request a second opinion. PerformCare will provide for a second opinion from an appropriate behavioral health care professional within the network or, if not available, arrange for the member to get one outside the network at no cost to the member.

## Chapter IX
## SUSPECTED/SUBSTANTIATED FRAUD, WASTE, AND ABUSE

PerformCare 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
- Services not provided as documented
- Fraudulent/inappropriate 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

Some common examples of fraud and abuse are:

- Billing for services using an incorrect CPT code
- Unbundling of a comprehensive service into individual components
- Billing or charging MA 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

Abuse is defined as any practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the MA program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the MA program or MCO, contractor, subcontractor, or provider (42 CFR Part 455.2). A provider includes any individual or entity that receives MA funds in exchange for providing a service (MCO, contractor, or subcontractor).

Fraud is any intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in an unauthorized benefit to the entity, himself/herself, or another responsible person (42 CFR Part 455.2).

Waste is any thoughtless, careless, or otherwise improper use of services by recipients, provision of and billing for such services by providers, or payment for the services by payers. Waste, as defined by the Centers for Medicare & Medicaid Services, means overutilization of services, or other practices that result in unnecessary costs.

All providers are obligated by the provider agreement to designate a Compliance Officer and notify PerformCare of any suspected fraud or abuse. The designated Compliance Officer should report such incidents within 72 hours of learning of a potential incident to the Special Investigations Unit (SIU). PerformCare provides a toll-free access line 24 hours a day, seven days a week, to ensure the immediacy of provider reporting of suspected fraud and abuse. Providers may use the PerformCare Provider Line (**1-888-700-7370**) to initiate any reports. Providers can also submit self-reports of suspected fraud or abuse to the PerformCare SIU via secure methods, such as secure email to **fraudtip@amerihealthcaritas.com**, fax (**1-844-688-2969**) encrypted flash drive or CD or other password protected, secure electronic method. If sending via certified postal mail, provide a written self-report of concerns to the SIU to the address below:

**PerformCare SIU**
**AmeriHealth Caritas**
**8040 Carlson Road**
**Harrisburg, PA 17112**

Provider self-reports of fraud, waste, or abuse to the SIU should include the following information, as well as all information deemed appropriate by the provider:

- The presenting problem/reportable issue identified
- Name and contact information for the person who conducted the audit
- The total amount of repayment

Providers must use an Excel spreadsheet and list each claim on a separate line on the spreadsheet. The spreadsheet can be submitted via a secure, electronic method, as stated above, or on a flash drive or CD, if convenient and must include a list of the audited claims as well as the information listed below:

- The member's name
- MA ID number
- Claim number
- Date of service
- Procedure code for the service billed
- Total units
- The amount of each individual claim to be repaid
- Name of the individual who provided the service (if applicable)

PerformCare will comply with all DHS mandatory or statutory regulatory requirements with respect to fraud and abuse.

In addition, DHS has established a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients. The hotline number is **1-866-379-8477** and operates between the hours of 8:30 a.m. and 3:30 p.m., Monday through Friday. Voicemail is available at all other times. Callers may remain anonymous and may call after hours and leave a voicemail if they prefer.

Suspected fraud and abuse may also be reported via the website at

**www.dhs.pa.gov/learnaboutdhs/fraudandabuse/index.htm** or emailed to **omaptips@pa.gov.**
These reports may also be done anonymously. The website contains additional information on reporting fraud and abuse.

## Applicable Laws and Regulations

There are five relevant laws and regulations that apply to fraud, waste, and abuse. They include: The federal False Claims Act; the federal Fraud Enforcement and Recovery Act of 2009; the federal Whistleblowers Protection Act; PA Code § 1101.75 — Provider prohibited acts, and PA Code § 1101.76 — Criminal penalties, and potential consequences of committing fraud, waste, or abuse. This section is intended to increase awareness of these laws. However, it is not a comprehensive list of laws pertinent to your responsibilities as a provider. (The language is in this section is accurate as of the date that the handbook is printed, and PerformCare recommends that providers consult with their attorneys or the statute to ensure that there have not been relevant amendments or updates).

### False Claims Act

The False Claims Act (FCA) is a federal law that prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contractors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. When PerformCare submits claims data to the government for payment (for example, submitting Medicaid claims data to DHS), we must certify that the data is accurate to the best of our knowledge. We are also responsible for claims data submitted by, or on behalf of our subcontractors, and we monitor their work to ensure compliance. The FCA encourages whistleblowers to come forward by providing protection from retaliation and rewards. Penalties for violating the FCA could include a minimum $10,957 to $21,916 fine per false claim, imprisonment, or both, and possible exclusion from federal government health care programs.

### The Fraud Enforcement and Recovery Act

The Fraud Enforcement and Recovery Act of 2009 (FERA) was passed by Congress to enhance the criminal enforcement of federal fraud laws, including the FCA. Penalties for violations of FERA are comparable to penalties for violation of the FCA. FERA does the following:

- Expands potential liability under the FCA for government contractors like PerformCare
- Expands the definition of false/fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like PerformCare
- Expands the definition of false record to include any record that is material to a false/fraudulent claim
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations

### Whistleblower Protection Act

To encourage individuals to come forward and report misconduct involving false claims, the FCA includes a "qui tam" or whistleblower provision. This provision essentially allows any person with actual knowledge of false claims activity to file a lawsuit on behalf of the U.S. government.

Under federal law, the whistleblower may be awarded a portion of the funds recovered by the government, typically between 15% and 30%. The whistleblower also may be entitled to reasonable expenses, including attorney's fees and costs for bringing the lawsuit.

In addition to a financial award, the FCA entitles whistleblowers to additional relief, including employment reinstatement, back pay, and any other compensation arising from employer retaliatory conduct against a

whistleblower for filing an action under the FCA or committing other lawful acts, such as investigating a false claim, providing testimony, or assisting in a FCA action.

The FCA includes specific provisions to protect whistleblowers from retaliation by their employers. Any employee who initiates or assists with an FCA case is protected from discharge, demotion, suspension, threats, harassment, and discrimination in the terms and conditions of their employment.

A person who brings a qui tam action that a court later finds was frivolous may be liable for fines, attorney fees, and other expenses.

**PA Code § 1101.75 Provider-prohibited acts**

(a) An enrolled provider may not, either directly or indirectly, do any of the following acts:

1. Knowingly or intentionally present for allowance or payment a false or fraudulent claim or cost report for furnishing services or merchandise under MA, knowingly present for allowance or payment a claim or cost report for medically unnecessary services or merchandise under MA, or knowingly submit false information, for the purpose of obtaining greater compensation than that to which the provider is legally entitled for furnishing services or merchandise under MA.

2. Knowingly submit false information to obtain authorization to furnish services or items under MA.

3. Solicit, receive, offer, or pay remuneration, including a kickback, bribe, or rebate, directly or indirectly, in cash or in kind, from or to a person in connection with furnishing of services or items or referral of a recipient for services and items.

4. Submit a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.

5. Submit a claim for services or items which were not rendered by the provider or were not rendered to a recipient.

6. Submit a claim for services or items which includes costs or charges which are not related to the cost of the services or items.

7. Submit a claim or refer a recipient to another provider by referral, order, or prescription, for services, supplies, or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are not medically necessary.

8. Submit a claim which misrepresents the description of the services, supplies, or equipment dispensed or provided, the date of service, and the identity of the recipient or of the attending, prescribing, referring or actual provider.

9. Submit a claim for a service or item at a fee that is greater than the provider's charge to the general public.

10. Except in emergency situations, dispense, render, or provide a service or item without a practitioner's written order and the consent of the recipient or submit a claim for a service or item which was dispensed or provided without the consent of the recipient.

11. Except in emergency situations, dispense, render, or provide a service or item to a patient claiming to be a recipient without first making a reasonable effort to verify by a current Medical Services Eligibility card that the patient is an eligible recipient with no other medical resources.

12. Enter into an agreement, combination, or conspiracy to obtain or aid another in obtaining payment from the Department for which the provider or other person is not entitled, that is, eligible.

13. Make a false statement in the application for enrollment or reenrollment in the program.

14. Commit a prohibited act specified in § 1102.81(a) (relating to prohibited acts of a shared health facility and providers practicing in the shared health facility).

(b) A provider or person who commits a prohibited act specified in subsection (a), except paragraph (11), is subject to the penalties specified in § § 1101.76, 1101.77 and 1101.83 (relating to criminal penalties; enforcement actions by the Department (DHS); and restitution and repayment).

**PA Code § 1101.76 criminal penalties**

A person who is convicted of committing an offense listed in §1101.75(a)(1)—(10) and (12)—(14) (relating to provider prohibited acts) will be subject to the following penalties:

1. For the first conviction, the person is guilty of a felony of the third degree and is subject to a maximum penalty of a $15,000 fine and seven years imprisonment for each violation.

2. When a person has been previously convicted in a state or federal court of conduct that would constitute a violation of § 1101.75(a)(1)—(10) and (12)—(14), a subsequent allegation, indictment or information under § 1101.75(a) shall be classified as a felony of the second degree with a maximum penalty of $25,000 and 10 years imprisonment.

3. In addition to the penalties specified in subsections (a) and (b) and as ordered by the court, the convicted person shall repay the amount of excess benefits or payments received under the program, plus interest on the amount at the maximum legal rate. Interest will be calculated from the date payment was made by the Department (DHS) to the date full repayment is made to the Commonwealth.

4. As ordered by the court, a convicted person shall pay to the Commonwealth an amount not to exceed threefold the amount of excess benefits or payments.

5. The convicted person is ineligible to participate in the program for 5 years from the date of the conviction.

## Consequences of Committing Fraud, Waste, or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil monetary penalties
- Criminal conviction/fines
- Civil prosecution
- Imprisonment
- Loss of provider license
- Exclusion from federal health care programs

As stated above, providers are responsible for the designation of a Compliance Officer to conduct assurance measures of services rendered and the billing of such services, including all relevant documentation. All potential incidents of fraud and abuse are to be reported to the PerformCare SIU.

## Chapter X
## PROVIDER NOTICES, POLICIES AND PROCEDURES, AND QUALITY IMPROVEMENT TRAININGS

Clarifying memos/notices should be maintained with the PerformCare Provider Manual to serve as procedure updates and clarifications. The information contained in provider notices should be shared with provider staff to clarify PerformCare expectations and procedures.

### Provider Notices

In order to keep our providers informed and up to date on changes to PerformCare policies and procedures, provider notices are published and distributed to our community. These notices are typically communicated via email from our Account Executives and sent via iContact. Additionally, all provider notices are posted to our website at **pa.performcare.org/providers/resources-information/policies.aspx**. Please be sure to check this site from time to time to ensure that you have not missed any important updates that may impact your practice or patients.

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

**Categories:**

- AD — Administrative update (includes administrative procedures or expectations pertaining to all levels of care. Excludes authorization procedures.)
- IBHS — IBHS update (includes authorization procedures)
- SU — Substance use all level of care updates (includes authorization procedures)
- MH — Mental health all level of care updates (includes authorization procedures)
- PC — Policy clarification

Example: AD 13 001

Category is AD (administrative); year issued is 2013; 001 indicates it is the first publication of the year.

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

### Policies and Procedures

PerformCare policies and procedures may also be distributed from time to time. Please see the PerformCare website for a full list of relevant policies that have been distributed to date or contact your Account Executive for copies.

### QI Trainings

The Quality Improvement department provides periodic trainings on quality improvement procedures such as Critical Incident Reports or Treatment Record Reviews. They also provide trainings on QI topics such as crisis planning, relapse prevention, and clinical practice guidelines. Check the website under **Training and Education** for new topics and upcoming webinars.

## Chapter XI
## COVERED SERVICES AND AUTHORIZATION REQUIREMENTS

### Non-Incentive Statement Regarding PerformCare Staff

PerformCare 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. Utilization management decisions are based solely on established medical necessity guidelines. PerformCare does not provide incentives to its employees who conduct utilization management activities for denying, limiting, or discontinuing medically necessary services.

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

### Member Services Staff

Member Services Specialists are a great resource for providers and are available 24 hours a day, seven days a week, 365 days a year. When calling Member Services please be sure to use the toll-free phone number for providers (**1-888-700-7370**) and choose the appropriate option to reach Member Services for pre-certification requests or questions about authorizations. 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 or Medical Assistance identification number

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

**Member Services staff can assist with questions about:**

#### Authorizations

Questions regarding status of approval and authorization numbers for IBHS, FMBHS, CRR, and RTF services will be answered by Member Services or forwarded to the appropriate department.

#### Clinical Care Manager (CCM) case assignment

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

### Eligibility questions

Member Services should not be contacted routinely to check member eligibility. However, we can assist providers if they are unsure if the person is a PerformCare member after properly checking the available eligibility verification resource. Providers are expected to check eligibility using EVS prior to initiation of service provision and prior to delivery at each appointment to ensure insurance eligibility for all services provided.

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 and the member's identification number and date of birth. You can check eligibility 24 hours per day, seven days per week using this phone number.

If you are interested in obtaining PROMISe-ready eligibility verification devices, PROMISe-ready Provider Electronic Solutions Software is available at the DHS website or by calling the Provider Assistance Center at **1-800-248-2152**.

### Locating Providers

Member Services can help members and family members find a selection of outpatient providers that are convenient to where the member lives or works.

### Inpatient referral and emergency intake

Member Services will direct callers to a Clinical Care Manager and alert Crisis Intervention if appropriate.

## Authorization Procedures by Level of Care

### Mental health outpatient services

Mental health outpatient services are psychiatric and psychological services provided to a member to increase the level of functioning and well-being in an outpatient setting. The objective is to support the member's treatment with the least intensive services. The service may be provided to members with chronic or acute disorders that require active treatment. Routine outpatient treatment includes individual, group, family therapy, psychiatric evaluation, Clozaril services and medication management. Routine outpatient services do not require registration or prior authorization. Non-routine outpatient services (as noted below) do require prior approval.

a. Routine outpatient services provided by a network provider do not require registration or prior authorization. Following treatment, the provider should submit the claim as described in Chapter XII.

Treatment services that will continue to require prior authorization/reauthorization or registration include:

- Music therapy
- Psychological/neurological testing (psychological and neuropsychological testing must be pre-authorized by submitting a written request to PerformCare, using the appropriate forms and codes)
- Psychiatric rehabilitation, including clubhouses and peer support
- Mobile mental health treatment
- Mobile psychiatric nursing
- Mobile Mental Health Intellectual Disabilities Service
- Assertive Community Treatment (ACT)

- Out-of-network treatment
- Any mental health outpatient therapy request when there is a current level of care approved that includes therapy, because this could be considered duplication of services. For example, if a member is currently being served in a program such as partial hospitalization, IBHS, or FBMHS, mental health outpatient is considered duplicative. Submit an Adjunct Mental Health Outpatient Request form if you would like consideration to be given for a duplicative service. This request must include the specific clinical reasons why the services should occur concurrently. If medical necessity is met for both services, an authorization will be issued.
- Registration is required for all initial targeted case management for mental health and substance use services (ICM, RC, and blended). Initial mental health TCM services require completion of the eligibility matrix in accordance with Policy CM-036.

Services must be delivered in accordance with all guiding bulletins, licensing requirements, regulations, and MA payment guidelines. Please refer to the most recent mental health outpatient authorization request forms and instructions.

**Best practice and psychiatric evaluations**

Registration is not required for 90791 EP (Mast/PhD) Best Practice Evaluation, 90792 EP (MD/DO) Best Practice Evaluation or 90792 HA (MD/DO) Psychiatric Evaluation which recommends Initial RTF, CRR HH, or any IBHS service.

Instead, providers are to submit a claim for payment for any of the above services within (60) days of the service date.

**Adding New Evaluators to the PerformCare Network to Conduct Best Practice Evaluations.**

When an evaluator seeks to begin performing Best Practice Evaluations (BPEs) within the PerformCare network, they must follow the guidelines listed in PerformCare Policy and Procedure in CM-CAS-055: Best Practice Evaluation and Continued Care Evaluation Requirements.

Licensed psychologists must submit their resume and their request to perform BPEs in the PerformCare network to their Account Executive (AE). At that time, the AE sends the information to a Psychologist Advisor (PA). The PA will outreach to schedule an orientation for the requesting evaluator. Simultaneously, the provider must complete CANS certification.

If a licensed psychologist who is already credentialed to perform BPEs wishes to add an associate to perform BPEs under their direction and supervision, the psychologist must submit an attestation form and the associate's resume to their AE. At this time, it is sent to a PA and Provider Relations for review. The PA will outreach to schedule the orientation and the associate must also simultaneously complete the CANS certification process.

Once the psychologist or associate completes the orientation process and is CANS certified, they are added to PerformCare's list of credentialed evaluators who can perform BPEs. The orientation process involves the review of the CM-CAS-055 policy and procedure, highlighting PerformCare's standards for completing BPEs.

The PerformCare Psychologist Advisor will outreach if trends are identified for BPE that do not meet standards. QI-CR-003: Credentialing Progressive Disciplinary Actions for Providers will be followed as needed.

### Substance use outpatient services

Substance use outpatient services provide structured counseling or psychotherapeutic services on a regular and predetermined basis to alleviate issues related to substance use. Outpatient is typically one of the least intensive services available and includes individual and group therapy.

Outpatient substance use treatment does not require registration or authorization. Providers should submit claims as described in Chapter XII.

Substance use intensive outpatient treatment and Certified Recovery Specialist requires registration via submission of the forms located on the PerformCare website.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines. Please refer to the most recent substance use outpatient authorization request forms and instructions.

### Crisis intervention services

Crisis intervention services are immediate, crisis-oriented services designed to ameliorate or resolve stress related to an acute problem of disturbed thought, behavior, mood, or social relationships. The service provides rapid response to situations that threaten the well-being of a person. Services include intervention, assessment, counseling, screening, and disposition services related to the crisis.

Crisis intervention services do not require prior authorization. No authorization number is required to submit a claim. Claims must be submitted in accordance with contract requirements related to the member's county. Contact the person within your agency that is responsible for contracting with questions related to your contract with PerformCare.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines.

### Peer support services

In 2003, OMHSAS committed to transforming the mental health system to include the development of services that facilitate and support recovery. Peer Support Services have been defined in Pennsylvania as one of these services. Certified Peer Specialists are individuals who self-identify as former or current participants of behavioral health services and have certification training approved by the Commonwealth. Services are self-directed and person-centered with a recovery focus. Peer support services facilitate the development of recovery skills. Services are multi-faceted and include, but are not limited to, individual advocacy, crisis support, and skills training. Peer support is designed on the principles of member choice and the active involvement of members in their recovery process.

- **Initial request:** Peer support requires registration using a form. The form can be found on the PerformCare website. Members are eligible if they meet requirements outlined in the OMHSAS peer support bulletins. The request form must be submitted to PerformCare via fax as directed on the form, prior to initiation of services. Services are authorized for up to 12 months.
- **Ongoing services:** Reauthorization of peer support should be requested on the same form used to request the initial authorization. Continued authorization is based on member continuing to meet criteria outlined in the peer support bulletin. A service plan must be submitted with all requests for continued authorization of peer support services.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and Medical Assistance payment guidelines.

### Mental health partial hospitalization

Mental health partial hospitalization is an active outpatient psychiatric day or evening treatment session that includes medical, psychiatric, psychological, and psychosocial treatment. Such treatment is comprised of individual, group, and family therapy as well as medication management and drug administration. Partial hospitalization is more intensive and restrictive than outpatient but less so than inpatient services.

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

- **Initial request:** Requires prior authorization by contacting PerformCare by phone before initiating services. If the request is for long-term partial for an adult, a request form is submitted to the Clinical Care Manager. Approval is based on the member meeting medical necessity guidelines.
- **Ongoing Services:** Continued authorization is based on the member meeting medical necessity guidelines, which is discussed during the live continued stay review conducted over the phone with a PerformCare Clinical Care Manager. PerformCare will inform provider of the continued stay review date at the time of the authorization.
- If a member has a primary insurance that covers the entire stay, PerformCare prior authorization is not required; however, PerformCare must be notified upon admission and discharge. Contact PerformCare for authorization immediately if the primary insurance denies while the member continues to potentially meet medical necessity for HealthChoices coverage.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and Medical Assistance payment guidelines.

### Substance use partial hospitalization

Substance use partial hospitalization is an active outpatient day or evening treatment session that includes medical, psychiatric, psychological, and psychosocial treatment. Per Chapter 709 Subchapter H, Standards for partial hospitalization activities, treatment methodology may include individual, group, and family counseling, biofeedback, and Antabuse (disulfiram) or other medications. Partial hospitalization is more intrusive and restrictive than outpatient but less so than inpatient services.

- **Initial request:** Requires prior authorization by contacting PerformCare by phone before initiating services. Approval is based on the member meeting American Society of Addiction Medicine (ASAM) criteria.
- **Ongoing services:** Continued authorizations are based on the member meeting ASAM criteria received during a live continued stay review with a PerformCare Clinical Care Manager.
- If a member has primary insurance, PerformCare prior authorization is not required; however, PerformCare must be notified upon admission and discharge.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines.

### Intensive Behavioral Health Services (IBHS)

IBHS are an array of therapeutic interventions and supports provided to a child, youth, or young adult in the home, school, or other community setting. There are three types of IBHS, including Applied Behavioral Analysis (ABA) services, Individual Services, and Group Services.

Written Orders are required for initial and ongoing IBHS and must have been completed by a licensed physician, licensed psychologist, certified registered nurse practitioner, or other licensed professional whose scope of practice includes the diagnosis and treatment of behavioral health disorders (i.e., Physician Assistant, Licensed Marriage and Family Therapist, Licensed Professional Counselor, or Licensed Clinical Social Worker). All prescribers of IBHS must be enrolled as Individual MA providers. Please see Medical Assistance Bulletin 99-16-07: Enrollment of Ordering, Referring and Prescribing Providers, Issue Date April 1, 2016, for additional information. Written Orders are valid for 12 months. Of note, a Best Practice Evaluation (BPE) may serve in lieu of a Written Order, if clinically appropriate, based on member need, and it meets all IBHS regulatory requirements.

- **Initial and reauthorization requests for Individual /ABA IBHS require prior authorization** with current Written Order (completed within the last 12 months) prescribing the service, an IBHS assessment, an Individual Treatment Plan (ITP), and a Provider Choice Form. It should be noted that PerformCare requires a Functional Behavior Assessment (FBA) be completed for all members prescribed ABA IBHS and this FBA may also serve as the IBHS assessment provided it meets all IBHS regulatory guidelines. Providers are required to follow IBHS Regulations and PerformCare P&Ps: CM-CAS-042 Initial & Re-Authorization Requirements for Individual IBHS — BC/MT/BHT & ABA Services and CM-CAS-043 Initial & Re-Authorization Requirements for IBHS — Group/Evidenced-Based Therapy/Other Individual Services. Please refer to PerformCare website for policies and procedures and all corresponding forms. PerformCare will review the documentation to see if the requested services meet medical necessity guidelines. PerformCare will mail a notification to either the family or legal guardian (i.e., Children and Youth Services and Juvenile Probation) and current provider regarding the medical necessity determination outcome. Approved service authorizations are also available to in-network IBHS providers via the electronic medical record system.
- **Initial request and reauthorization for Group IBHS require prior authorization** with a current Written Order (completed within the last 12 months) prescribing the service and a proposed treatment plan. PerformCare will review the documentation to see if the requested services meet medical necessity guidelines. PerformCare will mail a notification to either the family or legal guardian (i.e., Children and Youth Services and Juvenile Probation) and current provider of the medical necessity determination outcome. Approved service authorizations are also available to in-network IBHS providers via the electronic medical record system.

**Ongoing ABA/Individual/Group IBHS require prior authorization** with a new Written Order (completed in the last 12 months), updated IBHS assessment (or FBA if ABA IBHS is prescribed), and an updated ITP. Updates to the IBHS assessment/FBA and ITP must take place within 60 days of a prior authorization request. All current IBHS-related forms are available at **pa.performcare.org**.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines. Please see 55 PA Code Chapters 1155 & 5240 Intensive Behavioral Health Services Regulations for more information.

### Community Residential Rehabilitation-Host Home (CRR-HH)

CRR-HH is a covered service for children and adolescents under the age of 18.

- **Initial request: Requires prior authorization** and a Best Practice Psychological Evaluation or psychiatric evaluation (completed within the last 60 days), a completed ISPT Meeting Agreement or Disagreement form with signatures, and a proposed treatment plan. The active TCM, when involved, will facilitate the meeting. If TCM is not authorized, PerformCare staff will facilitate. PerformCare will review for medical necessity determination and notify parties including the family or legal guardian of the outcome.
- **Ongoing services: Require prior authorization** and a psychological or psychiatric evaluation (completed within the last 60 days), a completed ISPT Meeting Agreement or Disagreement form with signatures, and a treatment plan submitted by the CRR provider. Providers are required to follow PerformCare P&P CM-CAS-053 CRR-HH Initial and Re-authorization Process. PerformCare will review for medical necessity determination and notify parties including the family or legal guardian of the decision. PerformCare will inform provider of the continued stay review date at the time of the authorization.

All current forms are available at **pa.performcare.org.**

### Family-Based Mental Health Services (FBMHS)

- **Initial request: Requires prior authorization** and a referral to an evaluator or prescriber to recommend FBMHS, if it is appropriate. The evaluator or prescriber making the recommendation for FBMHS 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 the member meets medical necessity guidelines. PerformCare will review all the documentation to see if the requested services meet medical necessity guidelines. Providers are required to follow PerformCare P&P CM-CAS-051 Procedure for Prior Authorization for FBMHS. PerformCare will notify the family or legal guardian of the initial MNG outcome. A current psychological evaluation must be in the member's record as part of the initial assessment and will need to be completed within the first 30 days of treatment if a current psychological is not available. This is required to continue the service.
- **Ongoing services:** The FBMHS model is designed to be a 32-week program. In instances where an authorization extension is needed, the provider will submit the FBMHS Additional Units/Authorization Extension Request form.
- **FBMHS extensions and payment terms and conditions outlined in value-based purchasing arrangements with VBP providers supersede the Provider Manual when there is a conflict.**

All current authorization request forms are available at **pa.performcare.org**.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines. Family Support Service (FSS) spending is an integral part of FBMHS. While specific spending requirements of 5% to 10% of FSS budget do not apply under HealthChoices, PerformCare has developed a rate with the expectation that FSS will be provided as needed. Providers are required to keep a detailed record of FSS spending by month and by member to show how FSS dollars are meeting member needs. Providers will be required to provide a record of FSS spending to PerformCare upon request.

### Residential Treatment Facility (RTF)

RTF is a covered service for children and adolescents under the age of 21. A psychiatric RTF's payment for psychiatric services to individuals under age 21 includes compensation for the resident's room and board as well as a comprehensive package of treatment services. If the facility is enrolled in the MA program as a

Non-JCAHO RTF, the County Juvenile Probation, County Mental Health/Intellectual Disability Program, or Children and Youth program may cover room and board costs. Please contact your DHS OMHSAS Licensing Representative for questions regarding qualifications for JCAHO versus Non-JCAHO licensure and MA enrollment. Psychiatric evaluations are required for initial and ongoing RTF services.

- **Initial request: Requires prior authorization** and a psychiatric evaluation (completed within the last 30 days), a completed ISPT Meeting Agreement or Disagreement form with signatures, ISPT Summary, and a proposed treatment plan. The active TCM, when involved, will facilitate the meeting. If TCM is not authorized, PerformCare staff will facilitate. PerformCare will review for medical necessity determination and notify parties including the family or legal guardian of the outcome.
- **Ongoing services: Require prior authorization** and a psychiatric evaluation (completed within the last 30 days — a psychological evaluation will be accepted for reauthorization requests for non-JACHO programs), a completed ISPT Meeting Agreement or Disagreement form with signatures, ISPT Summary, and a treatment plan submitted by the RTF provider. Providers are required to follow PerformCare Policy and Procedure CM-CAS-054: RTF Initial and Re-authorization Process. PerformCare authorizes RTF for 90 days. PerformCare will review for medical necessity determination and notify the provider and family/legal guardian of the decision. PerformCare will inform provider of the continued stay review date at the time of the authorization.

All current forms are available at **pa.performcare.org**. Please contact your Account Executive for additional information regarding how PerformCare locates RTF services for members.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines.

### Substance use non-hospital withdrawal management

- **Initial requests:** Substance use non-hospital withdrawal management services are not required to be pre-authorized for admission but do require notification and authorization for length of stay and payment of the treatment stay. The provider is required to contact a PerformCare Clinical Care Manager within two business days after the discharge to provide clinical information and ensure discharge planning and after care services are in place to meet member's treatment needs. The Clinical Care Manager will generate the authorization for the members entire withdrawal management stay at this time based on ASAM Withdrawal Management Criteria. No prior notification is required to PerformCare because withdrawal management is not a prior authorized level of care. All necessary clinical information and generation of authorization will occur at the prior discharge contact as noted above.
- **Ongoing services: Require prior authorization** based on the member meeting ASAM criteria utilizing information received during a live continued stay review with a PerformCare Clinical Care Manager. PerformCare will inform provider of the continued stay review date at the time of the authorization.
- If a member has primary insurance, PerformCare pre-certification is not required; however, a Clinical Care Manager must be notified upon admission and discharge.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines.

### Substance use non-hospital residential

- **Initial request: Requires prior authorization** by contacting PerformCare by phone before initiating services.

- **Ongoing services: Require prior authorization** based on the member meeting ASAM criteria utilizing information received during a live continued stay review with a PerformCare Clinical Care Manager. PerformCare will inform provider of the continued stay review date at the time of the authorization.
- If a member has primary insurance, PerformCare pre-certification is not required; however, a Clinical Care Manager must be notified upon admission and discharge.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines.

### Mental health inpatient

- **Initial request: Requires prior authorization** by contacting PerformCare by phone before initiating services.
- **Ongoing services: Require prior authorization** and are based on the member meeting medical necessity criteria utilizing information received during a live continued stay review with a PerformCare Clinical Care Manager. PerformCare will inform provider of the continued stay review date at the time of the authorization.

If a member has primary insurance, PerformCare pre-certification is not required.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines.

### Substance use hospital inpatient

Hospital based withdrawal management

- **Initial request:** Substance use withdrawal management services are not required to be pre-authorized for admission but do require notification and authorization for length of stay and payment of the treatment stay. The provider is required to contact a PerformCare Clinical Care Manager within two business days after the discharge to provide clinical information and ensure discharge planning and aftercare services are in place to meet the member's treatment needs. The Clinical Care Manager will generate the authorization for the member's entire withdrawal management stay at this time based on ASAM Withdrawal Management Criteria. No prior notification is required to PerformCare because withdrawal management is not a prior authorized level of care. All necessary clinical information and generation of authorization will occur at the prior discharge contact as noted above.
- **Ongoing services: Require prior authorization** and are based on the member meeting ASAM criteria utilizing information received during a live continued stay review with a PerformCare Clinical Care Manager. PerformCare will inform provider of the continued stay review date at the time of the authorization.
- If a member has authorization through primary insurance, PerformCare notification and authorization is not required however, a Clinical Care Manager must be notified upon admission and discharge.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines.

Hospital-based Residential

- **Initial request: Requires prior authorization** by contacting PerformCare by phone before initiating services.

- **Ongoing services: Require prior authorization** and are based on the member meeting ASAM criteria utilizing information received during a live continued stay review with a PerformCare Clinical Care Manager. PerformCare will inform provider of the continued stay review date at the time of the authorization.
- If a member has authorization through primary insurance, PerformCare notification and authorization is not required; however, a Clinical Care Manager must be notified upon admission and discharge.

Services must be delivered in accordance with all guiding DHS bulletins, licensing requirements, regulations, and MA payment guidelines.

### Mental health inpatient and partial hospitalization prior authorization and concurrent review

When calling PerformCare for a mental health inpatient or partial hospitalization pre-certification or concurrent review, providers should be prepared to discuss the following areas with the Clinical Care Manager:

**Prior authorization for mental health inpatient/partial hospitalization**

- Diagnosis, including MH, SA, and physical health diagnosis
- Current medications and known history for both MH and PH, PCP information
- Presenting issue
- Current/history of suicidal ideation or attempts
- Current/history of self-injurious behavior/aggression
- Panic attacks/severe anxiety
- Appearance/activities of daily living/ memory impairment
- Judgment/insight/impulsivity
- Appetite/sleep
- Substance use/trauma/abuse/high risk behaviors, including route, frequency, first use, and last use of each substance
- Relapse triggers/treatment history/adherence/ symptom-free periods
- Member-specific goals for requested treatment:
  - Strengths/functional status
  - Cultural/language preferences
  - Natural supports/family/natural support participation in treatment/community-based supports/WRAP and/or psychiatric advanced directives
  - Family psychiatric history
  - Risk assessment
  - Diversion attempts
  - Social determinants of health
  - Housing issues and any other barriers to discharge, as well as tentative discharge plan

**Continued stay review for mental health inpatient/partial hospitalization**

- Diagnosis changes since admission (including MH, SA, and physical health)
- Medications (including dosages and frequency, as well as any barriers to adherence)
- Substance use concerns:
  - Was a substance use tool used for assessment?
  - What was the recommendation based on the tool?
  - What are member's substance use issues and current treatment (including route, frequency, amount, first use, and last use)?
  - What are family substance use issues?

  - What are family needs for treatment, trauma/abuse history and impact?
  - What is the provider doing to treat issues of trauma and abuse?
  - What are after care plans for treatment of trauma and abuse?
- Relapse triggers: What are member-specific relapse triggers that prompted this admission?
- Treatment history/adherence:
  - What are the member's barriers to treatment adherence?
  - What is the provider doing to address these barriers?
  - What is the plan to improve adherence to treatment upon discharge?
- Member-specific goals: What are the member's recovery-oriented goals for treatment?
- Strengths:
  - What are the member's strengths?
  - How are these strengths being leveraged to improve functioning?
- Progress:
  - What is the member's progress for each recovery-oriented goal (both in group and 1:1 sessions, if applicable)?
  - What are barriers to progress?
  - What steps is the provider taking to address barriers?
  - What is the clinical update since admission to address symptoms that met medical necessity criteria for this level of care (i.e., mood, affect, suicidal ideation, self-injurious behavior, history, psychotic symptoms, aggression, participation, sleep, appetite, activities of daily living)?
  - Specialized information related to eating disorder or violence?
  - What is the provider doing to improve presenting symptoms?
- Functional status:
  - Identify minimum of two life domains.
  - What is the member's functional status in current living situation?
  - What is the member's functional status in at least one additional life domain (work, education, volunteer setting, homeless shelter, etc.)?
  - What are barriers to improved functional status?
  - What steps is the provider taking to address barriers?
- Cultural/language preferences:
  - What are the cultural barriers/issues/concerns?
  - Identify how cultural preferences are impacting treatment.
  - What are considerations for aftercare related to cultural preferences?
- Natural supports:
  - Identify supports (family, friends, neighbors, clergy, pets, etc.)
  - Identify roles of each support in the member's treatment and aftercare planning.

- Family/natural support participation in treatment:
  - Dates of sessions held/progress. If no sessions, document barriers.
  - What is being done to overcome barriers?
  - When is next family session?
- Family psychiatric history
- Community-based alternatives (explore referrals to evidence-based treatment (i.e., peer support, mobile psychiatric nursing, TMC, etc.):
  - Identify supports (CYS, JPO, extracurricular activities, shelter, school, etc.).
  - Identify roles of each support.
  - Complex needs supports (i.e., physical health referrals).
  - What coordination is the provider doing with these supports?
- Physical health assessment/referral:
  - Identify unstable physical health conditions.
  - What steps is the provider taking to stabilize physical health symptoms?
  - Is member involved with a PCP?
- Prevention plan:
  - What methods will the member use to manage triggers to prevent readmission?
  - What is the safety plan/diversion plan?
  - What are the member's specific coping skills/strategies to prevent decompensation?
- Coordination of care:
  - What coordination of care is occurring with current service providers (funded by PerformCare, primary insurer, or county funds) and with the PCP?
  - What are the roles of involved staff (TCM, CTT/ACT, IBHS, OP, partial hospital, FBMHS)?
- Discharge recommendations submitted/approved:
  - What services are being recommended (TCM, ACT, IBHS, OP, partial hospital, FBMHS)?
  - What services have been approved?
  - What non-treatment related supports are included in the member's discharge plan?

### Substance use inpatient and partial hospitalization pre-certification and concurrent review

When calling PerformCare for a substance use inpatient or partial hospitalization pre-certification or concurrent review, providers should be prepared to discuss information included on the ASAM, including the risk rating for each dimension, with the Clinical Care Manager.

**Prior authorization for substance use inpatient/partial hospitalization** follows ASAM 6-dimension assessment:

**Dimension 1: Withdrawal/acute intoxication**
Substances used. Including route, frequency, first use, and last use of each substance. History of withdrawal symptoms/current withdrawal symptoms. Seizure history.

**Dimension 2: Biomedical complications**
Medical conditions. Is member involved with PCP?

**Dimension 3: Emotional/behavioral complications**
Mental Health, Substance Use and Physical Health diagnosis. Treatment history/adherence. Trauma/abuse history. Attending psychiatrist. Psychotropic and Physical Health medications including dosages and frequency. Clinical update/emotional/behavioral concerns.

**Dimension 4: Treatment Acceptance/Resistance**
Awareness/commitment to change. Motivation for treatment. Active treatment providers. Substance use treatment history.

**Dimension 5: Relapse potential/continued problem potential**
Relapse triggers/relapse potential. Relapse prevention skills/prevention plan. Periods of sobriety.

**Dimension 6: Recovery/living environment**
Living situation. Natural/sober supports. Cultural preferences. 12 step/sponsor involvements. Recovery barriers. Community-based supports.

**Continued stay review for substance use inpatient/partial hospitalization**

**Dimension 1: Withdrawal/acute intoxication**
Current withdrawal symptoms:

- What are current acute symptoms such as seizures, tremors, nausea, vomiting, diarrhea, sweats, elevated vital signs, etc.?
- What are current non-acute symptoms such as cravings, drug dreams, irritability, mild anxiety, etc.?

Medical interventions:

- What are current withdraw protocol tapers (medications)?
- What are current methadone/suboxone maintenance programs?

Relapse status:

- What is the provider doing to address relapse if applicable?

**Dimension 2: Biomedical complications**
Medical conditions:

- Identify unstable physical health conditions.

Physical health assessment/referral:

- What steps is the provider taking to stabilize physical health symptoms?
- What is extent of member involvement with a primary care physician?

**Dimension 3: Emotional/behavioral complications**
Mental health, substance use and physical health diagnosis. Treatment history/adherence:

- What is member's treatment history?
- What are barriers to treatment adherence/what is the provider doing to address these barriers/what is planned to improve adherence to treatment upon discharge?

Trauma/abuse: Impact and follow up

- What is current/history of trauma and abuse/what is the provider doing to treat issues of trauma and abuse?
- What are aftercare plans for treatment of trauma and abuse?

Attending psychiatrist/psychotropic and physical health medications, including dosages and frequency.

Clinical update: Include mental health symptoms and impact on treatment

- What is the clinical update since admission related to the member's symptoms that meet medical necessity guidelines: (i.e., mood, affect, suicidal ideation, self-injurious behavior, history, psychotic symptoms, aggression, participation, sleep, appetite, activities of daily living)?
- Specialized information (eating disorder, aggression, sexually maladaptive behaviors, trauma).
- What is the provider doing to improve presenting symptoms?

**Dimension 4: Treatment acceptance/resistance**
Awareness/commitment to change:

- What is member's stage of change?

Motivation for treatment:

- What are reasons for motivation?
- What are barriers to increasing motivation?
- What steps is the provider taking to address barriers?

Member-specific goals:

- List three to five recovery-oriented goals for treatment.
- What steps is the provider taking to aid member in meeting goals?

Progress:

- List member progress for each recovery-oriented goal/barriers to progress.
- What steps is the provider taking to address barriers?

Functional status:

- Identify minimum of two life domains.
- What is member's functional status in current living situation?
- What is functional status in at least one additional life domain (work, education, volunteer setting, homeless shelter, etc.)?
- What are member's barriers to improved functional status?
- What steps is the provider taking to address barriers?

Strengths:

- How are identified strengths being leveraged to improve member functioning?
- List activities that member is passionate about or interested in.
- How is the member being connected with these activities to improve recovery?

**Dimension 5: Relapse potential/continued problem potential**
Relapse triggers:

- List member-specific relapse triggers that prompted this admission.

Relapse potential:

- High, moderate, or low.
- Identify barriers to decreasing relapse potential.
- What steps is the provider taking to address barriers?

Relapse prevention skills:

- Identify skills member has developed to prevent relapse.
- Identify how these skills will support recovery.
- What steps is the provider taking to prepare member to use these skills in a less structured setting?
- What are barriers to identifying relapse prevention skills?
- What steps is the provider taking to address barriers?

Prevention plan:

- What will member use to manage triggers to prevent readmission?
- What is the safety plan/diversion plan?
- What are member specific coping skills/strategies to prevent decompensation?

**Dimension 6: Recovery/living environment**
Living situation

Natural/sober supports:

- Identify supports (family, friends, neighbors, member of clergy, pets, etc.).
- Identify roles of each support in member's treatment and aftercare planning.
- What steps is the provider taking to build supports?

Cultural/language preferences:

- What are the cultural barriers/issues/concerns?
- How are cultural preferences impacting treatment?
- What are considerations for cultural preferences?

Family/natural support participation in treatment:

- Dates of sessions held/progress (if no sessions, document barriers and what the provider is doing to overcome these barriers).
- Date of next family session.

Coordination of care:

- What coordination of care is occurring with current service providers (funded by PerformCare, primary insurer or county funds) and with the PCP?
- What are roles of involved staff (TCM, CTT/ACT, OP, partial hospital, other services)?

High-risk issues
Involvement of 12-step/sponsor:

- List current and history of involvement.
- Identify barriers to involvement with 12-step/sponsor.
- What steps is the provider taking to address barriers?

Recovery barriers:

- What are barriers to recovery: (legal, employment, education, etc.)?
- What steps is the provider taking to address barriers? Community-based alternatives (to include peer support services):
- Identify supports (CYS, JPO, YWCA, YMCA, extracurricular activities, shelter, school, etc.).
- Identify roles of each support.
- Complex needs supports (i.e., physical health referrals).
- What steps is the provider taking to coordination with these supports?
- Complex needs supports?

Discharge recommendations submitted/approved:

- What services have been recommended that require pre-certification (TCM, ACT, OP, partial hospital, other services)?
- What services have been approved prior to discharge?
- Were referrals made to recovery specialist, co-occurring treatment (if applicable) and MAT when appropriate?

Discharge plan:

- What non-treatment services will be involved to support member's functioning in the community?
- What treatment services will be involved with the member following discharge?
- How will member's after care plan provide support to deter future admissions?

### Correction of Authorizations

Providers must review authorizations upon receipt to ensure they accurately reflect the services requested. Providers have 30 calendar days to request correction to an authorization. After 30 days, it will be necessary to address the issue through administrative appeals. Providers should speak with the Clinical Care Manager responsible for approving the service about authorization errors related to these services:

- Mental health inpatient
- Mental health partial hospitalization
- Substance use withdrawal management
- Substance use residential

All corrections for children's services (IBHS/FBMHS/CRR/RTF) should be directed to children's support staff either by phone or written notification. See Appendix B for a detailed listing of all services that do and do not require prior authorization.

## Expectations for Treatment Planning and Progress Reporting

### Treatment plans (all levels of care)

Each treatment plan should be recovery-focused and strengths-based, and individualized with member input to the member's needs based on information provided in the evaluation. Treatment plans should be unique to each member's needs and interests to reflect member-centered planning rather than a "standardized" format. CASSP principles should guide the treatment plan for each child. The treatment plan should be written in clear and specific terms that can be understood by anyone who reads the plan, especially the natural caregivers and member where applicable. A copy of the treatment plan should be provided to the member and/or guardian as well as all other treatment team members not limited to day care provider, school staff, and after-school program, as appropriate and with appropriate releases of information in place.

All IBHS treatment plans must comply with current IBHS regulations.

Specific areas to be included in a treatment plan include but are not limited to:

### Assessment

At the start of services, clinicians have a set time period that is dependent upon the level of care to develop the initial treatment plan. To aid in the development of the treatment plan, clinicians should be using this time to also gather baseline data on the behaviors/symptoms identified for treatment. The baseline data will serve as a basis for comparison to determine progress on goals/objectives over the course of treatment. Each specific behavior/symptom identified for treatment should have a corresponding operational definition so all team members can identify and address behaviors accurately and consistently. For example, a goal to address "aggression" is very general and may present differently depending on the member or location. A more specific goal would be to target the actual behavior such as kicking and then develop an operational definition of that behavior.

### Goals

Treatment goals are intended to identify the final desired result from treatment. It often mirrors the criteria established for discharge from the current level of care. The goals and outcomes are to be stated in behavioral and measurable (quantitative, not qualitative) terms. Identification of goals and goal outcomes can be done through the evaluation, based on the diagnosis, team input and an assessment of the member's or family's needs. The individualized goals should take into consideration the member's strengths, typical developmental expectations, opportunities for growth, and address any barriers to progress. Goals should be clear and understood by all people involved with the member, including the member.

### Objectives

Objectives are the incremental tasks that when accomplished lead to achievement of the long-term goal. Objectives should be measurable and task-specific. These tasks may involve action by the member, the family, and/or other natural caregivers either independently or cooperatively to change behaviors. Breaking the long-term goal down into achievable smaller goals enhances motivation; therefore, several objectives may be identified or added over the course of treatment. Wording of the objectives should be in terms that can be understood by all people involved with the member.

### Methods/interventions

This section lists the specific strategies to be used by the team to address the treatment goals and will differ from a behavioral plan. There should be interventions for all team members to create the desired change in settings. There should be tasks specific to each person's role (e.g., mother, father, school, child care, therapeutic

staff support, etc.) to ensure the transfer of skills. The methods and interventions should be continually monitored and assessed by the lead clinician. If the intervention is not successful, then changes may be required to the treatment plan. The identified interventions should be written in clear and specific terms that can be understood by anyone who reads the plan. Each intervention should be clearly explained and demonstrated to the member and natural caregivers so they can fully engage in the treatment process.

### Target dates

There must be a target date associated with each task and goal. This date specifies when the team believes each objective and/or goals should be completed. These dates are used as a guide to maintain treatment momentum as well as gauge progress. Based on individual responses to treatment, however, they may need adjustment during the authorization period.

### Progress

It is critical to document progress that has been made as part of the treatment plan and medical record.

The information reported should be measurable and quantitative. The lead clinician should provide their assessment on whether the client is making positive progress or if they have regressed in a specific area. If the member has regressed there should be discussion of possible reasons and modifications to the treatment plan to promote progress for the next review period. The treatment plan should reference measurable data for each goal or objective as stated in the criteria. As an example, if baseline information is reported by counting (e.g., 5/10 occasions) than progress should be reported in the same format (e.g., 7/10 occurrences). Similarly, if baseline information is reported using percentages of the behavior being exhibited, progress should also be noted using percentages.

### Discharge criteria

Discharge criteria are established at admission and clearly outline when treatment has been completed and the child can be discharged from a particular level of care, or the current level of care is no longer medically necessary. This statement will remain consistent throughout the treatment of the member. The discharge criteria should be developed using realistic and measurable terms. They also may or may not be identical to the long-term goals identified by the team.

### Discharge/aftercare planning

Discharge/aftercare planning begins on the first day of treatment and should be documented and part of the treatment plan. This identifies what services and/or other supports are being recommended upon successful discharge from this service. Aftercare and discharge plans should be specific in noting the services recommended for continued treatment and/or community supports. The discharge/aftercare plan may be modified throughout the course of treatment but must be included in every treatment plan and discussed when treatment plan is reviewed. A target discharge date should be established at the start of treatment.

### Crisis plan

Each member should be assessed for any history or current symptoms and behaviors that have the potential to lead to a crisis situation. Upon completing the clinical assessment, if clinically appropriate, crisis plans must be included in the treatment plan for child and adult members and be member-specific while following Pennsylvania's initiative for recovery and resiliency. If the regulations that govern a particular level of care require a crisis plan for every member receiving that level of care, such as FBMHS and IBHS, then PerformCare's expectation is that a crisis plan is developed and made part of the medical record for those members.

The crisis plan should outline triggers, as well as early warning signs of what a crisis looks like for the member. It should outline the interventions or supports the member believes they need to de-escalate. For example: 10 minutes alone listening to music. It can also include directives or reminders for natural caregivers on how to best support the member while they are in crisis. For example: If not calm in 30 minutes, contact a specific person; do not touch me when I am upset, etc. The crisis plan should incorporate the individual member's strengths and interests as a means to prevent escalation of behaviors. The crisis plan should be assessed and modified by the team as needed until it proves effective in supporting the client through the crisis.

### Discharge Planning and Coordination with PerformCare

For all levels of care and services, discharge planning should begin as soon as the member enters treatment.

Providers should be developing treatment goals and discharge criteria as well as discussing the benefit of a recovery and resiliency plan that includes advanced directives that involve the member and family, as appropriate, in this process. There must be an understanding of the member's needs and goals to successfully complete treatment at the current level of care. While the member is in active treatment, the provider, in cooperation with PerformCare, will discuss how to affect a successful discharge. For inpatient treatment, this may involve the inpatient provider working with the targeted case manager as well as all other mental health providers working with the identified member. Discharge planning will be discussed at every continued stay review for inpatient and partial hospitalization and is part of the reauthorization request for IBHS and FBMHS.

PerformCare 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 PerformCare Clinical Care Manager.

- Date of discharge
- Diagnosis information (confirm and review changes)
- Medications and prescriptions
- Discharge plan (level of care, date, time and location of step-down appointment, transportation to step down appointment, and non-treatment natural supports that will be in place to support member)
- Risk/safety status:
  - Present active suicidal ideation 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 level of care?

- Member's clinical symptoms/presentation and relevant situational information since the last continued stay review and any new recommendations
- Family involvement in treatment and outcome
- Discharge residence

Discharge plans are critical in documenting progress and planning for ongoing services. **Discharge plans must be provided within two weeks after discharge from any PerformCare-funded service.** Documents may be submitted via fax or uploaded to PerformCare's system. **The discharge plan is considered part of the service PerformCare has purchased from you, therefore, in accordance with the Provider Agreement, lack**

**of receipt of the discharge plan by PerformCare may delay payment for services rendered. This becomes especially important when the discharge summary recommends other levels of care — CRR-HH has a 60-day expiration date and RTF has a 30-day expiration date.**

### Outpatient discharge

PerformCare should also be notified when a member discontinues outpatient services within the same time frame. The discharge plan must include:

- Specific information about where the follow-up services will be provided, including the provider address
- Background information/history
- Presenting problems
- DSM diagnosis and clinical indicators supporting discharge treatment recommendations

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

### Role of the TCM in discharge planning

Targeted case management is a critical and effective resource and will be valuable in assuring continuity of care across the service continuum. PerformCare has developed a means of tracking and notifying the TCM of hospitalizations to enable the TCM to become involved in discharge planning.

In instances where no TCM is assigned, a PerformCare Follow-Up Specialist will contact the providers to determine if appointments are kept as scheduled. Both the PerformCare Follow-Up Specialist and Clinical Care Manager will be involved in providing outreach to the members who do not keep scheduled appointments.

### Against medical advice and discharge plans

If a member leaves treatment against medical advice and there are no grounds for commitment, PerformCare requires that the provider notify the Clinical Care Manager by the next business day so that outreach efforts by PerformCare and TCM providers, if authorized, can be initiated quickly.

### RTF discharge planning and interruption in treatment

Clinically appropriate treatment for the member is expected to be the priority for all providers. In order to ensure a coordinated and orderly discharge, RTF providers will schedule and facilitate a pre-discharge planning meeting with all team members prior to giving notice of discharge at least 45 days prior to the anticipated discharge date. It is expected that providers give 30 days' notice (at a minimum). It may be clinically appropriate at times for a member to need inpatient hospitalization while in RTF treatment. It is expected that the member will return to the RTF upon discharge from inpatient and that no formal discharge will occur or be requested while the member is on an inpatient unit. The treatment team should reconvene upon the member's discharge from IP and return to RTF to discuss further treatment options. It is expected that this policy be followed if the treatment team determines that a discharge from the RTF is clinically indicated.

Members who present immediate significant risk to self or others should be assessed for mental health inpatient for stabilization, if needed, and return to the RTF setting as described in the policy statement above.

### CRR-HH discharge planning and interruption in treatment

Similar to RTF, clinically appropriate treatment for the member is expected to be the priority for all providers. To ensure a coordinated and orderly discharge, CRR-HH providers will schedule and facilitate a pre-discharge planning meeting with all team members prior to giving notice of discharge at least 45 days prior to the

anticipated discharge date. It is expected that providers give as much notice as possible, but not less than 30 days' notice prior to discharge. If an inpatient hospital stay is clinically appropriate while in CRR-HH treatment, it is expected that the member will return to the CRR-HH upon discharge from the inpatient unit, as clinically indicated. Formal discharge should not occur, nor should it be requested while the member is in the hospital. The treatment team should convene as soon as possible upon the member's discharge from inpatient care and return to the CRR-HH to discuss further treatment options. It is expected that this policy be followed if the treatment team determines that a discharge from the CRR-HH is clinically indicated.

Behavioral health treatment is not provided in detention or shelter programs. Members who present immediate significant risk to self or others should be assessed for psychiatric inpatient for stabilization, if needed, and return to the CRR-HH setting as described above.

### Medical Necessity Guideline Review Process

A medical necessity guideline review is defined as a determination made by a PerformCare Medical Director, licensed physician, or licensed psychologist in response to a provider or member request for approval to provide a service of a specific amount, duration, and scope. The outcome of the review may be:

- Approves the request completely
- Disapproves the request completely
- Approves provision of the requested services, but for a lesser amount, scope or duration than requested
- Disapproves provision of the requested services but approves provision of an alternative services
- Reduces, suspends, or terminates a previously authorized service; typically this is due to progress the member has made in treatment

There may be occasions when the physician or psychologist advisor cannot approve the requested service based on the information submitted for review. PerformCare Peer Advisors will make an attempt to outreach to the prescriber to give them the opportunity to discuss the supporting medical information and guidelines. The opportunity for a discussion between peers can often provide the additional information or clarification needed to avoid a denial of services. Please refer to Chapter III of this Provider Manual for a full discussion of grievance procedures, including immediate access to a physician advisor.

Denial notices are mailed to the member within two business days of the decision.

Denial notices follow the format as approved by DHS. Advanced notice will be given to the member for filing a complaint/grievance. For continued stay inpatient denials, the inpatient facility is contacted by phone 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. PerformCare is responsible for ensuring the member and provider receive the denial notice.

### Priority Populations

HealthChoices defines priority populations as members with serious mental illness and/or addictive disorders, and child and adolescent members with or at risk of serious emotional disturbance and/or who use 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.

Substance use disorder priority populations also include child and adolescents who use substances and people with addictions, including pregnant women and women with dependent children, intravenous drug users, and people with HIV/AIDS who use substances.

Providers participating in the PerformCare HealthChoices program will be required to identify all members seeking services who meet criteria for priority populations.

PerformCare will offer all state Medicaid plan and identified supplemental services to the populations referenced by DHS as priority populations.

## Special Needs Populations

PerformCare has developed coordination of care agreements with the PH-MCO/CHCs in an effort to support collaboration and coordination of assessment and treatment of PerformCare HealthChoices members. Coordination and communication among behavioral health providers, members, and other 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 coexisting disorders, shared communication requires the identification of a designated clinician to coordinate an individual's care. The PerformCare Clinical Care Manager will be accountable for facilitating this assignment for all cases and will monitor appropriate performance based on established standards of practice.

Coordination of care for children and adolescents with special needs requires an additional focus that is not found with adults. Many children who have a serious emotional disturbance and/or substance use disorders are involved with multiple child serving agencies. Coordination of care by PerformCare will be critical in the delivery of treatment with the school district, the Intermediate Unit, Children and Youth Services, and Juvenile Probation and Parole.

PerformCare will offer all state Medicaid plan and identified in lieu of services to the populations referenced by DHS as special needs populations.

## Clinical Practice Guidelines

The PerformCare Provider Advisory Committee 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, the guidelines do serve to identify PerformCare expectations when providing services to members. The Provider Advisory Committee (PAC) of PerformCare has set a goal of adopting several Clinical Best Practice Guidelines to serve as a framework for future QI initiatives. The Provider Advisory Committee includes representation from our provider network as well as county representation. The Provider Advisory Committee meets as needed to consider adoption of clinical practice guidelines. The committee has focused on common diagnoses with major depression, ADHD, substance use disorders, and schizophrenia as the initial areas of interest.

Clinical Practice Guidelines are located at **pa.performcare.org/providers/quality-improvement/clinical-practice-guidelines.aspx**.

**Attention-deficit/hyperactivity disorder (ADHD) (Children/Adolescents)**
Adopted the American Academy of Pediatrics "Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment Attention-Deficit/Hyperactivity Disorder in Children and Adolescents" (October 2019). Adopted the American Academy of Pediatrics "Systematic Barriers to the Care of Children and Adolescents with ADHD" (October 2019).

**Attention-deficit/hyperactivity disorder (ADHD) (Adults)**
Adopted the American Family Physician "Diagnosis and Management of Attention-Deficit/Hyperactivity Disorder in Adults" (May 2012).

Adopted the American Psychiatric Association "Practice Guideline for the Treatment of Patients with Substance Use Disorders" (May 2006). Includes April 2007 Guideline Watch.

In addition, the following TIPS have been adopted from Substance Abuse and Mental Health Services Administration (SAMHSA): TIP 26 - Substance Abuse among Older Adults, TIP 32 — Treatment of Adolescents with Substance Use Disorders, and TIP 42 - Substance Abuse Treatment for Persons with Co-Occurring Disorders.

Adopted the American Psychiatric Association "Practice Guideline for the Treatment of Patients with Bipolar Disorder" (April 2002). Includes November 2005 Guideline Watch.

Adopted the American Psychiatric Association "Practice Guidelines for the Treatment of Patients with Schizophrenia, Third Edition" (September 2020).

Adopted "Family-Based Mental Health Practice Guidelines" (September 2015). This practice guideline was a product of a workgroup that consisted of consumers, providers, county stakeholders, CABHC, and PerformCare.

Adopted the American Psychiatric Association "Practice Guidelines for the Psychiatric Evaluation of Adults" (2015).

**Videoconferencing-based telemental health**
Adopted the American Psychiatric Association and the American Telemedicine Association's "Best Practices in Videoconferencing-Based Telemental Health Guide" (April 2018).

Documents are copyrighted; however, clinicians are permitted to print one copy for their own use. Contact your Account Executive at **1-717-671-6500** if you need assistance to get a paper copy of these guidelines.

## Discharge Information

Discharges will be completed live with a Clinical Care Manager in the same manner as continued stay reviews are conducted.

The discharge review must be scheduled with the Clinical Care Manager prior to the actual discharge. Hospitals are strongly encouraged to consider if the member would benefit from peer support services and initiate referral prior to discharge as appropriate.

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

- Discharge/aftercare plans/appointments/barriers
- Discharge crisis plan
- Discharge diagnosis: DSM5
- Discharge medications
- Physical health assessment/referral:
  - Identify unstable physical health conditions/steps provider is taking to stabilize physical health symptoms
  - Involvement with a PCP

- New recommendations from this inpatient stay
- Discharge residence
- Presence of WRAP and/or psychiatric advance directive

Again, discharge plans are critical in documenting progress and planning for ongoing services. Discharge plans must be provided within two weeks after discharge from any PerformCare-funded service. Documents may be submitted via U.S. mail or fax. In accordance with the Provider Agreement, lack of receipt of the discharge plan by PerformCare may delay payment for services rendered. This becomes especially important when the discharge summary recommends other levels of care, especially CRR-HH, which has a 30-day expiration date, and RTF, which has a 30-day expiration date.

## Discharge Planning Reiterated

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. PerformCare expects that the discharging provider will ensure that continuity of care is maintained, and appointments are scheduled in new levels of care as appropriate, according to regulations, licensing requirements, and quality standards.

**Discharging inpatient providers are expected to ensure that follow-up appointments are scheduled to occur within seven days of discharge.** Members should not be asked to take responsibility for this activity. Peer support services should always be considered for members leaving inpatient services who qualify for these services.

## Preventive Behavioral Health Programs and Community Education

PerformCare is committed to providing community education and prevention programs for 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. PerformCare will design or select preventive health programs to prevent or detect the incidence, emergence, or worsening of behavioral health disorders. PerformCare considers such factors as age, sex, socioeconomic status, ethnic background, family support systems, cultural identity and practices, clinical needs, and risk characteristics to ensure our programs are relevant and significant to members. The development, oversight, and implementation of prevention programs are the responsibility of the PerformCare QI/UM Committee. PerformCare has implemented two preventive behavioral health programs:

### Early identification of ADHD

The goal of the program is early identification and appropriate treatment. Information is sent to parents of all identified members who reach age 6. 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.

### Bipolar disorder and screening for substance use

This program was developed in an effort to promote early recognition and offer treatment options for possible substance use issues for individuals with a bipolar disorder diagnosis in the transitional group of individuals ages 19 – 21. These members have already been identified as having an existing bipolar disorder through claims history but no known substance use diagnosis. This group of members are at risk for a co-occurring illness and may need additional support. Educating the member on the symptoms of abuse and the risk factors

that may contribute to the development of a substance use illness; encouraging self-reporting by screening; and offering treatment for substance use are the key components of the program.

For further information on preventive behavioral health programs, please refer to the PerformCare website or call the QI department at **1-717-671-6528**.

## Chapter XII
## CLAIMS AND CLAIMS DISPUTES

This section provides an overview of the claims process for PerformCare. The claims payment process was designed to ensure prompt and accurate payment for services provided to members of the PerformCare HealthChoices program.

Our goal is to make billing and claims payment as simple for providers as possible. In this spirit, PerformCare has developed a Claims Help Desk.

This service is available at **1-888-700-7370**, Monday through Friday from 8 a.m. to 4:30 p.m., to assist provider staff with claims questions.

### Completing and Submitting Claims Forms

PerformCare will accept the two existing claims forms, the UB-04 for hospital claims and the CMS-1500 for medical claims.

### Inpatient Admissions Over 30 Days

PerformCare has removed this requirement and claims will no longer reject if the claim spans a calendar month. Providers will need to keep timely filing in mind and bill accordingly. Timely filing for primary claims is based on date of service, and not based on discharge date. However, remember that claims cannot span a calendar year. This rule is for medical and hospital claims. Providers must bill separate claims when the date of service span over a calendar year.

### Timeliness of Claims and Claims Involving Third-Party Liability

Original claims must be received within 60 days for the Capital Area contract (Cumberland, Dauphin, Lancaster, Lebanon, Perry) and TCMA contract (Franklin, Fulton). Claims involving third-party liability must be received within 365 days of the date of service and no more than 60 days after the EOB date. At least one level of appeal is required to the primary insurance when the primary insurer refuses to pay for a service due to a medical necessity denial before PerformCare will pay, regardless of how long it takes the primary insurer to respond. The EOB from the primary insurance must be attached to the claim (one claim to one EOB). Each claim must have an EOB attached. Providers are not permitted to send multiple claims with one EOB attached. If billed this way, the first claim will process with the EOB, and the other will deny for the missing EOB. Secondary claims are now accepted electronically (see Provider Notice AD 16 106). For questions regarding electronic submissions of secondary claims, contact your claims clearinghouse.

## Authorization Number

An authorization number is required for any service that requires prior authorization. See Appendix B for a full list of authorization requirements by service. If appropriate, the claim forms must reflect the appropriate authorization number 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

On January 16, 2009, CMS published its final rule adopting updated versions of the standards for electronic healthcare and pharmacy transactions originally adopted under the Administrative Simplification subtitle of HIPAA.

The mandatory compliance date to adopt ANSI version 5010 for all covered entities was January 1, 2012. All claims submitted electronically through an electronic data exchange (EDI) must meet requirements outlined in 5010. If you submit individual claims through NaviNet or paper claims, these processes are unaffected.

PerformCare has a trading partner agreement with Change Healthcare, formerly known as Emdeon, for electronic claims to provide a more positive experience for our providers. **PerformCare's Change Healthcare Payer ID is 65391.** Change Healthcare is the EDI services leader in health care and is already used by a majority of providers as well as other payers. PerformCare accepts electronic claims via Emdeon or any clearinghouse that trades with Change Healthcare. Change Healthcare provides EDI services based on individual needs, giving flexibility to providers for testing and submitting claims. Providers may contact Change Healthcare for provider solutions by calling **1-866-369-8805** or visiting **www.changehealthcare.com/providers**.

ConnectCenter (**www.changehealthcare.com/solutions/medical-network/connectcenter**) allows users to upload a file of claims created in an EMR, practice management system, hospital information system, or similar application. To be processed, claims files must use the ANSI 837 5010 EDI format. This document provides some guidance on how to construct a compliantly formatted file, but it is not a replacement for the ANSI 837 Implementation Guideline.

Uploading an 837 Batch claim file:

- To submit completed 837 claim files, use the ConnectCenter file upload feature. This feature is found within the **Mailbox** menu.
- If you create claim files through a third-party application such as a PMS, HIS, or EMR system, work with your software vendor for any modifications needed to create properly formatted batch claim files.
- If you are not familiar with the ANSI 837 transaction format and not able to engage your software vendor for assistance, you should use the claim data entry tool provided in ConnectCenter to create claims online. Refer to the **Keying a Claim Quick Reference Guides** for more information about online claim creation.
- File names can contain alpha and numeric characters. You can use underscores, periods, and hyphens. Do not use spaces or any special characters other than underscores, periods, and hyphens.
- Please do not submit claims on the same day that you create a new ConnectCenter submitter account. An overnight configuration process must be executed before claim files can be correctly associated with your account.

### Plan Identifiers

The payer IDs (CPIDs) below should be used in the 2010BB NM1 segments to identify which plan is being billed. Please note that a different ID should be used for Institutional claims than for Professional claims.

Be sure to select the CPID from the column appropriate to the type of claims you are creating. As additional reference information, the five-character payer IDs that are more commonly used to identify these plans are included in this table, but these must not be used in the 2010BB NM1.

| Plan Name | Plan Payer ID | CPID for Professional Claims | CPID for Professional Claims |
|---|---|---|---|
| PerformCare-HealthChoices | 65391 | 6183 | 4657 |

**Acknowledgement and Claim Reports**
Claims files typically complete the first phase of processing within 10 to 15 minutes, which means that within 15 minutes newly uploaded claims should be visible in the **Claim Health Vitals, Work List,** and **Claim Search** views. In addition, a claim acknowledgement report will be delivered to your mailbox with information regarding any claims or batches that could not be successfully processed.

If you do not see claims or reports within 15 minutes of uploading your files, there may be a problem with your file configuration. Please contact support if this happens.

Batch reports can provide additional insight about the status of files uploaded. These reports are typically returned with one minute of file upload. To access these reports, choose **Mailbox** from the main menu. Change the **Directory** field to **All** to access reports. If you have a lot of reports, use additional filters such as date to shorten the list of reports returned.

The reports returned in this fashion can be challenging to understand. The most important thing to look for is the file status, which will be given in the first few lines of the report. Look for "**** TRANSFER OF FILE" followed by the name of your file. Immediately after the file name the report should say either "SUCCESSFUL" or "FAILED." If your file has a FAILED status, please contact either your vendor or Change Healthcare customer support for help correcting the problem.

**Next Steps/Getting Started**
Visit ConnectCenter:

- **https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214629**
- Scroll down to the **Getting Started** section and click the **Sign-Up** button to create an account.
- After logging in for the first time:
- Go to **Admin/Provider Management** to add information about providers for whom you bill.
- Go to **Payer Tools/Enrollment** to sign up to receive ERAs in ConnectCenter.

Need more help?

Call **1-800-527-8133**, **option 2** for questions about:

- Submitting new claims
- Eligibility
- Claim status
- Remits
- Enrolling for remits

Call **1-877-667-1512**, **option 2** for questions about:

- The status of old claims or old remits
- Access to reporting and analytics

### Electronic Funds Transfer (EFT)

PerformCare has arranged for provider payment services, consisting of virtual credit card (VCC), automated clearing house (ACH)/electronic funds transfer (EFT), and paper check payments as well as electronic remittance advice (ERA) provided through ECHO Health, Inc., a partner of Change Healthcare. This payment platform offers an easy method of signing up for electronic funds transfer (EFT), medical payment exchange (MPX), and paper checks.

Providers can review options and get enrollment information here:
**pa.performcare.org/assets/pdf/providers/claims-billing/echo-eft-provider-faq.pdf**.

For all claims and payment options and assistance, visit
**pa.performcare.org/providers/claims-billing/electronic-billing-services.aspx**.

### EFT Enrollment Instructions

Enrollment with ECHO for ACH/EFT payment is a fast, one-time process. Simply follow the instructions outlined in the following section to begin receiving electronic payments and remittance advices today.

### New EFT customers

Electronic funds transfers allow you to receive your payments directly in the bank account you designate rather than receiving them by VCC or paper check. When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed explanation of payment for each transaction will also be accessible to download from the Echo provider portal at **www.providerpayments.com**. If you are new to EFT, you will need to enroll with ECHO Health for EFT from PerformCare.

**Please note:** Payment will appear on your bank statement from PNC Bank and ECHO as "PNC – ECHO."

To sign up to receive EFT from PerformCare, visit
**https://enrollments.ECHOhealthinc.com/efteradirect/enroll. There is no fee for this service.**

To sign up to receive EFT from all of your payers processing payments on the Settlement Advocate platform, visit **https://enrollments.ECHOhealthinc.com**. **A fee for this service may be required.**

If you have questions regarding how to enroll in EFT, please refer to the PerformCare EFT enrollment guide:
**pa.performcare.org/assets/pdf/providers/claims-billing/echo-eft-provider-enrollment-guide.pdf**.

If you have additional questions regarding VCC, EFT, or ERAs, please call the Echo Health Support team at **1-888-492-5579** or reference our FAQ:
**pa.performcare.org/assets/pdf/providers/claims-billing/echo-eft-provider-faq.pdf**.

## Electronic Remittance Advice (ERA)

PerformCare now also offers ERAs (also referred to as an 835 file) through Change Healthcare/ECHO Health. To receive ERAs from Change Healthcare and ECHO, you will need to include both the Change Healthcare PerformCare payer ID (**65391)** and the ECHO payer ID (**58379**).

All Change Healthcare/ECHO HEALTH generated ERAs and a detailed explanation of payment for each transaction will be accessible to download from the ECHO provider portal: **www.providerpayments.com/Login.aspx?ReturnUrl=%2f**.

If you are a first-time user and need to create a new account, please reference Echo Health's Provider Payment Portal Quick Reference Guide for instructions.
**pa.performcare.org/assets/pdf/providers/claims-billing/echo-provider-payments-portal-quick-reference-guide.pdf**

Contact your practice management/hospital information system for instructions on how to receive ERAs from PerformCare under Payer ID 65391 and the ECHO Payer ID 58379. If your practice management/hospital information system is already set up and can accept ERAs from PerformCare, then it is important to check that the system includes both PerformCare and ECHO Health Payer ID 58379 for ERAs.

If you are not receiving any payer ERAs, please contact your current practice management/hospital information system vendor to inquire if your software has the ability to process ERAs. Your software vendor is then responsible for contacting Change Healthcare to enroll for ERAs under PerformCare and ECHO Health Payer ID 58379.

If your software does not support ERAs or you continue to reconcile manually, and you would like to start receiving ERAs only, please contact the ECHO Health Enrollment team at **1-888-834-3511**.

For enrollment support, please contact ECHO Health, Inc. at **1-888-834-3511**.

## Paper Claim Submission

Paper claims should be mailed to:
PerformCare
PA HealthChoices
P.O. Box 7308
London, KY 40742

Paper claims must be submitted on original pink and white CMS 1500 forms. Handwriting these forms is strongly discouraged for better, more accurate processing.

### CMS 1500 form and UB-04 form

Each claim form must indicate the member's diagnosis using ICD-10-CM diagnosis codes, as well as the procedures performed. When billing for professional services, there will be a CPT and HCPCS procedure code associated with the service. When billing for inpatient stays, there will be a DRG or a revenue code as appropriate. Reimbursement will be based on the PerformCare fee schedule provided through the contracting process or most recent update. The following section provides instructions for completing each accepted form. **Please be aware this instruction template has been updated since the last manual was published.**

Should any questions arise regarding the completion of these forms, please contact the PerformCare Claims Help Desk for assistance.

**CMS 1500 claim form completion guidelines paper submission**

| Block # | Required (R) Not required (N) Situational (S) | Instructions |
|---|---|---|
| 1 | R | Check applicable program (Medicaid) |
| 1a | R | Recipient Medicaid ID number |
| 2 | R | Patient's name (last name, first name, middle initial, as shown on the access card) |
| 3 | R | Patient's birth date (MMDDCCYY) and sex (check the box) |
| 4 | R | Insured name (SAME or "SAME AS PATIENT" is acceptable) |
| 5 | R | Patient's mailing address and phone number, including area code |
| 6 | R | Enrollee's relationship to insured (check box for self, spouse, child, other) |
| 7 | N | Enrollee address (number, apartment number, street, city, code, phone number with area code) |
| 8 | N | Enrollee's status (check boxes for single, married, other, employed, full-time student, part-time student) |
| 9 | S | Other enrollee name (last name, first name, middle initial) |
| 9a | S | Other enrollee policy or group |
| 9b | N | Reserved for National Uniform Claim Committee (NUCC) use |
| 9c | N | Reserved for NUCC use |
| 9d | S | Insurance plan name or program name, if applicable (**Do not list any Medicaid plans, schools, or county programs. This field is used only if the member has a primary Medicare or commercial carrier**.) |
| 10a – c | S | Enrollee's condition related to employment, auto accident, and other accident |
| 10d | S | Claim codes (designated by NUCC) |
| 11 | S | Insured policy, group or FECA number (if applicable) By completing this item, provider acknowledges having made good faith effort to determine if MA is primary or secondary payer. If item number 4 is completed, this field should be completed. |
| 11a | R | Insured date of birth |
| 11b | S | Other claim ID (designated by NUCC) |
| 11c | S | Insurance plan name or program name (if applicable) |
| 11d | R | Is there another health benefit plan? (**Only select yes if there is a primary Medicare or commercial carrier.**) |
| 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.)" |
| 13 | N | Insured or authorized person's signature |
| 14 | S | Date of current illness |
| 15 | S | Date of same or similar illness |
| 16 | S | Date client unable to work in current occupation |

| Block # | Required (R) Not required (N) Situational (S) | Instructions |
|---|---|---|
| 17 | R | Enter the name of the attending, prescribing or supervising physician (if required for your provider type) |
| 17a | N | **Enter the 9-digit MA provider number of the attending, prescribing or supervising physician** (if required for your provider type) |
| 17b | R | National Provider Identifier (NPI) of the **attending, prescribing or supervising physician** (if required for your provider type) |
| 18 | S | Hospitalization dates related to current services |
| 19 | R | ZZ qualifier and rendering taxonomy (if different from billing taxonomy 33b) |
| 20 | S | Required when billing for diagnostic tests |
| 21 | R | Diagnosis or nature of illness or injury (ICD-10-CM diagnosis code) |
| 22 | S | Medicaid resubmission code 7 corrected claim; 8 void claim/original claim number (must be billed if submitting a corrected claim or void) |
| 23 | S | Prior authorization number |
| 24a | R | Dates of service (note the start and end date — use one line per service per day) |
| 24b | R | Place of service (refer to the CMS 1500 manual at **www.nucc.org**) |
| 24c | N | EMG |
| 24d | R | Procedures, service, or supplies<br>Enter the applicable procedure codes and modifiers from PerformCare's fee schedule. |
| 24e | R | Diagnosis code<br>Enter the diagnosis reference number as shown in block 21 to correlate the diagnosis code to the procedure or service performed |
| 24f | R | Charges |
| 24g | R | Number of days or units |
| 24h | S | EPSDT family plan |
| 24i | R | ZZ qualifier (if billing rendering taxonomy in 24j) |
| 24j | R | The rendering taxonomy code (unshaded area) if different from billing provider and not listed in field 19 |
| 24j | R | The rendering NPI If rendering NPI is different from billing NPI |
| 25 | R | Federal tax ID number |
| 26 | R | Patient's account number |
| 27 | R | Accept assignment |
| 28 | R | Total charges<br>Enter the total sum of 24f lines 1 – 4 in dollars and cents |
| 29 | R | Amount paid by other insurance (if applicable)<br>Enter the total sum of 24k lines 1 – 4 in dollars and cents |

| Block # | Required (R) Not required (N) Situational (S) | Instructions |
|---|---|---|
| 30 | N | Reserved for NUCC use |
| 31 | R | Signature of physician/supplier of service and invoice date |
| 32 | R | Name and address of facility where services were provided (refer to the CMS 1500 manual at **www.nucc.org**) |
| **33** | **R** | **Supplier's billing name, address, ZIP code, and phone number** |
| **33a** | **R** | **Billing NPI** |
| **33b** | **R** | **ZZ qualifier and billing provider's taxonomy code** |

**UB 04 claim form completion guidelines paper submission**

| Block # | Required (R) Not required (N) Situational (S) | Instructions |
|---|---|---|
| 1 | R | Provider name, address, phone number |
| 2 | R | Pay-to name and address |
| 3a | R | Patient control number |
| 3b | S | Provider medical/health record number |
| 4 | R | Type of bill (refer to the UB-04 manual at **www.nubc.org**) |
| 5 | R | Federal tax number |
| 6 | R | Statement covers period (note a beginning and end date) |
| 7 | N | Reserved for assignment by the National Uniform Billing Committee (NUBC) |
| 8 | R | Patient name/identifier |
| 9 | R | Patient address |
| 10 | R | Patient birthdate |
| 11 | R | Patient's sex |
| 12 | R | Admission date (MMDDYY) |
| 13 | R | Admission hour (refer to the UB-04 manual at **www.nubc.org**) |
| 14 | R | Admission type (refer to the UB-04 manual at **www.nubc.org**) |
| 15 | R | Point of origin for admission or visit (indicates referral source) |
| 16 | R | Discharge hour (refer to the UB-04 manual at **www.nubc.org**) |
| 17 | R | Patient status (refer to the UB-04 manual at **www.nubc.org**) |
| 18 – 28 | S | Condition codes |
| 29 | R | Accident state |
| 30 | N | Reserved for assignment by the NUBC |
| 31 – 34 | R | Occurrence codes and dates |
| 35 – 36 | R | Occurrence span codes and dates |

| Block # | Required (R)<br>Not required (N)<br>Situational (S) | Instructions |
|---|---|---|
| 37 | N | Reserved for assignment by the NUBC |
| 38 | N | Responsible party name and address |
| 39 – 41 | R | Value codes and amounts (if applicable) |
| 42 | R | Revenue code (see PerformCare's fee schedule) |
| 43 | R | Revenue code description |
| 44 | S | HCPCS/rate |
| 45 | S | Service date (required for outpatient billing only; cannot be used for inpatient billing) |
| 46 | R | Service units |
| 47 | R | Total charges |
| 48 | S | Non-covered charges |
| 49 | N | Reserved for assignment by the NUBC |
| 50 | R | Payer identification<br>Enter the name of each payer organization from which you may anticipate payment. |
| 51 | R | Health plan identification number (if applicable) |
| 52 | R | Release of information certification indicator |
| 53 | R | Assignment of benefits certification indicator |
| 54 | S | Prior payments — amount paid by other insurance (if applicable) |
| 55 | N | Estimated amount due from patient |
| 56 | R | Billing NPI |
| 57 | N | |
| 58 | R | Insured's name (if applicable) |
| 59 | R | Patient's relationship to insured |
| 60 | R | Patient recipient number (10-digit Medical Assistance number) |
| 61 | S | Insurance group name (if applicable) |
| 62 | S | Insurance group number (if applicable) |
| 63 | R | Treatment authorization number |
| 64 | S (required when billing a corrected or void claim) | Original claim number |
| 65 | N | Employer name (of the insured) |
| 66 | R | Diagnosis and procedure code qualifier (ICD version indicator) |
| **67** | **R** | **Principal diagnosis code and present on admission indicator** |
| 67 A – Q | R | Other diagnosis code — secondary diagnosis (if applicable)<br>(ICD-10-CM diagnosis code) |

| Block # | Required (R)<br>Not required (N)<br>Situational (S) | Instructions |
|---|---|---|
| 68 | N | Reserved for assignment by the NUBC |
| 69 | R | Admission diagnosis code (ICD-10-CM diagnosis code) |
| 70 A – C | S | Patients reason for visit (required for outpatient) |
| 71 | S | Prospective payment system code (DRG) |
| 72 | S | External cause of injury (ECI) code |
| 73 | N | Reserved for assignment by the NUBC |
| 74 | S | Principal procedure code and date |
| 74 A – E | S | Other procedure codes and dates |
| 75 | N | Reserved for assignment by the NUBC |
| **76** | **R** | In the appropriate boxes, enter the NPI of the provider; the two-digit qualifier of G2; the nine-digit MA number; and the last name and first name. This can be the provider who ordered the admission or the provider who is responsible for determining the diagnosis or treatment of the patient. |
| 77 | R | Operating physician name and identifiers (including NPI) (if applicable) |
| 78 – 79 | S | Other provider names and identifiers (including NPI) |
| 80 | N | Remarks |
| 81 | R | B3 qualifier and billing provider's taxonomy code (no spaces or dashes) |

## Common billing errors

- **Paper claims must be submitted on original pink and white CMS 1500 forms. Handwriting these forms is strongly discouraged to avoid unnecessary delays in payment processing.**
- **NPI** is not registered with the PROMISe Medicaid Enrollment Number (see OMAP Bulletin Number 99-06-14: Instructions for Registering Your National Provider Identifier to DHS, issued November 22, 2006).
- Pay to **federal tax ID** is not up to date with the PROMISe Medicaid Enrollment Number.
- **Insured's ID number** — member's MAID/recipient number.
- **Diagnosis** (ICD-10 diagnosis codes only) — diagnosis should match the service you are billing (SA versus MH).
- **Place of service code** (must be valid for the service and provider type/specialty for the **rendering** provider).
- **Rendering provider** — the rendering NPI and taxonomy code if the rendering provider is different from billing and holds the license with the state to perform the service.
- **Billing provider:**
  - **CMS 1500**
    - » The billing NPI must always be provided in box 33a; the qualifier ZZ and billing taxonomy code must be in box 33b.

  - **UB-04**
    - The billing NPI must always be provided in box 56; the qualifier B3 and taxonomy code must be in box 81.
- **Qualifier:** The appropriate qualifier for a taxonomy code is ZZ for CMS 1500 and B3 for UB 04 claims.
- **Multiple-year claims:** Providers must bill separate claims when the dates of service span over a calendar year. This rule applies to medical and hospital claims.

As a reminder, per the November 2016 Provider Notice AD 16 106: Information System Update and Timeline, all claims, both CMS 1500 and UB 04, submitted electronically or on paper, must have a taxonomy along with the qualifier, in the appropriate boxes.

The review of the requirements are as follows:

- For paper CMS 1500 claims submission, qualifier and taxonomy should be listed in box 33b (billing information) and 24j (rendering provider). In addition, if using box 19 for the rendering provider, both qualifier and taxonomy should be listed. The qualifier for CMS 1500 paper submission is ZZ (Mutually Defined). For UB04 paper submission, the qualifier is B3 and should be listed in form locator 81 along with the appropriate taxonomy.
- For electronically submitted claims the taxonomy and qualifier should be PXC (health care provider taxonomy code):
  - **837P:**
    - Billing provider — Loop 2000A PRV Segment
    - Rendering provider — Loop 2310B PRV Segment
  - **837I:**
    - Billing provider — Loop 2000A PRV Segment

All electronic claims submissions must comply with HIPAA 5010 implementation Guide Standards. The standards and guidance are available at the Washington Publishing Company via **www.wpc-edi.com**.

## Claim Payment Disagreements

Please review EOBs closely to ensure you are paid correctly. It is the provider's responsibility to monitor payment that is received. In the event of a discrepancy, contact your Account Executive immediately.

PerformCare strongly suggests that providers bill their usual and customary charges rather than the rate indicated on the rate notice. In the event of a system or data entry error, this practice will help you avoid the need to resubmit corrected claims when the issue is resolved.

All claims payments will include an EOB. The EOB provides 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 PerformCare's Claims Provider Services at **1-888-700-7370**. A Customer Service Representative can help facilitate a review of the claims in question.

Please be prepared to provide the provider/facility name, provider/facility NPI, member name and ID number, CPT/Rev code, and DOS. Providers also have the option of submitting a claim inquiry via NaviNet. The new **Claim Inquiry** feature lets you request an adjustment and track responses on claims that were previously

finalized. For each submitted transaction, you will receive an electronic response to the claim inquiry. The response will indicate if the claim was adjusted or explain in detail why the claim was not considered for an adjustment. PerformCare encourages you to use the **Claim Inquiry** function. However, if you do not have NaviNet access, you can still contact Provider Services.

If the claim is denied as a result of a provider error that can be corrected, the Customer Service Representative will assist you in understanding the required corrections so you can resubmit 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 Account Executive can assist should you have questions about the process. PerformCare will complete the review within 30 business days. You will receive a written response to your request outlining the findings of the formal review. You must include all necessary information with your request because the decision of the reviewing committee is final.

## Claim Resubmission

### Resubmission of corrected claims

A corrected claim is defined as a claim that PerformCare paid incorrectly, either because the provider billed the wrong rate or number of units or PerformCare paid incorrectly. In cases where the resubmission serves to correct a claim that has already been paid, the claim must be clearly identified as a corrected claim and received within 365 days from date of service. Corrected claims may be submitted electronically through Change HealthCare or NaviNet or on paper submission to our London, Kentucky, claims address.

If there is an identified overpayment beyond 365 days from date of service, please send a refund check with documentation directly to the PerformCare Finance department at 8040 Carlson Road, Harrisburg, PA 17112.

**Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original PerformCare claim number.**

It is important to understand the difference between denied claims and rejected claims. Rejected claims are those returned without being processed or adjudicated. Rejected paper claims have a letter attached with a document control number (DCN). A DCN is not a PerformCare claim number. **Billing of a rejected claim should be done as an original claim.** If the claim was rejected, it is as if it never existed.

A corrected claim cannot be billed to change or correct the tax ID or the member name from what was originally billed. The claim would need to be submitted as an original claim under the correct tax ID. If the original claim was paid, a void claim should be submitted. **Note: A corrected claim cannot be submitted if the original claim denied for timely filing. Please follow the administrative appeal policy.** You can find the PerformCare claim number from the 835 ERA, the paper Remittance Advice or from the claim status search in NaviNet. If you do not have the PerformCare claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet to get the PerformCare claim number.

Corrected/replacement and voided claims may be sent electronically or on paper. If sent electronically, the claim frequency code (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values “7” for the replacement (correction) of a prior claim and “8” for the void of a prior claim. The value “6” should no longer be sent. In addition, the submitter must also provide the original PerformCare claim number in Payer Claim Control Number (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files). This is not a special requirement of PerformCare but rather a requirement of the mandated HIPAA Version 5010 Implementation Guide.

If the corrected claim is being submitted on paper, the claim needs to have the following to be processed as such: On a Professional CMS 1500 Claim, the resubmission code of "7" or "8" along with the PerformCare original claim number is required in Field 22. On an Institutional UB04 Claim, bill type should end in "7" or "8" Form Locator 4 and the PerformCare original claim number is required in Form Locator 64A Document Control Number. This field should only contain the PerformCare original claim number. If anything else is entered in this field the claim will reject.

**Unless you have an original PerformCare claim number, you may not resubmit a claim. Billing of a rejected claim is not considered a resubmission. Duplicate billing is not acceptable.**

**Paper claims must be submitted on original pink and white CMS 1500 forms. Handwriting the form is strongly discouraged for better, more accurate processing. Submit corrected paper claims to:**

**PerformCare**
**PA HealthChoices**
**P.O. Box 7308 London, KY 40742**

## TPL and Claims Submission

All Medicaid plans, including PerformCare, have a contractual obligation to ensure that a member's primary insurance is used first where applicable. All claims for members with Medicare or commercial insurance as the primary insurance must be billed with the EOB from that primary carrier attached (one EOB for one claim). If no EOB is attached, the claim will be denied as "missing EOB."

We understand there are services not covered by Medicare or commercial insurances. The following services are generally not covered by Medicare or Medicare Advantage plans, or are known to not be available for members under the primary insurers' networks, but are state Medicaid plan services in HealthChoices and covered by PerformCare. These services are exempt from the requirements to bill the primary Medicare insurer.

- IBHS (except when ACT 62 or ABA coverage applies)
- Residential treatment services for children and adolescents
- Targeted case management, FBMHS, crisis intervention services, and assertive community treatment teams
- Clozapine/Clozaril support services
- Non-hospital-based partial hospitalization programs (drug and alcohol and mental health)
- Substance use non-hospital services (withdrawal management, residential treatment, and halfway house)
- Drug and alcohol outpatient services
- Peer support services
- Mobile mental health treatment

Except in accordance with Act 62, which provides coverage for certain services to children with a diagnosis on the autism spectrum and ABA (discussed below), the following services are generally not covered by primary commercial insurances. Except for members who have a primary insurance and a diagnosis on the autism spectrum, these services are exempt from EOB requirements from the primary commercial insurer.

- IBHS (non-ABA)
- Residential treatment services for children and adolescents
- Targeted case management, FBMHS, crisis intervention services, and community treatment teams
- Clozapine/Clozaril support services
- Methadone maintenance
- Substance use non-hospital services (halfway house only)
- Peer support services
- Mobile mental health treatment

Note: Substance use non-hospital withdrawal management and residential treatment services still require EOBs from the primary commercial insurer.

Please be aware that providers must be Medicare-enrolled or enrolled in the commercial insurance plans in order to bill PerformCare for non-exempt services provided to members with Medicare or commercial insurance as a primary payer. Do not accept members with Medicare or commercial insurance as primary coverage until you have qualified Medicare- or commercial insurance-enrolled clinicians available to provide treatment.

We strongly encourage providers to become enrolled in the Medicare program or commercial insurance. Information about the enrollment process for Medicare is attached for your convenience. Enrollment information is also available online at **www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp**.

Providers are expected to make all reasonable efforts as required per MA enrollment to secure payment from the primary source (§1101.64 MA Manual), including assignment of clinicians that meet the primary insurer's credentialing requirements. PerformCare will not override TPL requirements for services provided that would have been paid by the primary payer had it been provided by a clinician who met criteria of the primary payer, when the provider has available such certified clinicians on staff, because the provider is not in network or because the provider did not follow proper authorization requirements for the primary insurance. This expectation applies to all services rendered at either the primary clinic site, satellite sites, or any location that is recognized as a place of service by the provider.

Special consideration is given when Medicare is the primary payer and there is documented evidence that there is not a provider of the required service within HealthChoices access standards. Commercial insurance is subject to the same access standards under Pennsylvania Department of Health regulations as PerformCare; thus, the commercial insurer is expected to fulfill its obligation to make payment for services included in their plan. If there is clinical support to bypass the TPL process, providers will be instructed to submit all claims on paper with an attached document. Further instruction will be provided as needed.

When submitting claims to PerformCare as a secondary payer, the EOB from the primary insurer must be attached to the claim when billing paper. Whether billing paper or electronically, **claims must be received within 60 days of your notification of payment or denial by the primary insurance company**.

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

## Act 62 and Third-Party Liability

Background: Coverage for autism services has changed since PA implemented Act 62 in July of 2008. Previous Act 62 TPL rules for PerformCare included exemptions for certain federal and out-of-state plans as well as self-funded plans. However, those TPL exemptions are no longer applicable in all cases. The conversion to IBHS and the use of ABA codes for members with or without a diagnosis of autism requires coordination of benefits and billing primary insurance plans because many commercial insurance plans cover ABA services. Medicaid remains the payer of last resort for these services and requires coordination of benefits. PerformCare is in the process of clarifying TPL non-covered service documentation requirements and updating our ACT 62 materials on our website, including our Provider Manual, but providers should use these TPL EOB requirements effective immediately.

1) ACT 62 and ABA Denial Letters and Explanation of Benefits: Providers must submit one denial or non-covered letter per CPT code billed per calendar year. The claim with EOB can be submitted via paper submission and mailed to:

**PerformCare of Pennsylvania**
HealthChoices
P.O. Box 7308
London, KY 40742

Claims can also be submitted electronically with the appropriate denial explanation code. After the denial is submitted and on file, providers can submit directly to PerformCare as primary for the remainder of the calendar year.

2) Tricare covers autism services, so exemptions for ACT 62 are not applicable to Tricare. Providers should attempt to become credentialed by Tricare if serving members with Tricare as primary insurance.
**https://tricare.mil/CoveredServices/IsItCovered/AutismSpectrumDisorder**

3) Insurance plans in all 50 states offer coverage for autism services. While there are variations and limitations to that coverage, a blanket exemption for out-of-state plans for members with a diagnosis of autism as originally permitted under ACT 62 implementation is no longer applicable, and TPL coordination of benefits with primary payers must be explored even for out-of-state plans.
**www.disabilityscoop.com/2019/10/01/autism-insurance-coverage-now-required-50-states/27223/**

**www.ncsl.org/research/health/autism-and-insurance-coverage-state-laws.aspx**

4) Self-funded insurance plans in Pennsylvania continue to be exempt from ACT 62, but may pay for ABA services (**www.autismspeaks.org/self-funded-health-benefit-plans**). Forty-five percent of companies with more than 500 employees include coverage for ABA or other intensive behavioral therapies, according to the Mercer National Survey of Employer-Sponsored Health Plans. Most companies of this size provide self-funded plans.

5) Providers billing any IBHS codes for a member with a diagnosis of autism that may be subject to ACT 62 requirements and/or providers billing any ABA codes regardless of diagnosis must coordinate benefits with the member's primary insurance plan, including attempting to come in-network with the insurance plan. As services have transitioned from BHRS to IBHS, providers should be working to ensure that they are credentialed with each member's primary insurance plan and working with families to develop a transition plan for any situations where they are unable to become credentialed. However, PerformCare expects that there will be no sudden interruptions in service and should notify the Clinical Care Manager in cases where a plan needs to be developed for a family to transition to a new provider covered by the primary plan.

6) Members with private insurance being newly referred to a provider for ABA services should be directed to an in-plan provider with that private insurance for the service if ABA is a covered service.

**Please reference Provider Notice IBHS 21 103: IBHS TPL/EOB Clarifications.**

Because of the unique requirements of Act 62, autism service providers must follow procedures for both MA and private insurers. For example, providers should request prior authorization from both PerformCare and the private insurance company (if prior authorization is required from the private insurer.) DHS did not create special rules for autism services. Therefore, for those members and services that are applicable, providers should follow the existing TPL regulation (Title 55 §1101.64 concerning third-party medical resources). The procedure codes covered as Act 62 services are subject to cost avoidance. This means that the MA program through PerformCare should not pay a provider for services unless the private insurer denies the service. More specifically, certain denial reasons are not acceptable for PerformCare to pay per the existing TPL regulations.

Common reasons for non-payment by PerformCare include but are not necessarily limited to the following:

- Failure to follow the proper authorization procedures of the primary insurer
- Failure to follow the proper billing procedures of the primary insurer
- Accepting a member and providing service when the provider is out-of-network and no out-of-network benefits are available through the primary carrier. If a provider refuses to join the private insurance network of the MA recipient, PerformCare is not required to pay the provider for the service. The MA recipient cannot refuse to use available private insurance to avoid a copayment, deductible, or coinsurance.
- Families should not intentionally disenroll from private insurance. By law, MA is a government program and is the designated payer of last resort. As a condition of MA eligibility, the enrollees are agreeing to use other available insurance resources first. Families that intentionally drop private insurance coverage are at risk of losing continued MA coverage.

## Expectations for PerformCare's Response to Claims Submission

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

**If you have not heard from PerformCare within 30 days after you sent the claim in, please contact the Claims Help Desk at 1-888-700-7370 to inquire on the status of the claim or check the claim status through NaviNet, as this will indicate whether or not the claim was received.** 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 provider/facility name, NPI, contact name, call back number, member's name and identification number, the procedure codes, and the dates of service and claim number if available for which you are billing. **Again, if you have not heard from PerformCare on a claim within 30 days of the date you believe it was submitted, contact PerformCare immediately as this may indicate that the claim was not received. Providers may also use NaviNet to check the status of claims at any time.**

### Claims Appeals

Claims appeals are subject to the administrative appeal process (review of administrative denial) described in Chapter V: Provider Relations Services. No claim that is 365 days old or older will be considered for payment regardless of the circumstances. Providers must have an internal auditing system to ensure that claims are submitted timely.

## Appendix A: Frequently Asked Questions

#### Provider Enrollment and Related Questions

##### How can I become a network provider?

All providers go through the credentialing process, which begins by completing an in-plan expansion application. Providers may obtain an application package by contacting Provider Relations at **1-888-700-7370**. All providers must be licensed and enrolled and in good standing within the Pennsylvania MA program.

##### How do I enroll with the Pennsylvania MA program?

All PerformCare HealthChoices providers must be enrolled in the Pennsylvania MA program. Providers can visit DHS' website at **www.dhs.pa.gov** or call the OMAP Enrollment Toll-Free Inquiry line at **1-800-537-8862**, **option 1** for more information on fee-for-service enrollments. To check the status of your application to be a MA provider, call **1-800-537-8862**, **option 1** but allow at least 45 days from the date the application was submitted. Please note that OMAP does not handle all types of enrollments. OMHSAS enrolls ICM, RC, BCM, FBMH, and crisis intervention services. For those enrollments, contact the behavioral health services line at **1-800-433-4459**. PerformCare's Provider Relations department assists with supplemental service enrollment when appropriate.

##### What if I cannot accept any new referrals or other changes occur that affect my ability to see members?

It is important that you tell your Account Executive 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. PerformCare will need the information in written form via fax **1-717-671-6522** or mail. A Provider Data Update Form may be used and is available on the PerformCare 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 Account Executive 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 credentialing application for enrollment. Please contact the Account Executive to request an application. If you are a provider with a license from OMHSAS to provide behavioral health services or with a license from DDAP to provide drug and alcohol services, you are probably categorized as a facility provider. If you are an individual clinician who works exclusively for a facility, it is not necessary to complete the individual application for enrollment. Please be certain to notify PerformCare if you have a new prescribing practitioner. Failure to enroll new ordering, referring, and prescribing providers in Medicaid may lead to problems when members get prescriptions filled. Except in the case of a supplemental service, anytime there is a change, DHS must also be notified.

## Clinical Operations and Authorization Questions

### How do I request authorization?

All services except crisis intervention, targeted case management and outpatient (psychiatric evaluation, psychological evaluation, medication management, family, individual, and group therapy) and substance use hospital and non-hospital withdrawal management require approval from a Clinical Care Manager before they are provided. Hospital withdrawal management does not require prior approval; however, it is important to contact the Clinical Care Manager prior to discharge so that an authorization can be generated for billing these services. Current authorization request forms as well as instructions for completing forms can be found on the PerformCare website under **Forms**. Inpatient psychiatric hospitalization and acute partial hospitalization require a phone call to PerformCare. You will have access to a live person 24 hours per day, seven 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 business days, depending on mail service. If you have questions about the status of your authorization request, you may contact PerformCare at **1-888-700-7370** or check authorization status through NaviNet. 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 ensure that all authorization requests are submitted per PerformCare 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 the 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 inquiries.

### What do I do if a member wants to go to a different provider?

As a provider, you are responsible for providing the member with other provider options and/or referring the member to PerformCare if they require additional information or experience any problems with transferring providers.

### 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 PerformCare 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 PerformCare. 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 30 days of the authorization request denial or date of service denial.**

#### How will I know about changes in authorization processes and other procedures at PerformCare?

PerformCare will share this information with providers through provider notices. Provider notices should be regarded as supplements and clarifications to the PerformCare Provider Manual and are considered incorporated by reference into the Provider Manual when they are issued. All such communications can be found on the website in the **Providers** section and are available for download.

### What do I do if a member needs emergency services?

PerformCare expects the provider to take immediate action to ensure the safety of the member and others. PerformCare should be contacted for service authorization at **1-888-700-7370** 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 to result in:

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

The lead clinician 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

#### When do I submit a claim for payment?

Claims must be received within 60 days from the date of service.

### When will I get paid?

A minimum of 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 XII: Claims and Claims Disputes of this manual. If you have not heard from PerformCare within 30 days of the date you believe you submitted the claims, call the Help Desk immediately at **1-888-700-7370**, as this may be an indicator that PerformCare has not received your claim.

**What if I have a question about my claim?**

PerformCare has a Claims Help Desk that is staffed from 8 a.m. to 4:30 p.m. each weekday. The phone number is **1-888-700-7370**.

**How do I check member eligibility?**

PerformCare is responsible for behavioral health services for HealthChoices members residing in Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, and Perry counties.

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

Providers should check the member's eligibility by using EVS at **1-800-766-5387** at no cost to you. When calling EVS, be prepared to supply your provider MA ID and the member's identification number and date of birth. You can check eligibility 24 hours per day, seven 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 at **1-800-233-7768** and TES at **1-800-843-5237**, **ext. 5604**. PROMISe ready Provider Electronic Solutions Software is also available at the DHS website or by calling the Provider Assistance Center at **1-800-248-2152**.

## Appendix B: Prior Authorization Requirements by Service

Prior Auth = MN decision and authorization required

Registration = Form/call and authorization required

No Auth/Unmatched = Pass thru and no authorization needed

Step down = Code can be billed under other service authorization

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| 00104 | Mental Health | ECT | ECT | ECT | Pre-Auth |
| 0114 | Mental Health | MH Inpatient | MHIP | MHIP | Pass-thru |
| 0124 | Mental Health | MH Inpatient | MHIP | MHIP | Pre-Auth |
| 0126 | Substance Use | SU W/D Mgmt | Hosp W/D Mgmt | Hosp W/D Mgmt | Pre-Auth |
| 0128 | Substance Use | SU Hosp | SU Hosp | SU Hosp | Pre-Auth |
| 0134 | CHILDREN'S ONLY | RTF | RTF JCAHO | RTF JCAHO | Pass-thru |
| 0154 | CHILDREN'S ONLY | RTF | RTF JCAHO | RTF JCAHO | Pre-Auth |
| 0204 | Mental Health | MH Inpatient | EAC | EAC | Pre-Auth |
| 90785 | Mental Health | MH Outpatient | Therapy | Interpreter | Add-on |
| 90785 | Substance Use | SU Outpatient | SU Therapy | Interpreter | Add-on |
| 90791 | Mental Health | Eval/Mngement | Eval/Mngement | Eval | Pass-thru |
| 90791 | Substance Use | SU Outpatient | SU Outpatient | Eval | Pass-thru |
| 90791EP | CHILDREN'S ONLY | IBHS Eval | IBHS Eval | IBHS Eval | Pass-thru |
| 90791UB | Mental Health | Eval/Mngement | Eval/Mngement | Eval | Pass-thru |
| 90792 | Mental Health | Eval/Mngement | Eval/Mngement | Eval | Pass-thru |
| 90792 | Substance Use | SU Outpatient | SU Outpatient | Eval | Pass-thru |
| 90792UB | Mental Health | Eval/Mngement | Eval/Mngement | Eval | Pass-thru |
| 90832 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90832 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90832HK | Mental Health | MH Outpatient | Therapy | DBT | Pass-thru |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| 90832HR | Mental Health | MH Outpatient | Therapy | PCIT | Pass-thru |
| 90832U5 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90832UB | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90833 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90833 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90834 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90834 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90834HK | Mental Health | MH Outpatient | Therapy | DBT | Pass-thru |
| 90834HR | Mental Health | MH Outpatient | Therapy | PCIT | Pass-thru |
| 90834U5 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90834UB | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90836 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90836 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90837 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90837 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90837HK | Mental Health | MH Outpatient | Therapy | DBT | Pass-thru |
| 90837HR | Mental Health | MH Outpatient | Therapy | PCIT | Pass-thru |
| 90837U5 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90837UB | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90838 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90838 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90846 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90846HR | Mental Health | MH Outpatient | Therapy | PCIT | Pass-thru |
| 90846UB | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| 90847 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90847 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90847HR | Mental Health | MH Outpatient | Therapy | PCIT | Pass-thru |
| 90847U5 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90847UB | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90849 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90853 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90853 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90853HK | Mental Health | MH Outpatient | Therapy | DBT | Pass-thru |
| 90853HR | Mental Health | MH Outpatient | Therapy | PCIT | Pass-thru |
| 90853UB | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90870 | Mental Health | ECT | ECT | ECT | Pre-Auth |
| 90875 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90875 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90875UB | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90876 | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 90876 | Substance Use | SU Outpatient | SU Therapy | Therapy | Pass-thru |
| 90876UB | Mental Health | MH Outpatient | Therapy | Therapy | Pass-thru |
| 95822 | Mental Health | MH Outpatient | Other | EEG | Pre-Auth |
| 95827 | Mental Health | MH Outpatient | Other | EEG | Pre-Auth |
| 96101TG | Mental Health | Testing | Psych Test | Psych Test | Pre-Auth |
| 96102TG | Mental Health | Testing | Psych Test | Psych Test | Pre-Auth |
| 96116 | Mental Health | Testing | Neurobehavioral Test | Neurobehavioral Test | Pre-Auth |
| 96118 | Mental Health | Testing | NeuroPsych Test | NeuroPsych Test | Pre-Auth |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| 96118UB | Mental Health | Testing | NeuroPsych Test | NeuroPsych Test | Pre-Auth |
| 96119 | Mental Health | Testing | NeuroPsych Test | NeuroPsych Test | Pre-Auth |
| 96121 | Mental Health | Testing | Neurobehavioral Test | Neurobehavioral Test | Pre-Auth |
| 96127 | Mental Health | MH Outpatient | Screen | Screen | Pass-thru |
| 96130 | Mental Health | Testing | Psych Test | Psych Test | Pre-Auth |
| 96131 | Mental Health | Testing | Psych Test | Psych Test | Pre-Auth |
| 96132 | Mental Health | Testing | NeuroPsych Test | NeuroPsych Test | Pre-Auth |
| 96133 | Mental Health | Testing | NeuroPsych Test | NeuroPsych Test | Pre-Auth |
| 96136 | Mental Health | Testing | Psych Test | Psych Test | Pre-Auth |
| 96137 | Mental Health | Testing | Psych Test | Psych Test | Pre-Auth |
| 96138 | Mental Health | Testing | Psych Test | Psych Test | Pre-Auth |
| 96139 | Mental Health | Testing | Psych Test | Psych Test | Pre-Auth |
| 96150 | Mental Health | MH Outpatient | Intervention | Intervention | Pass-thru |
| 96151 | Mental Health | MH Outpatient | Intervention | Intervention | Pass-thru |
| 96152 | Mental Health | MH Outpatient | Intervention | Intervention | Pass-thru |
| 96153 | Mental Health | MH Outpatient | Intervention | Intervention | Pass-thru |
| 96154 | Mental Health | MH Outpatient | Intervention | Intervention | Pass-thru |
| 96155 | Mental Health | MH Outpatient | Intervention | Intervention | Pass-thru |
| 97151 | CHILDREN'S ONLY | IBHS ABA | IBHS ABA | IBHS Assess | Pass-thru |
| 97153 | CHILDREN'S ONLY | IBHS ABA | IBHS ABA | BHT ABA | Pre-Auth |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| 97154 | CHILDREN'S ONLY | IBHS ABA | IBHS ABA | Group ABA BHT | Pre-Auth |
| 97155 | CHILDREN'S ONLY | IBHS ABA | IBHS ABA | BC ABA | Pre-Auth |
| 97155 | Mental Health | MH Outpatient | Eval | ASD Consultant | Pre-Auth |
| 97156 | CHILDREN'S ONLY | IBHS ABA | IBHS ABA | BC ABA | Step Down |
| 97158 | CHILDREN'S ONLY | IBHS ABA | IBHS ABA | Group ABA | Pre-Auth |
| 99201 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99201 | Substance Use | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99201UB | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99202 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99202 | Substance Use | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99202UB | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99203 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99203 | Substance Use | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99203UB | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99204 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99204 | Substance Use | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99204UB | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99205 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99205 | Substance Use | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99205UB | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| 99211 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99211 | Substance Use | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99211UB | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99212 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99212 | Substance Use | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99212UB | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99213 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99213 | Substance Use | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99213UB | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99214 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99214 | Substance Use | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99214UB | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99215 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99215 | Substance Use | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99215UB | Mental Health | Eval/Mngement | Eval/Mngement | Med Check | Pass-thru |
| 99221 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99222 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99223 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99231 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99232 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99233 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99238 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99241 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| 99242 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99243 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99244 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99245 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99251 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99252 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99253 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99254 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99255 | Mental Health | Eval/Mngement | Eval/Mngement | IP Consult | Pass-thru |
| 99281 | Mental Health | Eval/Mngement | Eval/Mngement | ER Consult | Pass-thru |
| 99282 | Mental Health | Eval/Mngement | Eval/Mngement | ER Visit | Pass-thru |
| 99283 | Mental Health | Eval/Mngement | Eval/Mngement | ER Visit | Pass-thru |
| 99284 | Mental Health | Eval/Mngement | Eval/Mngement | ER Visit | Pass-thru |
| 99285 | Mental Health | Eval/Mngement | Eval/Mngement | ER Visit | Pass-thru |
| 99291 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99292 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99304 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99305 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99306 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99307 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99308 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99309 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99310 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| 99341 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99342 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99343 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99347 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99348 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99349 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Pass-thru |
| 99401 | Mental Health | Crisis | Crisis | Bridge | Pass-thru |
| 99407 | Substance Use | SU Outpatient | Smoke Cess | Smoke Cess | Pass-thru |
| 99417 | Mental Health | Eval/Mngement | Eval/Mngement | Consult | Add-on |
| 99417 | Substance Use | Eval/Mngement | Eval/Mngement | Consult | Add-on |
| G0437 | Substance Use | SU Outpatient | Smoke Cess | Smoke Cess | Pass-thru |
| G2067 | Substance Use | SU Outpatient | SU Outpatient | Methadone | Pass-thru |
| G8942 | CHILDREN'S ONLY | IBHS MST | IBHS Individual | MST | Pass-thru |
| G9012 | Substance Use | SU Outpatient | SU Outpatient | COE Case Management | Pass-thru |
| H0001 | Substance Use | SU LOC Assessment | SU LOC Assessment | SU LOC Assessment | Pass-thru |
| H0004HE | CHILDREN'S ONLY | FBMH | FBMH | FBMH | Pre-Auth |
| H0004HF | Substance Use | SU Outpatient | SU Other | SU Other | Pre-Auth |
| H0004HK | CHILDREN'S ONLY | FBMH | FBMH | FBMH | Step-Down |
| H0004HT | CHILDREN'S ONLY | FBMH | FBMH | FBMH | Step-Down |
| H0004U7 | CHILDREN'S ONLY | FBMH | FBMH Exception | SPIN | Pre-Auth |
| H0004U7 | CHILDREN'S ONLY | IBHS SPIN | IBHS Individual | SPIN | Pre-Auth |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| H0004UK | CHILDREN'S ONLY | FBMH | FBMH | FBMH | Step-Down |
| H0006 | Substance Use | D&A TCM | D&A TCM | D&A TCM | Registration |
| H0006TF | Substance Use | D&A TCM | D&A TCM | D&A RC | Registration |
| H0013 | Substance Use | SU W/D Mgmt | NH W/D Mgmt | NH W/D Mgmt | Registration |
| H0013HE | Substance Use | SU W/D Mgmt | NH W/D Mgmt | NH W/D Mgmt | Registration |
| H0015 | Substance Use | SU IOP | SU IOP | SU IOP | Registration |
| H0018HF | Substance Use | SU Residential | SU Residential | SU RES ST | Pre-Auth |
| H0018HFHE | Substance Use | SU Residential | SU Residential | SU RES ST, Dual | Pre-Auth |
| H0019HA | CHILDREN'S ONLY | CRR | CRR | CRR_HH | Pre-Auth |
| H0019HE | CHILDREN'S ONLY | CRR | CRR | CRR_HHI | Pre-Auth |
| H0019HEHK | CHILDREN'S ONLY | CRR | CRR | CRR_ITP | Pre-Auth |
| H0019HQ | CHILDREN'S ONLY | CRR | CRR | CRR_GH | Pre-Auth |
| H0019SC | CHILDREN'S ONLY | RTF | RTF Non-JCAHO | RTF Non-JCAHO | Pre-Auth |
| H0020 | Substance Use | SU Outpatient | SU Outpatient | Methadone | Pass-thru |
| H0022 | Substance Use | SU Outpatient | SU Other | Intervention | Pass-thru |
| H0030 | Mental Health | Crisis | Crisis | Hotline | Pass-thru |
| H0031 | CHILDREN'S ONLY | IBHS | MH Assess | MH Assess | Pass-thru |
| H0031UB | Mental Health | Mobile Psych Nursing | Mobile Psych Nursing | Mobile Psych Nursing | Registration |
| H0032 | CHILDREN'S ONLY | IBHS Individual | IBHS Individual | BC | Pre-Auth |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| H0034 | Mental Health | Eval/Mngement | Eval/Mngement | Med Check Nurse | Pass-thru |
| H0034 | Substance Use | SU Outpatient | SU Outpatient | Med Check Nurse | Pass-thru |
| H0034HK | Mental Health | Clozapine | Clozaril Support | Clozaril Support | Pass-thru |
| H0034UB | Mental Health | MH Outpatient | Eval/Mngement | Med Check Nurse | Pass-thru |
| H0035HA | Mental Health | MH PHP | MH PHP | MH PHP | Pre-Auth |
| H0035HAHK | Mental Health | MH PHP | MH PHP | MH PHP | Pre-Auth |
| H0035HB | Mental Health | MH PHP | MH PHP | MH PHP | Pre-Auth |
| H0035HBHK | Mental Health | MH PHP | MH PHP | MH PHP | Pre-Auth |
| H0036 | Mental Health | MH Outpatient | Psych Rehab | Psych Rehab | Registration |
| H0037 | Mental Health | MH Outpatient | Therapy | AOP | Pre-Auth |
| H0038 | Mental Health | Peer Support | Peer Support | Peer Support | Registration |
| H0038HF | Substance Use | Certified Recovery Specialists | CRS | CRS | Registration |
| H0039HB | Mental Health | ACT | ACT | ACT | Pre-Auth |
| H0039HE | Mental Health | ACT | ACT | ACT | Pre-Auth |
| H0039UB | Mental Health | MH Outpatient | Other | Other | Pre-Auth |
| H0046HW | Mental Health | MH Outpatient | Other | Other | Pre-Auth |
| H0046SC | CHILDREN'S ONLY | IBHS IDT | IBHS Group | IDT | Pre-Auth |
| H0046U5 | CHILDREN'S ONLY | FBMH | FBMH Exception | JFACTS | Pre-Auth |
| H0046U5 | CHILDREN'S ONLY | IBHS JFACTS | IBHS Individual | JFACTS | Pre-Auth |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| H0046UB | Mental Health | Mobile Psych Nursing | Mobile Psych Nursing | Mobile Psych Nursing | Registration |
| H0047HW | Substance Use | SU Outpatient | SU Other | SU Other | Pass-thru |
| H2010HK | Mental Health | Clozapine | Clozaril Support | Clozaril Support | Pass-thru |
| H2011 | Mental Health | Crisis | Crisis | Crisis Walk-In | Pass-thru |
| H2014 | CHILDREN'S ONLY | IBHS Individual | IBHS Individual | BHT-A&A | Step-Down |
| H2015 | CHILDREN'S ONLY | IBHS ASP/ Stepping Stones | IBHS Group | ASP | Pre-Auth |
| H2015HA | CHILDREN'S ONLY | IBHS STAP | IBHS Group | STAP | Pre-Auth |
| H2019 | CHILDREN'S ONLY | IBHS Individual | IBHS Individual | MT | Pre-Auth |
| H2019HA | CHILDREN'S ONLY | IBHS FFT | IBHS Individual | FFT | Pre-Auth |
| H2019U1 | CHILDREN'S ONLY | IBHS Individual | IBHS Individual | MT-FLEX | Pre-Auth |
| H2021 | CHILDREN'S ONLY | IBHS EIBS | IBHS ABA | EIBS | Pre-Auth |
| H2021U6 | CHILDREN'S ONLY | IBHS EIBI | IBHS ABA | EIBI | Pre-Auth |
| H2021HQ | CHILDREN'S ONLY | IBHS Group | IBHS Group | IBHS Group | Pre-Auth |
| H2021EP | CHILDREN'S ONLY | IBHS Individual | IBHS Individual | BHT | Pre-Auth |
| H2030 | Mental Health | Psych Rehab | Psych Rehab | Psych Rehab | Registration |
| H2033 | CHILDREN'S ONLY | IBHS MST | IBHS Individual | MST | Pre-Auth |
| H2034 | Substance Use | SU HWH | SU HWH | SU HWH | Pre-Auth |
| H2034HE | Substance Use | SU HWH | SU HWH | SU HWH, Dual | Pre-Auth |
| H2035 | Substance Use | SU PHP | SU PHP | SU PHP | Pre-Auth |

| Core Code | Type | Level Of care | Mode | Service description | AuthReq |
|---|---|---|---|---|---|
| S9484 | Mental Health | Crisis | Crisis | Mobile | Pass-thru |
| S9485 | Mental Health | Crisis | Crisis | Mobile | Pass-thru |
| T1015HE | Mental Health | MH Outpatient | Therapy | Clinic visit | Pass-thru |
| T1015HF | Substance Use | SU Outpatient | Therapy | SU Clinic visit | Pass-thru |
| T1016 | Mental Health | TCM | TCM | TCM Under 21 | Registration |
| T1016HT | CHILDREN'S ONLY | FBMH | FBMH | FBMH | Step-Down |
| T1016UK | CHILDREN'S ONLY | FBMH | FBMH | FBMH | Step-Down |
| T1017TF | Mental Health | TCM | RC | RC | Registration |
| T1017TG | Mental Health | TCM | ICM | ICM | Registration |
| T1017UC | Mental Health | TCM | Blended | Blended | Registration |
| T1040 | Mental Health | MH Outpatient | Other | Other | Pass-thru |
| T2048HF | Substance Use | SU Residential | SU Residential | SU RES LT | Pre-Auth |
| T2048HFHE | Substance Use | SU Residential | SU Residential | SU RES LT, Dual | Pre-Auth |

This handbook may be updated with additional text provided by the Department of Human Services or other information we feel is important for you to know.

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