



Provider Manual

TABLE OF CONTENTS

I.	Introduction and Overview	1
	A. CommCare	1
	B. Quick Reference Guide	2
	C. Missouri Medicaid Managed Care and CommCare Contracts	3
	D. Health Plan Lock-In	3
	E. Provider Communications with Medicaid Recipients	3
II.	CommCare Members Rights and Responsibilities	4
III.	Eligibility and Benefits	5
	A. Eligibility Guidelines	5
	B. Explanation of Benefits	9
	C. Substance Abuse Services and CSTAR	10
	a. Western Region CSTAR Service Providers	10
	D. Diagnosis Not Covered Under Behavioral Health Benefit	10
IV.	Access to Services	11
	A. Member Choice of Provider	11
	B. Appointment Standards	11
	1. Family Health Partners	11
	2. Blue Advantage Plus	11
	C. Out-of-Network Services	12
	D. Communication with Primary Care Provider – FHP	12
	E. Communication with Primary Care Provider – BA+	12
	▪ Report to Primary Care Provider	13
V.	Pre-Certification/Prior Authorizations	14
	A. Provider Responsibilities	14
	B. Pre-Certification (Initial Review) for Facility-based Care	14
	C. Prior Authorization for Outpatient Office Visits	15
	D. Concurrent Review Process	15
	▪ Outpatient Authorization Request Form	16
	E. Confidentiality	18
	F. CMHC Interface with Facilities and Case Managers	18
	▪ Interface with Patients and Facilities	18
	▪ High-Risk Case Management	19
	▪ Notification Form for High-Risk Members	20

G. Psychological Testing Pre-Certification	21
VI. Claims Processing	21
A. Claims Filing Instructions.....	22
B. Place of Service Codes.....	27
C. Billing Codes	27
D. Coordination of Benefits (COB).....	28
VII. Complaint/Grievance and Appeals	28
A. Appeal Process.....	28
B. Complaints/Grievances/Inquiries.....	30
VIII. Quality Improvement.....	34
A. Overview	34
B. Provider Contracts.....	34
C. Confidentiality.....	34
D. Reporting to Regulatory Agencies.....	35
E. Annual Evaluation.....	35
F. Medical Records	35
IX. Medical/Surgical Services by Payer	37
A. Family Health Partners.....	37
B. Blue Advantage Plus	37
X. Definitions	37

I. Introduction and Overview

A. CommCare

The Community Network for Behavioral Healthcare, Inc. (CommCare) is a regionally based, not-for-profit, provider-sponsored, behavioral healthcare organization that offers managed care, employee assistance program, and consultation services to private employers, health maintenance organizations, insurance companies, and government agencies. CommCare was formed in 1995 by eight community mental health centers (CMHCs), three substance abuse agencies (SAAs), and an acute care state hospital.

CommCare's Network is composed of over 500 Providers in 25 counties in Missouri's Western region. Our continuum of care ranges from inpatient through outpatient mental health treatment, and includes an array of wraparound services. CommCare's method of delivering treatment is based on a community approach, while incorporating the concepts and principles of managed care. We strive to provide clinically sound, consumer-friendly and cost-effective behavioral healthcare services. We customize services to meet the needs of the payer and have particular expertise with managing Medicaid and other vulnerable populations. The primary advantage that CommCare has in the behavioral health field is the experience and the types of services that are required to treat public sector populations.

CommCare has attempted to provide current and accurate information in this manual to assist you in providing services to our Members and their families. Please call CommCare if you have any questions.

B. CommCare Managed Medicaid Quick Reference Guide for Mental Health Services

Family Health Partners (managed by CommCare)	
Member (Access) telephone numbers	800-409-2225
Requests for Authorization	800-409-2225
Authorization Request Fax Line	816-300-4228
ACI Crisis Line (24/7 Emergency)	888-279-8188
Member Services/Eligibility	800-347-9363
Claims Inquiry	913-362-0040 X4766
Complaints and Grievances	816-472-9012 (ask for Dir. Of UM)
Blue Advantage Plus (managed by New Directions)	
Member (Access) telephone number	913-982-8404
Requests for Authorization	913-982-8404 or 1-800-943-5558
Authorization Request Fax Line	913-982-8199 or 1-888-979-9272
Member Services/Inquiry	913-982-8404
Claims Inquiry	913-362-0040 X4766
Complaints and Grievances	913-982-8404
CommCare Contacts	
Justin Vana – V.P. of Clinical Operations	816-472-9012
Brian Baker – Director of UM	816-472-9012
Laurie Cox – Provider Relations	816-472-9012
Damon Horton - Credentialing	816-472-9012
CommCare Mental Health Case Managers	800-409-2225
Claims Mailing Address (all Managed Medicaid claims)	Epoch P.O. Box 399 Shawnee Mission, KS 66201-0399
CommCare Website	http://www.commcare1.org

C. Missouri Medicaid Managed Care and CommCare Contracts

The Missouri Medicaid Program implemented a managed care system in 1995. Healthcare is managed by Health Maintenance Organizations (HMOs) in three regions: Eastern, Central, and Western. The HMOs are responsible for the delivery of both physical health and behavioral health services. CommCare provides the behavioral health services for Members of two HMOs in the Western Region:

- Family Health Partners (FHP): CommCare is responsible for Utilization Management, Quality Improvement, claims adjudication, and credentialing
- Blue Advantage Plus (BA+): CommCare's Provider Network is contracted to deliver behavioral health services; New Directions authorizes the care for reimbursement.

D. Health Plan Lock-In

In the first 90 days following the initial enrollment into a Medicaid HMO, Members may change health plans for any reason. Members can also change a federally qualified HMO every six (6) months following their effective date of enrollment.

Managed Medicaid Members and 1115 Waiver Expansion populations have a 12-month lock-in to provide a solid continuum of care. After the initial 90-day period, the Member is only allowed to change health plans, without cause, every 12 months.

E. Provider Communications with Medicaid Recipients

As a health plan subcontractor, CommCare's Providers shall not conduct or participate in eligibility, enrollment, disenrollment, transfer, or SSI "opt out" activities.

Prohibited activities include:

- Requiring or encouraging the Medicaid Beneficiary to apply for an assistance category not included in Managed Medicaid;
- Requiring or encouraging the recipient and/or guardian to use the SSI "opt out" as an option in lieu of delivering Managed Medicaid health plan benefits;
- Mailing or faxing Managed Medicaid enrollment forms;
- Assisting a Medicaid recipient in filing out Managed Medicaid enrollment forms;
- Photocopying blank Managed Medicaid enrollment forms for potential Members;
- Distributing blank Managed Medicaid enrollment forms;
- Allowing recipient to use a Provider's phone to enroll or change Managed Medicaid health plans from a Provider site;

- Participating in three way calls to an enrollment counselor;
- Suggest Member transfer to another health plan;
- Other activities of enrolling a Member in a particular health plan or in any way assisting a Member to enroll in a health plan (their own or another).

II. CommCare Member's Rights and Responsibilities

Member's Rights

Members have the right to be treated with dignity and respect as individuals who have personal needs, feelings, preferences and requirements.

Members have the right to equal services and access to treatment, regardless of race, religion, gender, ethnicity, age, disability or source of payment.

Members have the right to privacy in their treatment and in fulfillment of their personal needs.

Members have a right to be treated by staff and Providers in a language they understand.

Members have the right to be fully informed of all services available at a Facility or in a continuum of care, of any changes or limitations on those services and available alternative treatment.

Members have the right to be provided an individualized treatment plan and to participate with their therapist in treatment planning decisions.

Members have the right to receive information about CommCare's services, Providers and *Care Management Guidelines* (medical necessity criteria).

Members have the right to be fully informed of all diagnostic and treatment procedures in order to give informed consent.

Members have the right to refuse treatment to the extent permitted by law without compromising their access to CommCare's services. However, Providers retain the right to discontinue treatment should the Member's refusal make responsible treatment impossible.

Members have the right to continuity of care as long as they remain eligible for services through the designated health plan.

Members have the right to voice opinions, recommendations and Grievances with respect to policies and services provided by any CommCare Provider.

Members have the right to appeal a denial of a level of care or a denial of reimbursement of a service.

Members have the right to confidential treatment of the clinical record. Information will be released only with their consent, except in an emergency or as required by law.

Member's Responsibilities

Members have the responsibility to provide, to the extent possible, information that CommCare needs to render appropriate care.

Members have the responsibility to participate in the development of treatment goals with their Providers.

Members have the responsibility to follow the plans and instructions for care upon which they have agreed with their Providers.

Members have the responsibility to keep their appointments and be on time.

Members have the responsibility to ask their Providers questions so that they understand the care and instructions they are given.

Members have the responsibility to take any prescribed medication as instructed and to report to their Provider any side effects they experience.

Members have the responsibility to follow CommCare's Grievances and Appeals Process if they are unhappy with the care from their Providers.

Members have the responsibility to contact CommCare with any questions regarding their care and these rights and responsibilities.

Members have the responsibility to treat Providers with respect.

III. Eligibility and Benefits

A. Eligibility Guidelines

In order to receive benefits, Missouri Medicaid recipients **MUST** join a Medicaid HMO if they are in one of the designated categories. The recipient's *Medical Eligibility (ME) Code* indicates whether he or she is included in the Managed Medicaid system. Each recipient's ME Code is available when checking eligibility through Missouri Medicaid's Automated Response Unit (1-800-392-0938) or Point of Service Terminal. (*A 9-digit Medicaid Provider number is needed to access the Automated Response Unit.*)

Included Recipients

- **Group I:** AFDC (caretakers and children) refugees and the Medicaid for Children population

ME Codes: 05; 06; 10; 17; 19; 20; 21; 22; 24; 25; 26; 27; 40; 48; 49; 50; 51; 60; 62; 63; 64

- **Group II:** Pregnant Women

ME Codes: 18; 43; 44; 45; 46; 47; 61

- **Group IV:** Children in State Custody*

**Note: Behavioral Health Services for Group IV is Fee-For-Service to Medicaid and not part of the Medicaid HMO; however, medical services for this Group will remain managed by the HMO.*

ME Codes: 07; 08; 28; 29; 30; 31; 32; 33; 34; 35; 36; 37; 38; 39; 52; 56; 57; 66

Co-payments for Groups I, II, IV

Co-payments for behavioral health services do not apply to Managed Medicaid Members in groups I, II, and IV; however, the recipient portion of pharmacy dispensing fees are collected according to current Medicaid policy.

- **Group V (CHIP)**

This group was added to respond to the expansion of healthcare coverage through Title XXI of the Social Security Act that established a new Children’s Health Insurance Program (CHIP). In Missouri, health care coverage has been expanded to provide coverage to uninsured children under the age of 19 from families with income up to 300% of the federal poverty level. To be considered uninsured, a child must have been without insurance coverage six (6) months prior to application.

ME Codes: 71; 72; 73	Co-pay is <u>not</u> required
74	Co-pay of \$5.00 <u>is</u> required for office visits
75; 76	Co-pay of \$10.00 <u>is</u> required for office visits

Group V Co-pay Requirements

The co-pay requirements for children with ME Codes “74” and “75” applies to both fee-for-service (traditional Medicaid) individuals and health plan Members. The provider of service is responsible for collecting the co-pay from the clients. Providers may deny services for children in ME Code “74” and “75” if the recipient does not co-pay by the third visit.

Procedures Requiring Co-pay

Provider Type: Psychiatrist/Psychologist/Licensed Clinical Social Worker/Licensed Professional Counselor and Clinical Nurse Specialist.

- Co-pay is to be collected at each visit. The exception to this is for procedure codes 90801 and 96100. It is only applied once per episode of care up to a maximum of six times per year for 90801 and a maximum of eight (8) times per year for 96100. If a co-pay for an office visit (99201) is collected, then a co-pay for 90801 cannot also be collected on the same day.

Excluded Recipients

- Medicaid eligible individuals who are permanently and totally disabled (ME Code: 04)
- Individuals eligible and receiving both Medicare Part A and Part B benefits
- Residents of a State Mental Institution, Intermediate Care Facility for the Mentally Retarded or Nursing Home (ME Codes: 14; 13; 16; 11)
- Pregnant Women who are eligible under the Temp Program (ME Codes: 58 and 59)
- Individuals eligible for Blind Pension or Aid to the Blind (ME Codes: 2; 3; 12; 15)
- Mentally Retarded Developmentally Disabled Waiver participants, not in state custody

Managed Medicaid Covered Population						
FHP Plan	Category of Assistance	Medical Eligibility Codes	ME Code Descriptions			
1	AFDC Adult (ADCA)	05	ADC Caretaker (ADC-AD)			
	AFDC Children (ADCC)	06	ADC Dept (ADC-CD)			
	Medicaid For Children (MPC)	40	Medicaid for Children			
		48	Refugee Poverty Child			
		49	DMH-Poverty			
		50	DYS-Poverty			
		51	HDN-Poverty (consent)			
		60	Newborn			
		62	MFC Health Initiative Fund			
		63	CWS Health Initiative Fund			
		64	CWS Health Initiative Fund (HIF only)			
		Refugee	10	Vietnamese Refugee		
			17	Indochinese AFDC		
			19	Cuban Refugee		
			20	Cuban Refugee AFDC		
			21	Haitian Refugee		
	22		Haitian AFDC			
	24		Russian Jew Refugee			
	25		Russian Jew AFDC			
	26		Ethiopian Refugee			
	27		Ethiopian AFDC			
	2		Medicaid for Pregnant Women (MPW)	18	Preg Women	
				43	Preg Woemen-60 days postpartum	
				44	Preg Women-60 days poverty	
		45		Preg Women-Poverty		
		46		Preg Women – Refugee Poverty		
		47		Preg Women-60 days Refugee Poverty		
4	AFDC Foster Care (ADCF)	07	AFDC Foster Care (consent)			
	Child Welfare Services (CWS)	56	Adoption Subsidy-4# Elig (consent)			
		08	CWS-FC (consent)			
		57	Adoption Subsidy-Homeless (consent)			
	Mental Health Not-covered by Managed Medicaid for Group IV	Division of Youth Services (DYS) Title XIX Homeless, Dependent, Neglected Children (HDN)	66	Consent		
			52	DYS-GR		
			28	Division MH (DMH) – FC		
			29	Division YS (DYS) – FC		
			30	JC-FC		
			31	Psych State - 22		
			32	Psych Private – 22		
			33	ICF/MR – under 128		
			34	ICF only – under 18		
			35	Adoption Subsidy-IV-E		
			36	Adoption Subsidy-FFP (consent)		
			37	Title XIS-FFP/HDN (consent)		
			Group V		38	AFDC-UP
					39	NON-DPS Medicaid
	A	1115 Waiver Children				
	B	1115 Waiver Children				
	C	1115 Waiver Children	71	1115 Waiver Up to 185% PL		
	D	1115 Waiver Children	72	1115 Waiver Up to 185% PL		
	E	1115 Waiver Children	73	1115 Waiver Up to 185% PL		
	F	1115 Waiver Adults/TANF	74	1115 Waiver 186% - 225% PL		
	G	1115 Waiver Children	75	1115 Waiver 226% - 300% PL		
	H	1115 Waiver Adults/TANF	76	1115 Waiver 226%- 300% PL		
	I	1115 Waiver Adult Non-Custodial	77	1115 Waiver 226% -300% PL		
	1115 Adults PFS	78	1115 Waiver 226% - 300% PL			
	1115 Adults Custodial	79	1115 Waiver 226%-300% PL			

B. Explanation of Benefits

To ensure that Managed Medicaid Members have access to CommCare's full array of services, it is essential that CommCare's Providers utilize our *Care Management Guidelines*. The Guidelines detail the Medical Necessity criteria for each of the services and identify the procedure codes to be used when submitting claims. **There are no inpatient day or outpatient visit limitations for this population.** Certification of a mental health service is contingent upon meeting Medical Necessity criteria.

Behavioral health services of children in the care and custody of the state will be reimbursed on a fee-for-service basis by the state Medicaid plan and are not managed by CommCare.

It is important for CommCare's Providers to monitor those children served who fall under the Jackson County Consent Decree as they move in and out of foster care. (While in foster care, services are paid fee-for-service and when discharged from foster care, an HMO will manage their benefits).

Targeted Case Management

Targeted Case Management Services for mental health services are not managed by CommCare and may be billed to the state by a Medicaid Provider on a fee-for-service basis according to the terms and conditions of the Medicaid program.

CPRP, Wraparound and Respite Services

The Department of Mental Health, Division of Comprehensive Psychiatric Services (CPS) contractors may provide and invoice DMH for CPRP, Wraparound and Respite Services provided to Seriously Emotionally Disturbed children and youth who are Managed Medicaid Members and who otherwise qualify for, and could benefit from, these services.

It is important for the Provider to remember that Members can only access Targeted Case Management, CPRP, and other CPS funded wraparound services from their assigned Community Mental Health Center, which is determined by their census tract address.

C. Substance Abuse Services and CSTAR

Services provided by a Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) Provider (type 86) are not the responsibility of the HMOs providing Managed Medicaid services. CSTAR services have been "carved-out" of Managed Medicaid and will be reimbursed on a fee-for-service basis according to guidelines established by the Missouri Division of Alcohol and Drug Abuse.

Populations served by CSTAR include pregnant women, women and children, adolescents and men eligible and receiving Medicaid benefits.

Members seeking CSTAR services will be provided a list of CSTAR Providers from which to choose.

Inpatient detoxification services will remain the responsibility of the health plan.

Western Region – CSTAR Service Providers	
Community Mental Health Consultants, Inc. 815 South Ash Nevada, MO 64772 Telephone: 417-667-8352 Fax: 417-667-9216 Certified Programs: CSTAR-General Population, Outpatient	Preferred Family Healthcare, Inc. 900 East LaHarpe Street, P.O. Box 767 Kirksville, MO 63501-0767 Telephone: 660-665-1962 Fax: 660-665-3989 Certified Programs: Compulsive Gambling, CSTAR-Adolescent, General Population, Outpatient, Prevention-Primary
Comprehensive Mental Health Services 10901 Winner Road, P.O. Box 520169 Independence, MO 64052 Telephone: 816-254-3652 Fax: 816-254-9243 Certified Programs: Compulsive Gambling, CSTAR-Adolescent, Women/Children, Detoxification-Social Setting, Outpatient, Residential-More than 30 days	ReDiscover 901 NE Independence Avenue Lee's Summit, MO 64086 Telephone: 816-246-8000 Fax: 816-246-8207 Certified Programs: Compulsive Gambling, CSTAR-General Population, Women/Children
Pathways Community Behavioral Healthcare, Inc. 1800 Community Drive, P.O. Box 507 Clinton, MO 64735 Telephone: 660-885-8131 Fax: 660-885-2393 Certified Programs: Adolescent, Compulsive Gambling, CSTAR-Adolescent, General Population, Detoxification-Social Setting, Information and Referral, Outpatient, Prevention-Primary, Residential-Less than 30 days	Scott Greening Center for Youth Dependency, Inc. 2750 Cherry, P.O. Box 410021 Kansas City, MO 64108-0021 Telephone: 816-474-7677 Fax: 816-474-7671 Certified Programs: CSTAR-Adolescent

D. Diagnoses Not Covered under Behavioral Health Benefits

Disease Category	DSM-IV
Delirium, Dementia, and Amnestic and other Cognitive Disorders **	Delirium (293.1 – 780.090) Dementia (290.XX – 294.8) Amnestic (294.0 – 294.8) Other Cognitive Disorders (294.9)
Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence	Mental Retardation (317 –319) Learning Disorders (315.00, 315.1, 315.2, 315.9) Motor Skills Disorder (315.4) Communication Disorders (315.31, 315.39, 307.0, 307.9) Pervasive Developmental Disorders (299.00, 299.10, 299.80) *** Feeding and Eating Disorders (307.52 – 307.59) Tic Disorders (307.22, 307.21, 307.20) * Elimination Disorders (787.6, 307.7, 307.6)
Mental Disorders Due to a General Medical Condition Not Elsewhere Classified	293.89, 310.1, 293.9 **
Substance-Related Disorders	Caffeine-Related Disorders (305.90, 292.89, 292.9) Nicotine-Related Disorders (305.10, 292.0, 292.9)
Sexual and Gender Identity Disorders	Sexual Desire Disorders (302.71, 302.79) Sexual Arousal Disorders (302.72) Orgasmic Disorders (302.73, 302.74, 302.75) Sexual Pain Disorders (302.76, 306.51) Sexual Dysfunction Due to a General Medical Condition (625.8, 608.89, 607.84, 625.0, 302.70) Paraphilias (302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.3, 302.82, 302.9)
Sleep Disorders **	Dyssomnias (307.42, 307.44, 347, 780.59, 307.45, 307.47) Parasomnias (307.47, 307.46, 307.47) Other Sleep Disorders (780.XX)

*If OCD related, psychiatric services may be appropriate

**Medical rule out required; Psychiatric consultation appropriate

***Psychiatric consultation appropriate

IV. Access to Services

A. Member Choice of Provider

Health plan Members have “freedom of choice” to access any Providers within CommCare’s Network. The Member must be able to receive Medically Necessary services from the selected Provider. If the Provider cannot deliver any of the Covered Services to the Member, then it is the responsibility of that Provider to assist the Member in obtaining the services from another CommCare Provider by calling CommCare for assistance (1-800-409-2225).

B. Appointment Standards

1. CommCare Providers are required to meet the following appointment standards for Managed Medicaid members managed by CommCare (Family Health Partners):

- Emergency Services
 - Life-Threatening Immediate
 - Non-Life Threatening Within 6 Hours
- Urgent Within 24 Hours
- PCP Referrals Within 3 Days
- Routine Appointments Within 7 Days Preferred
Must be within 21 days
- Patient Discharged from
Facility-based Services Within 7 Days

2. CommCare Providers are required to meet the following appointment standards for Managed Medicaid Members in **Blue Advantage Plus**:

- Emergency Services
 - Life-Threatening Immediate
 - Non-Life Threatening Within 6 Hours
- Urgent Within 24 Hours
- All Routine and Patients
Discharged from
Facility-based Services Within 7 Days

C. Out-of-Network Services

When a Member presents to an out-of-network Provider with an emergency situation, that Provider will remain responsible for delivering care until the Member can be safely transferred to a Provider in CommCare's Network.

Behavioral health services delivered by an out-of-network Provider for other than Emergency Services are not covered under the Member's behavioral health benefit.

D. Communication with Primary Provider – Family Health Partners

CommCare's philosophy is one of promoting continuity of care. Toward this goal, Providers are required to communicate with the Member's Primary Care Providers (PCPs), unless it is documented that the Member declines to sign a release of information. Please inform the Member that coordinating his or her care with the PCP is critical to the integration of mental health and medical care. This communication to the PCP assists in avoiding medication incompatibility and alerts the PCP to the emotional needs of the patient.

CommCare's PCP Report Form (see next page) is to be completed at the time of admission and discharge and updated to reflect significant changes in the Member's treatment plan or medication regime. This is a contractual requirement.

E. Communication with Primary Care Provider – Blue Advantage Plus

When healthcare providers make a concerted effort to communicate with one another, the patient invariably benefits. Of course, the patient must first give written authorization. With this in mind, BA+ encourages Providers to help patients understand the important reasons for sharing information with the PCP. Likewise, patients should be encouraged to ask their PCPs to share information with their behavioral healthcare Provider.

The BA+ forms authorizing services for behavioral healthcare contain questions related to communication with PCPs.



CONFIDENTIAL
REPORT TO PRIMARY CARE PROVIDER
 Date Of Report _____

TO: PCP/Center Name		
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE:	FAX:	

BEHAVIORAL HEALTH INFORMATION

FROM:		
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE:	FAX:	

Yes, notify the PCP No, do not notify the PCP

PATIENT INFORMATION

Patient:	DOB: ____ / ____ / ____
Insurance/ID #	

The above-named patient is currently receiving mental health/substance abuse services.

Date of Initial Visit: ____/____/____ Initial Report Interim Report Termination Report

Presenting Program: _____

Treatment Plan/Recommendation:		
Medications:		
Axis I	Axis III	Axis V
Axis II	Axis IV	

 (Provider Signature)

 (Patient Signature)

This Form is considered to be confidential.

V. Pre-Certification/Prior Authorization

(For BA+ Members, follow instructions found in your New Directions Provider Manual.)

A. Provider Responsibilities

Members may access behavioral health services in three ways:

1. Direct contact with a CommCare Provider;
2. Calling CommCare's toll-free telephone line **(1-800-409-2225)**; or
3. Through a referral from a Primary Care Provider or other agency (e.g., DFS, Juvenile Court, etc.)

Except for Emergency Services, the Provider must verify eligibility and enrollment status of the Member, prior to rendering any services.

Providers are required to obtain prior authorization by calling CommCare (except where a different procedure has been specifically established).

All Facility-based services require pre-certification by calling CommCare. (1-800-409-2225).

Facility-based services include:

- Inpatient Services
- 23-Hour Observation
- Sub-Acute Program (Children only)
- Partial Hospital Program Services
- Intensive Outpatient Services
- Rapid 3-Day Evaluation (Children only)

B. Pre-Certification (Initial Review) for Facility-Based Care

It is the responsibility of the Provider to call CommCare to pre-certify Facility-based care. The following is an outline of the information that will be required when you call to pre-certify.

1. Caller's Name and Phone Number
2. Member's Name and DCN #
3. Facility Name
4. Admitting Physician
5. Date of Admission
6. Level of Care
7. Precipitating Event/Stressors
8. Currently in Treatment/History of Treatment
9. Family System
10. Clinical Information
 - Mental Status
 - Substance Abuse History
 - Danger to Self and Others

- Precautions
- Physical/Medical Concerns
- Medications
- Diagnosis

The CommCare Mental Health Case Manager (MHCM) will review the clinical information using the Care Management Guidelines. If Medical Necessity criteria are met, appropriate days are authorized. A Certification letter will be sent, within one working day, to the Provider.

If the MHCM cannot certify the care, the case will be referred to CommCare's Medical Director who may consult with the attending physician. Alternate services may be suggested.

C. Prior-Authorization for Outpatient Office Visits

Providers are required to obtain prior authorization for all outpatient services (except where a different procedure has been specifically established.) This can be accomplished by either phone or fax. Please utilize the outpatient authorization request form on the next page. Feel free to reproduce this page for your use. You may call in the information to CommCare's Case Manager using the form or you may complete the form and fax it to CommCare at 816-300-4228. CommCare will send an authorization letter within two working days.

All authorizations and therapy visits will need to be renewed prior to their expiration date. Medication check referrals will be authorized for the calendar year.

D. Concurrent Review Process

CommCare's MHCM will request a Concurrent Review of Facility-based services on the last certified day. Information needed for both inpatient and outpatient reviews includes:

- Medication changes and responses to medications
- Current signs and symptoms (mental status)
- Current treatment plan: Treatment plans are expected to demonstrate clear, specific goals and objectives, with measurable outcomes and identified target dates. Authorization requests to CommCare should reflect progress toward each goal and objective.
- Family involvement/situation
- Discharge plan and expected date of discharge



OUTPATIENT AUTHORIZATION REQUEST FORM

**FAX REQUEST TO (816) 300-4228 OR
CALL 1-800-409-2225**

Provider _____ Date _____

Address where services provided _____

Facility/Group Name _____

Phone _____ Fax _____

CLIENT NAME	DCN, SSN or DOB
DIAGNOSIS: Axis I	Axis I
Axis II	Axis III
Axis IV	Current Axis V (GAF) Last Year

Lethality Risk Low or None Contracted for safety Otherwise addressed (specify) _____

Substance Abuse _____

Community or other resources utilized _____

Medications have been considered Yes No (If not prescribed, why) _____

Prescribed by PCP Psychiatrist Other Declined by Patient

Current symptoms, relevant tx hx, personal resources _____



Behavioral tx goals 1) _____

Progress: _____

2) _____

Progress: _____

3) _____

Progress: _____

REQUEST (check appropriate box to indicate number and type of visits requested)	
<input type="checkbox"/> 5 – 90862’s	<input type="checkbox"/> 6 – 90806’s
<input type="checkbox"/> 6 – 90807’s	<input type="checkbox"/> 6 – 90847’s
<input type="checkbox"/> Other (specify)	
Frequency (e.g. weekly)	Date to start this authorization

Number of Authorized sessions to date _____ Expected number of sessions until termination _____

Date client first seen (under CommCare) _____

-Would your client benefit from supportive phone calls from a CommCare Mental Health Case Manager?

Yes (Phone Number _____) No

-Have you sent the client’s “Report to the Primary Care Provider”? Yes No

If “no” why not?: _____

Provider Signature: _____

THE INFORMATION ON THIS FORM IS CONFIDENTIAL

As previously mentioned, the MHCs will review the clinical information using the Case Management Guidelines and will certify additional inpatient days when Medical Necessity criteria are met. If the requested days cannot be certified, the case will be referred to the Medical Director who may consult with the attending physician.

Hospital liaison personnel from a CMHC and/or a CommCare MHCM may make an onsite visit to the Facility to review the case with the Facility staff and, when possible, meet with the patient to discuss discharge planning.

Discharge Plan

Prior to discharge a detailed plan will be developed in conjunction with the Member and the Provider responsible for post-discharge follow-up. A follow-up appointment must be scheduled within seven (7) days of discharge from an inpatient facility. If a member is moving to an alternate level of Facility-based services (e.g., partial hospitalization), that level of care must also be pre-certified by CommCare.

E. Confidentiality

CommCare abides by all applicable federal and state regulations governing the release of behavioral health information.

The health plans must have access to Members' clinical records, as required by regulatory bodies, to perform audits.

A release of information signed by the Member or by the Member's parent/guardian is required from any other individual, including the PCP, requesting to review the patient's clinical record.

CommCare Providers must meet HIPAA standards.

F. Community Mental Health Center (CMHC) Interface with Facilities and CommCare Case Managers

- *Interface with patients and facilities:* Within one (1) working day of pre-certification, the CommCare Case Manager will notify the appropriate CMHC representative that one of their Members has been admitted to a Facility-based level of care.

It is expected that the CMHC responsible for the Member will become involved in the care of the patient and discharge planning will begin immediately. This may require facilitating discharge planning and making an onsite visit. It is expected that the CMHC contact will communicate closely with the CommCare Case Manager.

Follow-up outpatient appointments for Members being discharged from Facility-based care must occur within seven (7) days of discharge.

CommCare requires that this be documented in Case Management notes by the CommCare Case Manager. At times, it may be appropriate for the CommCare Case Manager to be involved in planning sessions, either at the hospital or at the CMHC. The CommCare Case Manager will call patients to ensure that they know of appointments, have adequate transportation, and have followed-up with their prescriptions.

- *High Risk Case Management:* It is expected that Members who fall under the parameters of High Risk Case Management will receive intensive Case Management from both the CommCare Case Manager and the appropriate CMHC clinical staff. Parameters of High Risk Case Management include, but are not limited to the following:
 - Patients readmitted within 30 days of discharge
 - Patients receiving Facility-based care
 - Adults or children who are Seriously and Emotionally Disturbed (SED) and who meet criteria for permanent, total disability
 - Members who also have serious medical issues
 - Members with suicidal or homicidal past or present behavior
 - Children who are in The Missouri Alliance for Children and Families Case Management Organization (CMO)

The following form must be completed and faxed to CommCare as notification of Members in need of High Risk Case Management.

CommCare
Notification Form for
High-Risk Members

You must fax to CommCare this notice on individual patients having any of the clinical parameters noted below when they first access your services. Keep a copy in the Member's chart.

Check all that apply:

- Long-term diagnoses with documented exacerbation of symptoms more frequently than once a year. Example: Schizophrenia, Bipolar Affective Disorders, Multiple Personality Disorders, and Eating Disorders.
- Members that are resistant to treatment. Example: Members receiving multiple psychotropic medications and who have not responded to conventional outpatient treatment.
- Members with serious medical management problems. Example: HIV, diabetes, cancer, and chronic fatigue syndrome.
- Any referral to partial hospital, intensive outpatient, home health, or a treatment modality not within the Member's contract.
- Members identified as high-risk through any other methodology currently being employed by you and/or CommCare to identify high-risk Members.
- Complex cases. Examples: abuse history, DFS involvement, school suspension, homicidal ideation or attempt history, co-morbid medical problems.
- Request by a Provider or Member for preventive services due to high-risk for inpatient or residential treatment services.

Patient's Name _____ DCN Number _____

Patient's Address _____ Patient's Phone Number _____

Patient/Guardian Name _____

Services Receiving From You (Regardless of funding source)

Fax to:

CommCare (816) 300-4228

_____ Date/Time

_____ Your Name

G. Psychological Testing Pre-Certification

- All Psychological Testing requires Pre-Certification through CommCare.
- Providers must demonstrate that a thorough clinical interview and observation have taken place prior to a request for testing.
- Providers must indicate how a test will answer a particular clinical question and specify how the test results will affect treatment planning.
- Requests for more than one test of one type (e.g., two projective or two personality inventories) require clear justification.
- Only licensed psychologists will be certified to conduct Psychological Testing.

Information the Case Manager will request when you call for Pre-Certification:

- What tests do you want to perform?
- What clinical questions are you attempting to answer by Psychological Testing and how will the results guide treatment?
- Which tests will answer which questions?
- How many hours are you requesting for administration, scoring, and review of these tests?

VI. Claims Processing

All Providers are required to submit appropriate claim forms or encounter forms (CMS or HCFA 1500 for outpatient services, UB 92 for inpatient) for all services. All Providers, including those paid under a capitation reimbursement methodology, are also required to submit in a timely manner for data purposes.

- **Claims submitted after 180 days from the date of an outpatient service or the date of a hospital discharge will be denied for lack of timely filing.**
- Claims submitted **must** reference a prior authorization number issued by CommCare (except where a different procedure has been specifically established).
 - The date of service must be within the authorization period.
 - The service code must match the authorized service code.
 - The Provider must be a member of CommCare's Provider Network.
 - The Member must be eligible for services at the time of service.
 - The submitted authorization number must match the prior authorization number.

- It is strongly recommended that the Member’s eligibility be verified on the day the service is to be rendered. Reimbursement of services is contingent on the Member’s eligibility at the time of the service.
- All claims are to be submitted to:

Epoch
 PO Box 399
 Shawnee Mission, KS 66201-0399

Claims Inquiries

Claims inquiries may be made by calling 913-362-0040 extension 4766, or by writing to the address above.

If you believe a claim has been incorrectly reimbursed or denied, call the above Claim Inquiry line. If you are attempting to resubmit a claim or to expedite the processing of a claim, please include a copy of the original claim form and a copy of the Explanation of Payment (EOP) Report received with the original claim reimbursement. This request should be made within 30 days of the original claim payment.

A. Claims Filing Instructions

COMPLETING THE CMS 1500 CLAIM FORM

All office visit claims must be filed on the CMS 1500 or HCFA 1500 claim form.

The following is a description of each section of the CMS1500 Claim Form.

CMS 1500

1. Type of health insurance coverage	Check appropriate box, usually group health plan or other
1A. Insured’s ID number	Enter the certificate number shown on the Member’s ID card, including any letters
2. Patient’s name	Last, first, middle initial
3. Patient’s date of birth and gender	Include month/day/year (02/13/1970)
4. Insured’s name	List the name printed on the identification card
5. Patient’s complete address	As requested
6. Patient’s relationship to Member	As requested
7. Insured’s address	Complete only if the patient’s address is different from that of the person named on the ID card
8. Patient status	Check appropriate boxes

9A-D. Other insurance coverage (Remember: Medicaid is the payer of last resort)	If the patient has a Medigap policy, enter information according to Medicare guidelines. If the patient has insurance with more than one company, enter as much information as is available to you. At minimum, enter the name and address of the employer through whom the other coverage was obtained
10A. Was condition related to patient's employment?	Check appropriate box
B. Was condition related to an auto accident?	Check appropriate box
C. Was condition related to another accident?	Check appropriate box
D. Reserved for local use	Leave blank
11A-D. Insured's policy group number	If the patient has health insurance coverage with more than one company, list as much information as possible here
12. Patient's or authorized person's signature	Signature on file
13. Authorization of payment to physician	Leave blank
14. Date of illness, injury, accident	Enter date of accident, last menstrual period or onset of illness. (Do not repeat date of service for patients receiving continuing treatment – Use onset date)
15. If patient has had same or similar illness, give first date	Enter month, day and year the patient first consulted you for this condition (MMDDYY)
16. Dates patient unable to work in current occupation	Leave blank
17A. Name and identification number	Enter the name of the referring physician or Primary Care Physician
18. Hospitalization dates related to current services	Leave blank
19. Reserved for local use	Leave blank
20. Outside lab	As requested
21. Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis code(s). Report codes to the fourth or fifth character, as defined by the ICD9. List primary diagnosis first
22. Medicaid resubmission code	Leave blank
23. Prior authorization number	Obtain from CommCare

24A. Date of service	Include date of each service. “From” and “to” dates are acceptable, if the number of services is consecutive and is given in the “days or units” column and all SERVICES ARE EXACTLY THE SAME
B. Place of service	For each service, indicate one of the POS codes (See page 37)
C. Type of service	Include the three-digit code which identifies a specific category of service
D. Procedure code	Enter the appropriate code which best describes the services rendered; include any necessary modifiers. If you need to describe an unlisted code or an unusual circumstance, use an attachment
E. Diagnosis code	Reference the appropriate diagnosis code used in Box 21 for each procedure
F. Charges	List your total charge for each service
G. Days or units	If “from and to” dates were used in 24A, report the number of services here. (Anesthesia claims report time in units of time: 1 unit – 15 minutes)
H. EPDST	Leave blank
I. EMG	Leave blank
J. COB	Leave blank
K. Reserved for local use	Leave blank
25. Federal Tax ID Number	Required
26. Your patient’s account number	If you list this number, it will be printed on your voucher
27. Accept assignment	Not required
28. Total charge	Enter the total of charges listed on 24F
29. Amount paid	Not required by Epoch
30. Balance due	Leave blank
31. Signature of physician	Physician’s name, typed, stamped, or computer printed and date
32. Name and address of Facility where services were rendered	Enter name of hospital, skilled nursing facility, or location where all or a portion of the services were rendered outside your office or the patient’s home
33. Physician’s name, address, zip code and phone number	

CMLS 1500 Minimum Required Fields

Field #	Description
#1	Type of Coverage
#1a	Insured's ID #
#2	Patient Name
#3	Patient's D.O.B.
#4	Insured's Name
#5	Patient's Address
#6	Patient's Relationship to Insured
#7	Insured's Address
#9	Other Insured's Name
#9a	Other Insured's Policy or Group Number
#9b	Other Insured's D.O.B.
#9c	Other Insured's Employer Name or School Name
#9d	Other Insured's Insurance Plan Name or Program Name
#10a-d	Is Patient's Condition Related to:
#11	Insured's Policy Group or FECA Number
#11a	Insured's D.O.B.
#11b	Insured's Employer Name or School Name
#11c	Insured's Insurance Plan Name or Program Name
#11d	Is there another Health Benefit Plan?
#12	Patient's Signature or Signature on file
#13	Insured's Signature or Signature on file
#21	Diagnosis or Nature of Illness
#23	Prior Authorization Number
#24a, b, c, d, e, f, g	Service Information
#25	Federal Tax ID Number
#26	Patient's Account Number
#28	Total Charge
#30	Balance Due
#31	Signature of Provider (Including Credentials)
#32	Name and Address of Facility Where Services Were Rendered
#33	Physician's, Supplier's Billing Name, Address, Zip Code If applicable

Completing the UB Claim Forms

Each claim form must, at minimum, contain the following information:

Required Data	Inpatient UB 92	Outpatient UB 92
Provider Identification Data (Name, Billing Name, Address)	1	1
Provider's Internal Control Number	3	3
Type of Bill Code (UB 92's only)	4	4
Provider's Tax Identification Number	5	5
Statement Covers Period (From and Through: MMDDYY)	6	6
Patient's Name	12	12
Patient's DOB (UB 92= MMDDYYYY; HCFA 1500 = MMDDYY)	14	14
Patient's Sex (M = Male; F = Female)	15	15
Inpatient Admission Date	17	N/A
Admit Type Code (UB 92 Only)	19	19
Admit Source Code (UB 92)	20	20
Discharge Status Code (UB 92)	22	22
Provider's Medical Record Number	23	23
Family Planning Indicator	24 = 4	24 = 4
EPSDT Indicator	N/A	N/A
Responsible Party Name, Address, City, State, Zip	38	38
Revenue Code (UB 92)	42	42
Place of Service Code	N/A	N/A
Type of Service Code	N/A	N/A
Service Description	43	43
Amount	44	44
Line-Item CPT4 or HCPCS Level II or III Code	N/A	N/A
Date of Service	N/A	45
Units of Service	46	46
Amount of Charge	47	47
Primary Payer (MBC/CommCare)	50A	50A
Provider Number	N/A	N/A
Release of Information (Y=Yes; N=No)	52A	52A
Benefits Assigned Indicator (Y-Yes; N=No)	53A	53A
Patient's Name	58A	58A
Relationship to Patient (For Medicaid always "01")	59A	59A
Medicaid DCN	60A	60A
Authorization Code	63A	63A
Principal Diagnosis (ICD9 Code) Format without Decimal	67	67
Other Diagnosis ICD9 Code	68-75	68-75
Admitting Diagnosis Code	76	76
Accident E-Code (ICD9 Code)	77	77
Procedure Type Code (9=ICD) (4=CPT4)	79	79
Primary Procedure Code with Procedure Date (MMDDYY)	80 (ICD9 or CPT4)	80 (ICD9 or CPT4)
Other Procedure Codes with Date of Procedure	81A thru 81E	81A thru E
Provider Medicaid Number	82	82
Surgeon	83	83
Payer Address: EPOCH P.O. Box 399 Shawnee Mission, KS. 66201-0399	84	84
Provider Representative Name of "Signature on File"	85	85
Date Claim Prepared and Mailed (MMDDYY)	86	86

B. Place of Service Codes

11	Office, Community Health Centers
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Hospital ER
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospital
53	CMHC
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
72	Rural Health Center or Federally Qualified Health Center
99	School-based Clinic

C. Billing Codes

Description of Procedure	Revenue Code (UB 92)	CPT Code (HCFA 1500)
Inpatient Service (Psych only)	124	
Extended Observation (23-Hour)	762	
3-Day Rapid Evaluation (Youth Only)	918	
Crisis Respite Services	660	
Partial Hospital		
Full Day	912	
Half Day	910	
Sub-Acute Program (Youth Only)	129	
Social Setting Detoxification	911	
Intensive Outpatient Services	915	
In-Home Services (Youth Only)		90808
Psychiatric Evaluation		
Diagnostic Interview		90801
Interactive Diagnostic Interview		90802
Outpatient Psychotherapy/Counseling Services		90804
Individual Psychotherapy (20-30 Minutes)		90805
Individual Psychotherapy with Med Eval & Mgmt (20-30 Minutes)		90806
Individual Psychotherapy (45-50 Minutes)		90807
Individual Psychotherapy with Med Eval & Mgmt (45-50 Minutes)		90853
Individual Psychotherapy with Med Eval & Mgmt (45-50 Minutes)		90846
Individual Psychotherapy with Med Eval & Mgmt (45-50 Minutes)		90847
Group Therapy		
Family Therapy (without Client)		90853
Family Therapy (with Client)		96100
Psycho-education Groups		90862
Psychological Testing		
Medication Management		
Community Case Management/Service Coordination		99499
Crisis Intervention Services		90899
ECT		90870
		90871

D. Coordination of Benefits (COB)

Third Party Liability is defined as any individual, entity or program that is, or may be, liable to pay all or part of the health care expenses of a Medicaid Beneficiary.

By law, Medicaid is the payer of last resort. This means that the health plan shall be used as a source of payment for Covered Services only after all other sources of payment have been exhausted.

CommCare shall deny payment if a third party health carrier is responsible for payment. However, if a third party health insurance carrier (other than Medicare) requires the Member to pay any cost sharing (co-payment, coinsurance or deductible), CommCare is responsible for paying the cost-sharing amounts, even if the services were provided by an Out-of-Network Provider. The liability for such cost sharing amounts shall not exceed the amount CommCare would have paid under its contracted fee schedule.

VII. Complaints, Grievances, and Appeals

Overview of Appeal Process

CommCare has established the following process to facilitate the handling of appeals of denials resulting from a lack of medical necessity. A Provider also may appeal an administrative denial if the Provider believes that contracted requirements (such as precertification or timely filing) were met. Appeals are the right of the patient, patient advocate, member, attending physician, other ordering physician, other attending provider or the facility rendering service. The facility may initiate an appeal at the request of the patient, patient advocate, attending physician, or ordering physician.

Expedited appeals are those requested while the patient is still receiving services in the level of care that was non-certified. A Board Certified Physician Consultant (PC), who did not make the original non-certification decision and whose specialty matches the attending provider's specialty, will be asked to review the case. The MHCM will notify the CommCare Vice President of Clinical Operations and the Director of UM the same working day that the request for an expedited appeal is received. The review of the expedited appeal will be completed within one working day, or within seventy-two (72) hours, whichever occurs first, of the receipt of all necessary information. If the PC recommends certification of the level of care or services, the care will be certified. If the expedited appeal does not result in the overturning of the denial, the attending provider or requesting party will be told of his/her right to make a standard appeal for a clinical peer review.

The standard appeal can be in writing or by telephone and must be received within one hundred eighty (180) days of the non-certification determination. Standard appeals are processed when the appeal is received after the patient has been discharged from the level of care that was non-certified. The MHCM will notify the CommCare Vice President of Clinical Operations and the Director of UM the same working day that the request for standard appeal is received. All standard appeals must be reviewed and have a certification decision within thirty (30) days of the receipt of the information needed to perform the review.

The information submitted is reviewed by the MHCM to determine if additional certification is warranted. If the MHCM's review does not produce a reversal of the non-certification, a Board Certified Physician Consultant (PC), who did not make the original non-certification, and whose specialty matches the attending provider's specialty, will review the case. The PC may choose to contact the attending provider for additional information and/or clarification of existing information, even if the attending provider has not requested peer-to-peer conversation during the review with the Medical Director.

If the PC recommends certification for the level of care or services, the care will be certified and the MHCM will proceed with completion of the review. If a non-certification letter was generated, a reversal letter will be sent to the appropriate parties within one business day.

If the PC agrees with the original decision for non-certification, the following will occur:

- The MHCM will telephonically notify the attending provider or requesting party the same day, unless the PC has already told him/her of the non-certification decision.
- The attending provider or requesting party will be told of his/her right to request, in writing or telephonically, a Committee review.
- Written notification of the non-certification decision will be sent within one business day to the attending provider, the hospital, the patient or Member, and to the payer, as appropriate.
- Letters will include the principle reason for the non-certification decision and the procedures to initiate an appeal of the decision.
- Conversations of the MHCM or PC with the attending provider, including offering a Committee Review, will be documented by the MHCM.

If an appeal is made for further review, CommCare offers a Committee Review. The MHCM will notify the CommCare Director of UM the same working day that the request for a Committee review is received. Medical records will be requested if they are not already available. Medical documentation received will be forwarded to the Review Committee. This Committee review will be completed within thirty (30) days of receipt of all information needed to perform the review. Letters will be issued to communicate the Committee's decision to the appropriate parties (i.e., hospital, provider and patient) within one business day. Final decisions will be forwarded to the payer, as outlined in the contract between CommCare and the payer. Upon request, the clinical rationale for the determination, as well as the criteria or guidelines utilized, will be sent in writing to all parties who received the original determination.

B. Complaints/Grievances/Inquiries

Action – The denial or limited authorization of a requested service, including the type of level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure of CommCare to act within specified time frames.

Appeal – A request for the review of an action.

Inquiry – Is a request from a member for information that would clarify health plan policy, benefits, procedures, or any aspect of health plan function that may be in question. Inquiries should be probed so as to validate the possibility of an inquiry actually being a grievance or appeal.

Notifying Members of Right to File A Grievance or Appeal

CommCare notifies Members of their right to file a grievance or appeal with the plan, Division of Medical Services and/or Missouri Department of Insurance through the following methods:

- A. Members receive information about the grievance and appeals procedure from their health plan.
- B. Each CommCare employee is educated by the department manager on the member grievance policy. Annual employee training is given on the member grievance and appeal process.
- C. Utilization Management staff will notify the Member in writing each time a service is denied, reduced or terminated, and inform the Member of his/her right to file a grievance or appeal.
- D. CommCare staff will notify the Member in writing of his/her right to file a grievance or appeal each time the Member expresses dissatisfaction with a notice of action.

Inquiry Procedure

CommCare operates a customer service function that answers Members' questions, files inquiries, and resolves issues. Member Inquiries regarding claims/payment issues (untimely filing, unpaid claims, collections, etc.) are evaluated, investigated, and resolved either during the initial telephone contact or subsequently. All inquiries are evaluated to determine if they should be classified as grievances or appeals and, if so classified, the relevant procedure is followed.

Grievance Procedure

- A. To initiate a grievance, the Member may:

A. Expedited Appeals

Expedited appeals are reviews requested while the patient is still receiving, or has not yet begun to receive, services at the level of care that was not authorized. A Board Certified Physician Consultant (PC), who did not make the original decision to not authorize and whose specialty matches the attending provider's specialty, will be asked to review the case. The Mental Health Case Manager (MHCM) will notify the Director of UM the same working day that the request for an expedited appeal is received, as well as documenting this in the CommCare UM system. The review of the expedited appeal will be completed within one working day, or within 72 (seventy-two) hours, whichever occurs first, of the receipt of all necessary information. If the PC recommends certification of the level of care or services, the care will be authorized and the MHCM will mail reversal letters, if the initial denial letters have been sent. The attending provider or requesting party will be told of his/her right to make a standard appeal for a clinical peer review.

B. Standard Appeals

Except for members of Family Health Partners (FHP), the standard appeal can be in writing or by telephone and must be received within 180 (one hundred eighty) days of the notice of action. FHP members must appeal with 90 (ninety) days, per contract. Standard appeals are processed when the appeal is received after the patient has been discharged from the level of care that was not authorized. The MHCM notifies the Director of UM the same working day that the request for a standard appeal is received, as well as documenting this in the CommCare UM System. A member is sent written acknowledgement of the receipt of his or her appeal within 10 (ten) business days of receiving the appeal. All standard appeals must be reviewed and have a notice of action letter within 30 (thirty) days of the receipt of the information needed to perform the review.

1. A Board Certified Physician Consultant (PC), who did not make the original decision to not authorize, and whose specialty matches the attending provider's specialty as a clinical peer, reviews the case. The Medical Director or MHCM provides the PC with the clinical information that has been provided. The PC may choose to contact the attending provider for additional information and/or clarification of existing information, even if the attending provider has not requested peer-to-peer conversation during the review with the Medical Director.
2. If the PC recommends certification for the level of care or services, the care is authorized and the MHCM will proceed with completion of the review. If a non-authorization letter was generated, a reversal letter is sent to the appropriate parties within one business day.
3. If the PC agrees with the original decision to not authorize, the following occurs:
 - a. The MHCM telephonically notifies the attending provider or requesting party the same day, unless the PC has already told him/her of the decision to not authorize.

- b. The attending provider or requesting party is told of his/her right to request, in writing or telephonically, a Committee Review.
 - c. Written notification of the decision to not authorize is sent within one business day to the attending provider, hospital, the patient, or insured, and to the payer, as appropriate.
 - d. Letters include the principle reason for the decision to not authorize and the procedures to initiate an appeal of the decision.
 - e. The MHCM documents the conversation of the MHCM or PC with the attending provider, including the offer of a Committee Review.
4. CommCare provides an opportunity for Members and/or their representatives to present their cases in person to the appellate body and review any records used in the appeals process. The Quality Improvement Committee serves as CommCare's appellate body for appeals.
5. CommCare may exceed the timeframe for the resolution of an appeal by up to 14 (fourteen) calendar days if:
- a. The Member requests the extension, or
 - b. CommCare documents how the delay is in the Member's best interest. If the timeframe for the resolution is increased, CommCare notifies the Member in writing of the reason for the delay, as well as the Member's Health Plan.
6. Members can appeal an adverse determination by requesting a State Fair Hearing.

The phone numbers to make notifications of Complaints/Grievances are listed in the Quick Reference Guide of this manual (p.2). Complaints may be filed with:

- The Customer Service Department of the appropriate health plan.
- The Division of Medical Services at 1-800-392-2161 or write:
 Recipient Services
 Missouri Division of Medical Services
 PO Box 6500
 Jefferson City, MO 65102

Members have the right to ask for a State Fair Hearing at any time.

- The Missouri Department of Insurance at 1-800-726-7390 or write:
 The Missouri Department of Insurance
 PO Box 690
 Jefferson City, MO 65102-0690

CommCare urges Providers to be involved in resolving patient concerns to avoid these issues being elevated to the Complain/Grievance process.

VIII. Quality Improvement

A. Overview

CommCare's Quality Improvement (QI) Program provides a framework for the continuous improvement of the Covered Services provided to health plan Members while assuring the provision of appropriate, affordable and accessible care. This is to be accomplished by identifying, evaluating and monitoring the quality of behavioral health care services delivered by CommCare and its Network of Providers.

COMMCARE'S PROVIDERS ARE CONTRACTUALLY REQUIRED TO PARTICPATE IN COMMCARE'S QUALITY IMPROVEMENT PROGRAM. From time to time CommCare may initiate focus studies at the request of a Health Plan, the Department of Mental Health, or as a result of an identified QI concern. **PROVIDERS MUST NOTIFY COMMCARE OF ALL SUICIDE OR HOMICIDE ATTEMPTS BY MEMBERS IN THEIR CARE FOR QUALITY OF CARE MONITORING PURPOSES.**

Quality indicators routinely monitored include, but are not limited to:

- Timely access to care and availability of services
- Member, and Provider Complaints and Appeals
- Clinical Services
- Prevention and outreach services
- Member, Provider and health plan satisfaction
- Annual HEDIS Report
- Sentinel events

The scope of the QI program ensures that CommCare will meet and exceed established standards with regards to access to care, continuity and coordination of services, clinical care, collaboration, and integration. QI is coordinated with performance monitoring activities including Utilization Management; credentialing; Complaints, Grievances and appeal resolution, Member satisfaction; and treatment record review.

B. Provider Contracts

CommCare contracts with individual practitioners and organizational Providers for the delivery of behavioral health services. Contracts require cooperation and compliance with QI activities and standards. These contracts will specify sanctions for non-compliance with CommCare's policies and procedures. When practitioners and Providers are not in compliance with QI standards, due-diligence investigation will precede corrective actions.

C. Confidentiality

CommCare follows the State and Federal laws regarding confidentiality of information. CommCare staff have access to records that contain private and privileged information that is protected in a reasonable and prudent manner.

CommCare will abide by all applicable federal and state regulations in regards to the release of information pertaining to behavioral health services.

CommCare and health plans will have access to all Members' clinical records for the fulfillment of its contract, or as required by regulatory bodies, to perform audits on said records.

A release of information signed by the Member or by the Member's parent/guardian will be required from any third party, including the PCP, requesting review of clinical records for behavioral health services.

In accordance with the Health Insurance Portability and Accessibility Act of 1996 (HIPAA), CommCare has revised confidentiality policies and procedures and activities to comply with HIPAA. CommCare expects its Providers to be HIPAA compliant.

D. Reporting to Regulatory Agencies

CommCare provides routine and ad hoc reports to its health plans, the Department of Medical Services and the Department of Mental Health. Additionally, CommCare conducts focused studies for the purpose of improving administrative and/or clinical services. CommCare also participates in state wide Managed Medicaid Mental Health QI Committees.

E. Annual Evaluation

CommCare prepares an annual written evaluation of the QI program, which includes:

- Annual Clinical Indicators
- Monitoring and Reporting Frequency
- Methodologies for Data Collection and Measurement
- Performance Thresholds

CommCare will also identify trends related to the quality of clinical care and service performance measures, as well as provide an analysis of the overall effectiveness of the QI program on service delivery.

CommCare prepares an annual QA/QI work plan for the managed care delivery system.

F. Medical Records

Consistent and complete documentation in the treatment record is an essential component of quality of care. CommCare will perform an annual audit of Provider records according to the following standards:

1. Each page in the treatment record contains the patient's name and identification number.

2. Each record includes the patient's address, employer or school, home and work phone numbers, including emergency contacts, marital/legal status, appropriate consent forms, and guardianship information, if relevant.
3. All entries in the treatment record include the responsible clinician's name, professional degree, and relevant identification number, if applicable.
4. All entries are dated.
5. The record must be legible.
6. Relevant medical conditions are listed, prominently identified, and revised.
7. Presenting problems and relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
8. Special status situations such as imminent risk of harm, suicidal ideation, or elopement potential are prominently recorded, documented and revised in compliance with written protocols.
9. Each record indicates what medications have been prescribed, the dosages, and the dates of initial prescription and refills.
10. Clear documentation of allergies and adverse reactions.
11. A medical and psychiatric history is to be documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.
12. For children and adolescents, prenatal and perinatal events and a complete developmental history (physical, psychological, social, intellectual, and academic) are documented.
13. For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over the counter drugs.
14. A mental status evaluation documents the patient's affect, speech, mood, thought content, judgment, insight, attention/concentration, memory and impulse control.
15. A DSM-IV diagnosis is documented, consistent with the presenting problems, history, and mental status examination, and/or other assessment data.
16. Treatment plans are consistent with the diagnosis and have objective, measurable goals and estimated time frames for goal attainment or problem resolution.
17. The focus of treatment interventions is consistent with the treatment plan goals and objectives.
18. Informed consent for medication and the patient's understanding of the treatment plan are documented.
19. Progress notes describe the patient's strengths and limitations to achieve treatment plan goals and objectives.
20. Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.
21. The treatment record documents preventive services as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources.
22. The treatment record reflects continuity and coordination of care between the primary clinician, consultants, ancillary Providers, and health care institutions.
23. The treatment record documents the dates of follow-up appointments or, as appropriate, a discharge plan. There is clear documentation of "no show" or cancelled appointments.

CommCare requires that the Provider retain the above record for seven (7) years from the date of service. If the individual is a minor, the record must be maintained until the individual reaches ages 21.

For review purposes other than an appeal or a legal request, CommCare will reimburse for medical record duplication, unless otherwise provided for by contract or law. The request for payment can be submitted to the Director of Utilization Management.

IX. Medical Surgical Services by Payer

When providing services to Members of CommCare, it is the responsibility of the Provider to coordinate care with the Member's HMO and PCP, especially regarding the provision of health/behavioral health services. Here are some helpful numbers to access medical/surgical services.

A. Family Health Partners

Customer Service	1-800-347-9363
Medical/Surgical Prior Authorizations	1-888-691-4872
24-hour Nurse Advice Line	1-800-347-9369
Transportation	1-800-890-6026
Pharmacy-PCS	1-800-345-5413
Pharmacy Prior Authorization/Medical Exceptions	1-888-413-2723
Bridgeport Dental	1-877-394-9994
Vision: Call FHP Customer Service	1-800-347-9363
TDD (Telecommunication Device for the Deaf)	1-816-855-1863
Laboratory Network: LabCorp, Regional Lab Alliance, Physicians Reference Labs, Rockhill Medical Laboratory, and participating hospitals.	

B. Blue Advantage Plus

Customer Service	1-888-279-8186
Medical/Surgical Prior Authorizations (24-hr/day)	1-800-892-6116
Transportation	1-800-872-0508
Pharmacy	816-395-2176
Doral Dental	1-800-417-7140
Vision (VSP)	1-800-877-7195
TDD (Telecommunication Device for the Deaf)	816-842-5607

Other Helpful Numbers:

Child Abuse and Neglect Hotline	1-800-392-3738
Parental Stress Hotline	1-800-367-2543
Poison Control Center	1-800-366-8888

X. Definitions

3-Day Rapid Evaluation: Provision of an in-depth evaluation within a twenty-four hour living environment which is supportive, structured, clean and safe for children or youth who are experiencing a psychiatric crisis. The purpose of the in-depth evaluation is to make a differential diagnosis or to recommend treatment interventions.

Access and Appointment Standards: Measurable time frames within which Providers must arrange for needed behavioral health services for health plan Members.

Administrative Denial: A denial of payment for services on the basis that administrative procedures were not followed. The grounds for Administrative Denial are one of the following:

1. CommCare's Policies and Procedures for Medical Necessity and Utilization Review were not followed;
2. Covered Services were not properly authorized in advance;
3. Services delivered or performed were not Covered Services;
4. Member was no longer eligible for benefits;
5. Claim was not submitted on an acceptable form or format or within one hundred eighty (180) days from the date of service; and
6. The service is not a reimbursable service according to the Provider's Agreement with CommCare.

Adverse Determination: A determination that an admission or request for continued Covered Services provided has been reviewed and, based upon the information available, does not meet CommCare's requirements for Medical Necessity or appropriateness for that level of care. The payment for the requested service is, therefore, denied, reduced or terminated.

Appeals Process: The documented policy and procedure to be followed when a Provider/Member requests a review for care that was considered non-authorized.

Behavior Management Services: Provision of protective oversight to children and youth experiencing an acute crisis related to a psychiatric disorder.

Capitation: A payment method whereby participating Providers are reimbursed with a per member per month (PMPM) amount for each Member within the participating Provider Network without regard to whether a Member has received or sought services during that month. **Sub-Capitation** refers to a process whereby only a portion of the overall Capitation amount is paid to a specific participating Provider.

Case Management: The coordination of care and services by the CommCare Mental Health Case Manager.

Certification, Pre-Certification or Behavioral Authorization: A process of determination by CommCare that an admission to, or request for continued services has been reviewed and, based on the information provided, satisfies CommCare's requirements for Medical Necessity, appropriateness of level of care and effectiveness.

Clinical Review Criteria: The written screening procedures, clinical protocols and practice guidelines used to determine the necessity and appropriateness of services.

Community Case Management/Service Coordination: Coordination of services to assist clients in maintaining therapeutic gains and progressing toward less intensive services, usually provided by the staff of a CMHC.

Complaint/Grievance: A verbal or written expression which indicates dissatisfaction or dispute with health plan policy, procedure, claims or any aspects of the health plan's functions. All Complaints/Grievances must be logged, tracked, and investigated whether received by telephone, in person or in writing.

Concurrent Review: The utilization review conducted by CommCare during the Member's stay in a Facility-based service or while receiving outpatient services.

Covered Services: Mental health and substance abuse services which are covered under the benefit terms of a Health Plan, subject to any applicable deductible, co-payment, and limitation provision of that plan.

Crisis Respite Services: Provision of a twenty-four hour environment which is supportive, structured, clean and safe for individuals who are experiencing a psychiatric crisis.

Discharge Planning: The formal process for determining, prior to discharge from a Facility, the coordination and management of the care that a Member will receive following discharge. Discharge Planning activities are facilitated and coordinated by CommCare to ensure compliance with CommCare's *Care Management Guidelines*.

Emergency Services: Services for the sudden and, at the time, unexpected onset of a health condition that manifests itself with symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of health and medicine, to believe that medical care is required.

Enrollee, Member, Covered Person, Policyholder, Beneficiary or Insured: An individual who is covered under the benefit terms of a health plan.

Extended Observation Unit: A secure treatment environment where the client can remain for up to 23 hours. This service is designed for individuals who are in acute emotional distress.

Facility: An institution delivering Covered Services to Members, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers and rehabilitative and other therapeutic health settings.

Health Plan Benefit: A policy, contract, Certification or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of Covered Services.

In-Home Services: An in-home crisis stabilization service for individuals who are at risk of unnecessary out-of-home placement due to an acute psychiatric crisis or severity of illness.

Inpatient Services: A twenty-four hour protected psychiatric treatment environment, designed for those individuals who are a significant danger to themselves or others, or who are significantly disabled and cannot meet their basic needs and role functions.

Inquiry: A request regarding information that would clarify plan policy benefits, procedures or any aspect of a health plan's function that may be in question.

Intensive Outpatient Services: A structured day or evening program which generally provides nine or more hours per week of structured services consisting of counseling and education around psychiatric or substance abuse issues. The individual's need for medical services is addressed through consultation or referral agreements.

Managed Medicaid Program: The Medicaid managed care program is operated by the State of Missouri Division of Medical Services. The State of Missouri has total authority to determine eligibility for the Managed Medicaid Program and controls the enrollment process.

Medical Director: A Psychiatrist licensed to practice medicine under the laws of the State of Missouri who is contracted by CommCare to coordinate and monitor the Utilization Review, Quality Improvement, and medical management responsibilities of CommCare.

Medical Necessity: The mental health and substance abuse services which CommCare determines to be:

1. Consistent with the diagnosis and treatment of the Member's condition, disorder, or disease;
2. Consistent with the type, amount and level or place of service with regard to the standards of good clinical practice in the local medical community;
3. Not solely for the convenience or preference of Members, families or other Providers; and
4. The least restrictive and least intrusive level of behavioral health services which can safely be provided to the Member.

Medication Management: Psychotropic medication adjustment and monitoring.

Network: A group of participating Providers contracted to provide Covered Services to Members.

Outpatient Psychotherapy Counseling Services: Solution-oriented counseling services designed to maximize a patient's strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder that interfere with a client's personal, familial, vocational, or community adjustment.

Partial Hospital Program: A time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable, therapeutic milieu for a period of 3-6 hours per day.

Primary Care Provider or Primary Care Physician: A participating health care professional designated by the health plan to supervise, coordinate or provide initial care or continuing care to a Member, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the Member.

Prospective Review: A utilization review process conducted by CommCare prior to an admission or a course of treatment.

Psychiatric Evaluation: A comprehensive evaluation conducted by a Psychiatrist that identifies the patient's presenting problem/symptom, a brief description of the patient's level of functioning, includes a mental status exam, and which identifies initial treatment strategies and interventions.

Psycho-educational Groups: Educational groups designed to provide participants with skills to enhance their functioning.

Psychological Testing: Assessment of an individual in response to diagnostic or treatment questions.

Quality Improvement: A system of evaluating and assuring that the types, amount, and length of care and treatment delivered to Members are outcome oriented and consistent with generally accepted medical principles and practice.

Quality Improvement Program: Those procedures and protocols implemented and/or approved by CommCare to monitor the quality of services provided to Members.

Retrospective Review: A utilization review of Medical Necessity for services that is conducted by CommCare after services have been provided to a Member, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Social Setting Detoxification: A process of withdrawing a person from a specific psychoactive substance in a safe and effective manner without the need for on-site access to medical and nursing personnel.

Sub-Acute Program: Provision of a twenty-four hour living environment less intensive than acute inpatient but which is supportive, structured, clean and safe for individuals who are experiencing a psychiatric crisis. All interventions focus on the reintegration into the family or alternative living arrangement.

Utilization Management Program or Utilization Review Process: A set of formal techniques designed to monitor the use of, or evaluate the clinical (medical) necessity,

appropriateness, efficacy or efficiency of services. Techniques may include Prospective Review, Concurrent Review, Appeals Process, Discharge Planning or Retrospective Review.

Wraparound Services: A variety of supportive services which are required to maintain a child or adolescent within his or her home or community setting.