PsycHealth Care Management L.L.C.

Caring & competent professionals providing bilingual clinical and administrative services in mental health.

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Provider Manual

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PsycHealth Care Management L.L.C.
Mission Statement

PsycHealth, a licensed, professional service corporation, was founded in 1989, under the direction of licensed clinical psychologist, Madeleine Y. Gómez, Ph.D. Dr. Gómez received her Ph.D. from the Northwestern University Medical School/Department of Behavioral Sciences. PsycHealth. has been certified as a Women's Business Enterprise and Minority Business Enterprise by both the City of Chicago and the County of Cook since 1990.

PsycHealth is a multi-disciplinary team of independent and salaried mental health professionals, providing managed mental health services, clinical mental health services, 24 hour emergency services coverage, utilization review and management, community seminars and preventive health education. Additionally, PsycHealth maintains and administrates a network of mental health and substance abuse specialists throughout the seven-county metropolitan Chicagoland area and throughout Illinois, Indiana, and the Midwest region, offering minority and multi-lingual clinicians as well as clinical sub-specialties, including child psychiatry, family therapy, substance abuse, sexual dysfunction, employee issues, and physical/sexual abuse.

PsycHealth is dedicated to the service provision and management for those individuals seeking mental health treatment regardless of the individual's ethnic background, language spoken, sex, religion, or sexual orientation. PsycHealth. supports the human rights of each individual. PsycHealth actively promotes mental health via healthy lifestyle choices. We also work for non-violence, non-violent methods of discipline in child rearing, and alternatives to violent interactions. PsycHealth advocates for and upholds the rights of the child and the rights of the older adult. PsycHealth is positioned against abuse of all types including child abuse, abuse of the elderly, emotional abuse, sexual abuse, domestic violence, and abuses of power.

We seek to provide services that, while being fair and ethical, are both treatment and cost effective for consumers, taxpayers and third party payers. PsycHealth has offered and continues to offer its services pro bono when deemed necessary and appropriate.

We believe that compassion and consideration is of utmost importance. We recognize that as we help each person, we help our families, our friends, and ourselves.

At PsycHealth we affirm that:

1. UM decisions are based on medical necessity, which includes appropriateness of care and services, and the existence of available benefits;

2. This organization does not specifically reward practitioners, health plan staff, or other individuals for issuing denials of coverage, care or service; and

3. Incentive programs are not utilized to encourage decisions that result in under/over-utilization.

PsycHealth also affirms that there is no conflict of interest between PsycHealth and its UM decision makers.

MEMBER'S RIGHTS AND RESPONSABILITIES

PsycHealth coordinates mental health services. We support human rights. We respect and protect the rights of our members or their guardians without discrimination. We support and respect your dignity, worth, confidentiality and privacy.
You are the center of the Care Team. PsycHealth understands that members have certain rights and responsibilities as part of the Care Team.

- You have the right to be treated with respect, concern and dignity.
- You have the right to be informed of and receive facts on your rights, responsibilities and health care.
- You have the right to receive facts about PsycHealth, PsycHealth policies, services, benefits, available services, practitioners, providers, and accepted clinical guidelines for care.
- You have the right to receive quality care.
- You have the right to receive a care plan.
- You have the right to join in with your care team and to make decisions about your care plan.
- You have the right to discussions in plain language about treatment options, costs and benefits. This includes options that may be higher priced or are not covered benefits.
- You have the right to be treated in the least restrictive setting.
- You have the right to complain or appeal about PsycHealth or the care provided.
- You have the right to confidentiality as provided by law.
- You have the right to your Health Records. Your record is confidential and private.
- You have the right to be treated with non-discrimination, respect, privacy and dignity.
- You have the right to be protected from abuse, neglect, exploitation and harassment.
- You have the right to make suggestions about our rights and responsibilities policy.
- You have the right to have a family member, support person, or other person present. They can be involved in treatment decisions or make health care decisions, as permitted by law.
- You have the right to have an Advance Directive. This states wishes for health care decisions.
- You have the right to be informed about health problems, treatment options, and possible outcomes for care planning. Discharge planning includes deciding about care options, providers or need to transfer to another facility.
- You have the right to request, accept or refuse care, treatment or services. You have the right to be informed of the medical outcomes if you refuse care.
- You have the right to change of providers or a second opinion.
- You have the right to an interpreter and /or translation services.

• You have the right to privacy and confidentiality when you are receiving care.
• You have the right to practice and get advice about cultural, spiritual and ethical beliefs, if it does not affect the rights of others.
• You have the right to ask for support for difficult decisions about care.
• You have the right to be free from restraints or seclusion, unless medically necessary or needed for safety.
• You have a right to safety, including zero tolerance for violence.
• You have a right to resources and advocacy facts.
• You have a right to kindly care at the end of life.
• You have a right to review medical records and receive answers about that record. You can ask to make changes to that record. You can get copies as per the law.
• You have the right to keep records confidential. Records will only be shared with those who can legally see them. You may request facts on who has received your record.
• You have a right to receive a copy of and details about bills.
• You have the right to ask about business links between payors, hospitals, and other health care providers that may affect care.
• You have a right to request an electronic version of your medical record, if the medical record is electronic.
• You have a right to not share your record with a health plan if you have paid out of pocket for services or per the law.

You and/or your family member, support person, or other person acting on your behalf have the responsibility to:

• Provide correct and complete information about yourself and your health, including your current contact information, medical and behavioral health complaints, past health problems and hospital visits, medications you have taken and are taking (including prescriptions, over-the-counter and herbal medicines), alcohol and drug use and any other information you think your caregivers need to know
• Share your thoughts on a care plan that you accept
• Follow plans and instructions for the care plan you have agreed to with your providers
• understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
• Share what you expect in your care, including your pain or safety needs
• Follow your agreed-upon care plan and report on your progress
• Ask questions about your care, treatment, and services
• Share any concerns about your care plan or attending treatment
• Learn what can happen if you do not follow the care and attend treatment
• Provide your Advance Directive if you have one.
• Respect the rights, property, privacy, dignity, and confidentiality of others
• For more information about your Patient Rights and Responsibilities, please see the link to our website http://www.psychealthltd.com/pdf/Member_Rights.pdf or contact the Quality Department at PsycHealth

PROVIDER SERVICES DEPARTMENT

The Provider Services Department acts as a liaison between all participating practitioners and providers and the various departments of PsycHealth Provider Services is supported by senior staff in Administration, Quality Improvement who are responsible for oversight of the daily

operations of the Provider Services Department.

The Provider Services Department is responsible for the following functions:

- Recruitment of Practitioners and Providers, Network Development and Management
- Contracting of Practitioners and Providers
- Orientation of new practitioners and providers
- Educating practitioners and providers regarding PsycHealth Policies and Procedures
- Credentialing and Re-credentialing of practitioners and providers
- Conducting site visits and treatment record reviews
- Problem resolution for practitioners and providers
- Development of Provider Newsletter

Provider Orientation Program

The Provider Orientation Program is the first step in our commitment to developing a long lasting professional partnership with our contracted practitioners and providers. It also allows for the communication of valuable input and feedback from our networks practitioners and providers. The purpose of this information is to orient network practitioners and providers to PsycHealth's Mission Statement, clinical philosophy, operational and administrative policies and procedures. The PsycHealth Provider Manual is reviewed annually.

Orientation Packet / Provider Manual

- The orientation packet includes a guide to current products managed by PsycHealth, a Key Departmental Staff Contact Information form, current and archived newsletters, sample bi-lingual publications available to members and providers.
- The provider manual includes key policies and procedures, claims submission information, credentialing requirements and treatment record documentation requirements.

Ongoing Provider Education

- PsycHealth maintains a website www.psychealthltd.com
- Provider newsletters are written and distributed quarterly, archival copies are available on the website.
- Provider Manual is reviewed annually, and any key updates are distributed via mail to all providers.
- Provider education is available by PsycHealth staff, as needed or requested, to individual providers or medical groups on specific topics.

Provider Newsletter

PsycHealth. distributes a provider Newsletter on a quarterly basis to all network practitioners and providers. The newsletter updates practitioners and providers on new or revised products and operational procedures, the latest clinical research and publications, quality improvement initiatives and reports. We welcome relevant submissions and suggestions for topics of

discussion to be included in the newsletter. Please contact the Provider Services Department if you have a recommendation for the newsletter. All newsletters, current or archival, can be downloaded by visiting our website at www.psychealthltd.com.

How to Contact the Provider Services Department

The PsycHealth Provider Services Team is available from 8:30 am – 4:30 pm Monday through Friday via the following toll free number: (800) 753-5456. We welcome your comments, questions, concerns, complaints and feedback of any kind.

CREDENTIALING AND RE-CREDENTIALING

PsycHealth follows the State of Illinois Single Credentialing Cycle including use of State form, credentialing schedule, and other requirements. This applies when a provider is initially credentialed, when a provider credentials data changes substantively, or when a provider patient or quality assurance issue requires it.

Data collection will coincide with a single-credentialing cycle that allows for collection of recredentialing data once and not more than every 3 years except as noted in the section above.

The following process will apply:

A. Recredentialing Cycle will be based on the variable of the last digit of each providers Social Security Number;

B. Provides for a one-month notification period for each digit during which the credentialing department notifies those Physicians/Practitioners being recredentialed and of the time period during which the data is expected to be submitted: and provides for a two-month collection period for each digit during which the credentialing department receives data from those providers being recredentialed.

C. The single credentialing cycle reflects a six-month "OPEN" period when PsycHealth cannot collect data from a Provider except as noted in section above. This period coincides with the Illinois Department of Public Regulation's licensing schedule of physicians.

D. The single credentialing cycle is as follows:

Year	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Month	**Notify**	**Notify**	**Notify**	**Notify**	**Notify**	**Notify**
January	4's	8's	0's	4's	8's	0's
February						

March						
April	5's	9’s	1's	5's	9's	1’s
May						
June						
July	6's	Open	2’s	6's	Open	2’s
August						
September						
October	7's	Open	3’s	7's	Open	3’s
November			Open			
December			Open			

E. Once recredentialing is begun PsycHealth may continue to request date from the provider outside of the single cycle if it is not submitted by the deadline date listed in the schedule

F. PsycHealth will monitor, on a monthly basis, in between recredentialing cycles, information on sanctions, limitations on licensure and complaints in accordance with NCQA standards.

Practitioner Credentialing is a process all prospective practitioners must complete to evaluate their professional credentials and experience. The purpose of the credentialing process is to ensure that all PsycHealth practitioners meet the professional competency criteria established by the Credentialing Committee and the standards established by the National Committee for Quality Assurance (NCQA). The credentialing process is initiated with the submission of a signed Provider Agreement and a complete application to PsycHealth Primary source verification is conducted on all professional information requested in accordance with NCQA guidelines to ensure providers are qualified to treat a given population. The credentialing data elements requiring primary source verification and the minimum requirements for each are listed at the end of this manual.

Site visits will be conducted at new provider sites prior to making a decision to include a practitioner or provider in the network to ensure there are adequate facilities available. A review will be conducted on the practitioner’s policies and procedures for maintenance of treatment records a mock or blinded treatment record may be reviewed to ensure compliance with appropriate treatment record keeping practices. The credentialing specialist will notify the applicant of missing data elements and secure the required information.

The process of primary source verification must be completed no later than 180 days from receipt of the complete credentialing application. Information obtained through the credentialing process is then submitted to the Credentialing Committee for evaluation. The Credentialing Committee makes the final recommendation. You will be notified in writing of the Committee’s decision.

Re-Credentialing

As a participating network practitioner, you will undergo a re-evaluation of your credentials according to the 36 month Re-Credentialing cycle or as required by state or federal regulations. Re-credentialing of all licensed or certified network practitioners is conducted every 3 years to verify that the practitioner has no new professional liability claims and is still in good standing with various professional entities including, but not limited to, Medicare/Medicaid and the state department of professional regulation. Utilization management data, complaint information, quality improvement study results, treatment record review data and member satisfaction data are also evaluated at the time of re-credentialing. The Credentialing Committee has final responsibility for recommending reappointment of the practitioner to the panel of network providers. The decision to accept or deny inclusion in the network is based upon the needs of the network, quality improvement data and the professional information obtained.

Practitioners Rights During the Credentialing and Re-Credentialing Process

During the Credentialing and Re-credentialing processes, all practitioners have the right to:

- review the information obtained in support of their application;
- to be notified of any information obtained during the credentialing process that varies substantially from the information provided to PsycHealth by the practitioner;
- correct any erroneous information provided, and;
- confidentiality of all information obtained during the credentialing process except otherwise permitted by law;

Practitioner's Right to Appeal

A practitioner has the right to appeal an adverse decision not to appoint/reappoint him/her to the PsycHealth network reached as a result of information obtained during the credentialing process. In the event that the Credentialing Committee recommends an alteration of a practitioner's network status, the practitioner will be notified in writing of the determination. Information on how to appeal this decision will be included in the written notification.

Reporting of Adverse Decisions

In accordance with federal law, the National Practitioner Data Bank (NPDB) and the State Licensing Agency shall be notified of all practitioners and providers who have been terminated from the PsycHealth network for quality of care issues. The practitioner or provider will be notified during the termination process that a report may be sent to the licensing agencies and NPDB. The practitioner or provider will then have the opportunity to further clarify issues and provide additional relevant information. In all cases, the practitioner or provider have the right to appeal an adverse credentialing determination.

Termination Events

Not withstanding any other provisions in the PsycHealth Provider Agreement, PsycHealth may terminate its Provider Agreement at any time upon notice of the occurrence of any of the following events:

- Failure to maintain adequate malpractice or general liability insurance;
- Practitioner's conviction of a felony or misdemeanor involving moral turpitude;
- Professional incompetence of a practitioner or non-performance of professional responsibilities;
- Failure to comply with quality improvement and utilization review procedures and standards as established by PsycHealth, including but not limited to access and availability standards, billing practices, credentialing timelines.
- Suspension or revocation of the licenses required to fulfill the professional responsibilities;
- Physical disability, including alcohol or drug abuse, which impairs the practitioner's ability to practice his/her profession in a competent manner;
- Practitioner being a party to malpractice or other litigation or arbitration that has resulted in material judgments, settlements or awards against the practitioner.

ACCESSING SERVICES

Accessibility Standards

Accessibility is the extent to which a member can obtain available services at the time they are needed. This refers to both telephone access as well as the ability to schedule an appointment.

Emergency Services

Emergency services do not require pre-certification. However, under circumstances when the PsycHealth UM staff is contacted, UM staff will provide, arrange for or otherwise facilitate all

needed emergency services. PsycHealth will follow the "prudent layperson" standard in making UM decisions related to emergency services. Emergency services are never denied.

A representative of PsycHealth is available twenty-four hours a day to provide assistance with accessing emergency mental health and substance abuse benefits.

Non-Urgent Referral Requests

Non-urgent referrals will be provided during normal business hours according to the certificate of benefits established by the member's health plan. Providers and members are encouraged to contact PsycHealth review staff at the numbers listed below for their initial request.

Additional visits must be prior authorized by PsycHealth The provider may complete the PsycHealth Outpatient Authorization of Services form and fax in, or call. PsycHealth requires 5 business days notice to process these requests. A copy of the completed referral will be fax or mailed to the provider.

A copy of the Outpatient Authorization of Service form can be found on the PsycHealth website.

PsycHealth Telephone Number for Routine Calls: (847) 864-4961
PsycHealth Toll Free Phone Number: (800) 753-5456
PsycHealth Fax Number: (847) 864-9930

Triage and Referral

All requests for services will be evaluated on the basis of medical necessity and services must be available to the member in accordance with the following accessibility standards:

Care Type	Definition	Access Standard
Life Threatening Emergency	A situation in which a member is at imminent risk for harm to self or others.	Immediately
Non-Life Threatening Emergency	A situation where the member is markedly distressed and there is a strong potential for rapid decompensation.	Within 6 hours
Urgent	A situation in which a member's condition could	Within 24 Hours

	be anticipated to deteriorate to the point of being at risk of harm to self or others if not evaluated or treated.	
Routine	A request for a referral for members who are presently at no risk for harm to self or others.	10 Business Days

On Call Coverage/Covering Practitioners

In the event that a practitioner is unavailable to members who are in active treatment, the practitioner is responsible for arranging adequate emergency coverage during the absence. PsycHealth must be notified of all coverage arrangements. Covering practitioners must adhere to all PsycHealth administrative requirements, including but not limited to fee schedule, authorization procedures, accessibility standards and co-payment collection. *The covering practitioner must be of equivalent licensure level.*

Covering practitioners are not required to be a PsycHealth participating provider but it is recommended. All claims submitted by the covering practitioner should include the authorization number and indicate the provider for whom services are being covered. Payment for claims submitted without this documentation may be denied.

After Hours Access to Outpatient Practitioners

When a patient is referred to a practitioner for mental health treatment it the expectation of PsycHealth that the practitioner educate the patient on how to access care after normal business hours. You must provide your patients with a telephone number to call during non-business hours. Patients should be informed that if they call this number they will be contacted by you or your covering practitioner within a reasonable and appropriate timeframe. The after hours access information may be an answering service or a recording. If it is an answering service, the service shall instruct the patient as to how they will be placed in touch with you. If a recorded message is provided it may include:

- A telephone number where you can be reached,
- A pager number for you and instructions on how to activate a page and return call from you,
- The ability to leave a message and stating that you or your covering practitioner will return your call in a specified timeframe.

If the after hours access line is a recording it must also include the telephone numbers for local emergency services or law enforcement if patient cannot wait for a return call from you.

Nondiscrimination of Service

You must accept new referrals from PsycHealth without regard to race, religion, gender, sexual orientation, place of residence, national origin, insurance plan, age or physical or mental health status.

The only circumstances under which you may refuse a PsycHealth referral are:

- The patient requires treatment outside the scope of your clinical licensure or expertise.
- Your panel is closed to all new patients.

If you decide to stop accepting new referrals for any reason (such as: due to vacation, leave of absence, illness or your panel is full) you must notify PsycHealth in writing at the following address:

PsycHealth Care Management L.L.C.
Attn: Provider Services Department
P.O. Box 5312
Evanston, IL 60201

Or Fax to: (847) 864-9930

Written notification should include a brief reason for the inability to accept referrals, an effective date and an end date if applicable.

Change in Office Demographics

If Provider decides to change his/her office address or substantially change weekly hours of operation of Provider's office(s) or discontinue operations at such office(s), then Provider shall promptly provide PsycHealth with 30 days advance written notice and include the effective date of such change.

UTILIZATION MANAGEMENT PROCEDURES

Telephonic Reviews

When conducting telephonic reviews, PsycHealth personnel shall routinely provide the following information (orally):

- First Name, Title and Corporation Name
- Utilization Review requirements of the benefit plan
- PsycHealth operational review policies and procedures

On-Site Reviews

In situations where an on-site review is warranted the following guidelines shall be followed:

- On-site reviews must be conducted during normal business hours of the provider unless other arrangements have been made.

- On-site reviews must be scheduled at least one business day in advance.

- PsycHealth personnel must carry appropriate identification (picture ID) and wear appropriate facility provided ID while on premises.

- PsycHealth personnel must register with the appropriate contact person prior to requesting access to any clinical information.

- PsycHealth personnel must agree not to remove medical records from areas designated by provider and follow reasonable administrative procedures so as not to disrupt the facility operations or patient care.

Information Required for Initial Review

PsycHealth review staff shall routinely request the following demographic information when conducting an initial review:

- Patient demographics – name, address, date of birth, insurance ID#
- Subscriber demographics (if other than patient)
- Date and time of admission
- Patient's room number or location
- Attending physician/practitioner information – name, address, phone/fax numbers, degree, license/certification status
- Physician's Federal Tax ID number
- Facility demographics – name, address, phone/fax numbers, accreditation status, type of facility, Federal Tax ID number
- Treating staff qualifications and contact person for detailed clinical information

PsycHealth review staff shall routinely request the following clinical data when conducting an initial review:

- Primary, secondary, tertiary diagnoses, multi-axial diagnoses per DSM IV (may be provisional)
- Current symptomatology sufficient to support diagnoses, appropriateness of the level of services proposed
- Proposed treatment plan including objective measurable treatment goals and timeframes for achieving goals.
- History of present illness including past treatment history
- Patient's prognosis
- Proposed length of stay and/or frequency/duration of services

Information Required for Concurrent (Continued Stay) Review

Efforts are made to ensure that concurrent reviews always be conducted prior to the termination of authorization to ensure that no lapse in authorization and care coordination occurs. Therapeutic goal setting and discharge planning are expected to commence immediately upon admission to any level of care. Clinical case coordinators are available to facilitate this process and provide feedback as needed.

- Patient demographics sufficient to locate record
- Changes or updates in member demographics

- Name and title of contact providing review information
- Primary, secondary, tertiary diagnoses, multi-axial diagnoses per DSM IV (may be provisional unless final review prior to discharge)
- Progress made toward treatment goals since previous review
- All medications prescribed including dosages and frequencies, and relevant doctor's orders (precautions, specialty assessments)
- Results of specialty assessment reports
- Additional days, services and procedures proposed including frequency and duration
- Reasons for proposed extension including current symptomatology sufficient to support diagnoses, appropriateness and level of services proposed
- Discharge/aftercare plans

Information in addition to the above data elements, including but not limited to a second opinion, may be requested or voluntarily submitted when there is significant difficulty in reaching or agreeing upon a review determination.

PsycHealth will provide the above information to all relevant internal departments to avoid duplicate requests for this information from members or providers.

DISCHARGE PLANNING GUIDELINES

The PsycHealth Clinical Care Coordinator (CCC) communicates with the designated facility discharge planner(s) to formulate, update and implement an effective discharge plan. Evaluation of potential discharge planning/case management needs, is initiated during the first review following notification of admission and continues to develop at any time throughout the concurrent review process. The initial anticipated discharge plan will be updated and modified, if indicated, by the CCC during each subsequent concurrent review, to facilitate a smooth, timely, and safe discharge when the patient's condition stabilizes. Discharge plans will be implemented by generating the appropriate referrals to contracted vendors/ancillary providers according to the patient's needs. The CCC is responsible for documenting pertinent clinical information and discharge plans in the PsycHealth case management system.

Assessment of Patient Needs:

- Discharge planning between CCC and the designated facility discharge planners should consider diagnoses, symptoms, treatment history, risk factors, social supports, provider specialty, provider and patient locations, patient and/or family preferences and the patient's continued need for treatment.
- Potential impediments to accessing and following through with aftercare plan should be identified, minimized, and addressed prior to discharge.

Development of Discharge Plan:

- CCC will assist in identifying in-network providers to meet aftercare needs.
- CCCs are actively involved in coordinating the discharge plan with the hospital treatment team members and patient. Where appropriate and indicated, treatment planning involves coordination and/or review of aftercare plans with the patient's PCP.
- Approved providers must be utilized. In the event that in-network providers are not available, special agreements will be arranged, instituted, and approved by the PsycHealth Clinical Director.
- The use of community resources, where available, should not be overlooked, and may be incorporated in the discharge plan

Implementation of Discharge services:

- Finalized aftercare plans are communicated to the patient by the designated facility discharge planner(s). Clarification and modification of the plan may be obtained by the patient via communication with the designated facility discharge planner(s) or direct communication with the CCC.
- The initial aftercare appointment with a behavioral healthcare provider should be scheduled to occur ideally within 7 days but no longer than thirty (30) days of discharge and documented on the member's discharge instruction sheet obtained from the hospital.
- All aftercare plans and pertinent case management notes must be submitted to the Health Care Organization (HCO) within 1 working day of discharge.
- Ongoing case management will be performed by a CCC post discharge.

Coordination of Medical and Behavioral Health Care

Engaging in consultation and collaboration between the behavioral health provider and the medical provider is central to the delivery of appropriate and integrated care. In keeping with the philosophy that it is important to treat the whole person when addressing behavioral health care issues, PsycHealth providers are expected to coordinate care with the member's Primary Care Physician. To facilitate this process, behavioral health providers should obtain, upon initial evaluation, signed consent from the member to exchange clinical information with that member's PCP.

Consent forms for the release of patient information can be downloaded from our website at www.psychealthltd.com. PsycHealth Clinical Care Coordinators are available to assist our providers in linking with the member's PCP.

Practice Guidelines

PsycHealth Adopts explicit Clinical Practice Guidelines that define standards of practice pertaining to improving the quality of care for behavioral health diagnoses and substance abuse disorders. PsycHealth Peer Review committee has adopted American Psychiatric Associations Practice Guidelines latest edition for use. Selected Guidelines are distributed to individual providers for specific quality improvement initiatives or activities.

The guidelines are:
based on current clinical principles and practices and professional standards
developed with involvement from appropriate providers with current knowledge relevant to the ciriteria under review
evaluated and updated, at least annually by PsycHealth
based on the support the patients right to be treated in the least restrictive setting and with "the least medicine necessary for the improvement or stabilization of the patient" (Gomez&Hall, p77).

PSYCHEALTH GUIDELINES FOR OUTPATIENT UTILIZATION REVIEW

New referrals are generally authorized for 1 initial evaluation and 3-5 follow up visits, unless otherwise stated on the referral. Treatment review is required for authorization of additional sessions. The following is a list of required information for each referral type:

Outpatient Therapy:

- Results of evaluation, including DSM (current version) diagnosis
- Presenting symptomatology
- Progress toward treatment goals
- Proposed treatment plan including frequency and modality of services
- Communication with Primary Care or Medical Specialist
- Anticipated number of sessions needed

All outpatient therapy authorizations are for a frequency of one session per week. If a member requires more intensive intervention than one session per week, a special prior authorization must be obtained. *If a member is seen more than once in a week without a special authorization, the additional session(s) may be denied for "Session not Authorized".*

Medication Evaluation and Management

- Results of evaluation, including DSM (current version) diagnosis
- Presenting symptomatology
- Progress toward treatment goals

- Medications prescribed including dosages
- Communication with Primary Care or Medical Specialist
- Proposed treatment plan including frequency and modality of services
- Anticipated number of sessions needed

The PsycHealth CCC will authorize additional sessions based upon the information provided, the recommended treatment plan and the patient's available benefit. A PsycHealth Utilization Review Form is available for download on our website to assist you with the information required and the review process.

Electroconvulsive Therapy (ECT), inpatient or outpatient, requires prior authorization and approval by PsycHealth Medical Director.

REVIEW STAFF QUALIFICATIONS

Non-licensed UM Administrative/Support Staff

Non-licensed personnel shall be limited to administrative duties not requiring clinical review or clinical judgment such as collection and transfer of demographic data, verification of member eligibility and benefits. Non-licensed personnel are directly supervised by a Licensed staff member.

Clinical Care Coordinators

Clinical Care Coordinators are responsible for the day-to-day coordination and documentation of all information pertaining to utilization management cases throughout the review process. Specific responsibilities include, but are not limited to, Inpatient and Outpatient Utilization Review, case management activities and discharge planning.

PsycHealth Clinical Care Coordinators are required to be licensed and/or certified (active/unrestricted) in order to make review determinations regardless of the level or type of review. A Clinical Care Coordinator is empowered to authorize care and services but cannot deny care or services. Clinical review staff report to the Director of Clinical Services and always have the support of a licensed (active/unrestricted), board certified MD available to assist in review determinations.

Senior Clinical Coordinator

Participates in the training, supervision and management of all Clinical Care Managers and non-licensed UM administrative staff. The Senior CCC is Masters level licensed (active/unrestricted) behavioral healthcare clinician with a minimum if 5 years experience in

utilization management. A thorough knowledge and understanding of JCAHO, URAC and/or NCQA Standards is also required. This position reports directly to the President and Medical Director.

Medical Director/Physician Advisors

The Medical Director holds the highest position of responsibility and oversight in the UM Program. The Medical Director must be a licensed (active/unrestricted) board certified psychiatrist and possess a thorough knowledge of current Clinical Practice Guidelines, clinical risk management and requirements of the JCAHO, URAC and/or NCQA Standards. Responsibility for oversight of the specialty physician advisors in accordance with PsycHealth policies and procedures belongs to the Medical Director as well. They must be available for review of an expedited appeal within the required timeframe for each health plan.

- All PsycHealth physician advisors and clinical staff involved in UM decision making are required to annually sign an Affirmation Statement affirming that there is no conflict of interest and have not been offered or received any incentives to limit or deny coverage or treatment to members.

- All licensed clinical staff must submit to Professional Employee Competency Verification process similar to provider credentialing.

- All PsycHealth consulting and/or contracted participating network physicians must be currently licensed in the state in which they practice and must submit to and comply with the policies and procedures of the PsycHealth Credentialing Plan.

- Training in the principles of utilization management, performance improvement, URAC, and NCQA Standards is required of all PsycHealth personnel. All PsycHealth staff are encouraged to attend continuing education programs to keep current with the latest research and treatment protocols.

QC Portal

- QC Portal is PsycHealth's online system for PsycHealth providers to verify member eligibility, enter requests for outpatient referrals and submit claims electronically. QC Portal allows you to view the status of all data in real-time. Once Providers have received outpatient referral authorizations and submitted claims they can request sign up on QC Portal.
- Providers should contact QC Portal via email at QCPortal@psychealthltd.com to coordinate sign up and training.

MEDICAL NECESSITY CRITERIA

The PsycHealth UM Staff apply professionally and nationally recognized and approved criteria when performing utilization review of requested healthcare services in a consistent and professional manner. These criteria are based upon sound clinical evidence and currently accepted clinical practice guidelines.

The Executive QI Committee annually select, review, update, and approve nationally recognized medical criteria used in medical necessity review and LOS determinations. Review and input from the Peer Review Committee consisting of a multi-disciplinary representation of board certified, credentialed, licensed and actively practicing MDs and other behavioral health providers will be included before final approval. The most current edition of criteria will be utilized.
The Committees will explore other nationally recognized medical criteria options as necessary.

The screening criteria to be used for all prospective, concurrent, and retrospective review, and case management activities are:

- **APOLLO Managing Behavioral HealthCare Manual, 2019**
- **ASAM Criteria (Addictive, Substance Related and Co-occurring Conditions).**

If it is identified that a diagnosis is not well represented within the nationally recognized criteria, additional scientific medical resources, evidence-based objective criteria, clinical pathways, and guidelines will be consulted for consideration by the Peer Review Committee and Executive Committee.

A provider may request a copy of selected criteria related to a case by contacting the Quality Department by email or phone.

Clinical Services Descriptions

Definitions of the available levels of care are specified below:

24 Hour Inpatient Care

Acute Inpatient Psychiatric Admission: Inpatient psychiatric admission is required for treatment of a psychiatric disorder requiring admission to a hospital for 24 hour care to reduce the imminent risk of harm to self or others. Assessment of the member's presentation deems that services and care cannot be safely provided at a less restrictive setting.

Acute Chemical Detoxification: Detoxification is a medical regimen intended to safely reduce the amount of alcohol or drugs from a member's body and to control the degree of active withdrawal symptoms. These services may be provided in an inpatient or ambulatory setting depending on the needs of the member. Chemical detoxification is always conducted under the supervision of a qualified physician.

Inpatient Substance Abuse Rehabilitation: Inpatient substance abuse treatment will be utilized in only the most high risk/acute cases requiring 24 hour supervision and is designed to provide short term and intensive educational and multi-disciplinary treatment.

Adolescent Substance Abuse Residential Rehabilitation: Adolescent substance abuse residential treatment will be utilized in only the most high risk/acute cases requiring 24 hour supervision and is designed to provide short term and intensive educational and multi-disciplinary treatment and a stable environment to facilitate the recovery process.

Day/Night Ambulatory Treatment

Partial Hospitalization Program/Day Treatment (PHP): PHP is a program providing a more comprehensive and multi-disciplinary treatment plan at a less restrictive level of care than an

inpatient setting to address mental health and/or substance abuse disorders. Services are provided in an outpatient setting with a minimum of six hours a day and a frequency of at least three days a week.

Intensive Outpatient Program (IOP): IOP Programs provide a more comprehensive and multi-disciplinary treatment plan at a less restrictive level of care than a day treatment or inpatient setting to address mental health and/or substance abuse disorders. Services are provided in an outpatient setting with a minimum of three hours a day and frequency of at least three days a week.

OUTPATIENT AMBULATORY TREATMENT

Outpatient Home Health: Psychiatric home health benefits will be utilized as an acute, short term, crisis stabilization for members who are assessed to be free of imminent risk for harm to self or others and are not in need of a more structured level of care **and one** of the following: 1) member is homebound or 2) there is clear and reasonable evidence that member requires home health care in order to decrease risk of re-hospitalization.

Outpatient Medication Evaluation and Management: Outpatient medication management benefits will be utilized as stabilization for members who are assessed to be free of imminent risk for harm to self or others and are not in need of a more structured level of care. Outpatient medication management sessions generally occur monthly and always in an office setting.

Outpatient Psychotherapy: Outpatient psychotherapy benefits will be utilized as an acute, short term, crisis stabilization for members who are assessed to be free of imminent risk for harm to self or others and are not in need of a more structured level of care. Outpatient psychotherapy sessions generally occur weekly and always in an office setting.

Psychiatric Consultations in Non-Psychiatric Facilities: Psychiatric consultations will be utilized when a member is on a medical unit in a hospital for medical problems and is exhibiting symptoms consistent with imminent risk for harm to self or others, psychosis or member needs chemical dependence treatment.

Electroconvulsive Therapy (ECT): Electroconvulsive Therapy will be utilized as an acute, short term, crisis stabilization to prevent life threatening illness for members with severe psychiatric symptoms who are assessed to be at imminent risk for harm to self or others and for whom problems have persisted despite multiple pharmacological interventions based on an evaluation by a psychiatrist. ECT may be done either on an inpatient or outpatient basis depending on other symptoms.

NON-CERTIFICATION DETERMINATION

Case Closure Due to Lack of Information: A Case Closure occurs when there is a lack of adequate clinical information requisite to make a determination within the established timeframe for the type of care requested. *A Case Closure is **NOT** a denial or approval of services.* You may resubmit a new request for authorization accompanied by all necessary clinical documentation. The new referral request will be processed in accordance with standard referral procedures.

Denial: A denial is a decision to deny authorization of plan benefits for any service, procedure, or consultation. There are 2 types of denial determinations:

Administrative Denial: A denial determination based upon:

- benefit plan limitations as stated in the member's Certificate of Coverage
- failure to comply with contractual requirements

Such denials must be appealed on an administrative level directly to the health plan.

Medical Necessity Denial: A denial determination based upon failure to meet medical necessity criteria for the type and level of care requested. Medical necessity denials must be made by a psychiatrist to ensure that appropriate clinical judgement is used. If the clinical staff determines that a request for service does not meet criteria for medical necessity, the Medical Director or appropriate physician advisor is consulted. *Only the Medical Director or appropriate physician advisor can make a determination to deny benefits.*

Particular consideration is given to the following areas when making a determination:

1. The service requested is required for the appropriate diagnosis and/or treatment of a DSM diagnosis.

2. There is not a less restrictive level of care or more appropriate treatment alternative which may be utilized for effective intervention.

3. The requested service or procedure is considered to be safe and effective according to clinical evidence reported by recognized medical professionals and publications.

Denial Process

If the provider requests a service, level of treatment or additional sessions that the CCC determines may not meet medical necessity criteria, the CCC informs the provider that the requested treatment regimen must be reviewed by the Medical Director/Physician Advisor. The CCC presents the case to the Medical Director to determine if a denial based on medical necessity is appropriate. If a determination to deny is made, the provider is offered an opportunity to have a Peer-to-Peer conversation with the Medical Director/Physician Advisor. Once that conversation has occurred the Medical Director/Physician Advisor issues a determination. If the provider declines the offer for a Peer-to-Peer conversation, the denial determination is issued. The CCC documents the determination made by the Medical Director/Physician Advisor in the case management system. If the request is denied the provider and member are notified of the denial determination and their right to appeal the decision.

Information Required in a Notification of a Medical Necessity Denial

Verbal, written, or electronic notification of a denial must include the following information:

- Type of review conducted
- Specific reasons for denial
- Date of admission or onset of services
- Date of denial
- An explanation of the right to appeal
- Where and how to request an appeal

APPEAL RIGHTS

Appeal: An appeal is defined by URAC as a formal request for review of an organizational determination, such as services have been denied or reduced. There are 2 categories of appeal:

Administrative Appeal: An administrative appeal is conducted at the administrative level when the denial determination is based upon contractual issues or benefit coverage.

Medical Necessity: In all instances where a benefit is denied based upon a medical necessity determination, a member, provider, and/or facility have the right to appeal the decision. All appeals must be conducted by a Medical Director/Physician Advisor not involved in the previous denial determination.

Appeal Levels: There are 2 levels of appeal available to all appellants. The appellant is offered a first level appeal through PsycHealth The first level appeal may qualify as standard or expedited. If the first level appeal results in the denial determination being upheld, the appellant has a right to a second level appeal through the HCO. A second level appeal is never expedited and is always considered a standard level appeal.

Expedited Appeal: An expedited appeal is available when the issue in question must be addressed immediately because the denial of benefits was issued for services that are currently being administered or are scheduled to be administered imminently. An expedited appeal may be requested on first level appeals only.

Standard Appeal: An appeal is considered standard when the issue in question does not convey a sense of urgency, the services have already been rendered.

You may request an expedited appeal of a UM denial by calling 1-800-753-5456 and request to speak with the Case Management department for further direction; or, request a standard appeal in writing by sending your request and all supporting documentation to be considered to:

PsycHealth Care Management L.L.C.
Appeal Department
P.O. Box 5312
Evanston, IL 60204-5312

QUALITY IMPROVEMENT

PsycHealth is committed to the process of Quality Improvement as part of the framework to evaluate and improve the quality of care and services provided. Providers are required as part of the contract to cooperate with the quality improvement program as needed. Your feedback and participation may be solicited for a number of quality improvement initiatives, including but not limited to, provider satisfaction surveys, treatment record reviews, member complaints, clinical and non-clinical quality issues.

Provider and Member Experience Surveys: In an effort to continually improve our relationships with our practitioners, providers and members, PsycHealth annually conducts surveys of in-network providers and members to assess their level of satisfaction with various aspects of our operational and clinical procedures. Results of the surveys are communicated via newsletter, and/or web site. Opportunities for improvement are identified through survey data in order enhance our relationships and improve the services PsycHealth provides to our network of providers and our customers.

Case and Complex Case Management:
Case Management (CM) is the collaborative process of assessment, planning, care coordination, evaluation, and advocacy to address and meet and individual and/or family's comprehensive health needs through communication and linkage to available resources to promote quality of care, cost - effective outcomes, and optimal health of the member.
Complex Case Management (CCM) is the systematic assessment and coordination of care and services provided to members who are experiencing multiple complex and/or high cost conditions requiring assistance and coordination of multiple services and/or health needs with significant barriers to self-care. Generally CCM cases in Behavioral Health present with one or more critical, complicated or catastrophic events or diagnoses (include high risk acuity , relapse risk, and social determinants impacting the case) that require extensive use of resources and help navigating the system(s) to facilitate appropriate delivery of care and services.

Providers have the ability to request case management and complex case management services for their members through the Provider Portal or by contacting the Clinical Care department.

Treatment Record Review

Medical record documentation is required to record pertinent facts, findings and observations about the patient's health history, including past and present illnesses, tests, treatments and outcomes. The medical record chronologically documents the care provided promoting quality care. The medical record should facilitate:

- the ability of the treating providers to evaluate and plan the patient's immediate treatment and to monitor health over time;

- communication and continuity of care among providers involved in the patient's care;

- appropriate utilization review and quality of care evaluations;

- accurate and timely claims review and payment;

- collection of data that may be useful for research and education.

A well documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided.

Payers have a contractual obligation to our enrollees, we require reasonable documentation that services are consistent with the insurance coverage. PsycHealth may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided;
- the services have been accurately reported.

Treatment Record Review Requirements

PsycHealth may request access to the treatment records of our members for cause or as permitted by state and federal law for the purposes of peer review and/or billing audits. Treatment record reviews will be conducted on a regular basis of all high volume provider sites in accordance with PsycHealth policies and procedures. The records should include demographic information, health history, details of ongoing clinical issues and further dispositional plans. At a minimum all records should include the following information:

- DSM diagnosis
- A comprehensive treatment plan including goals and treatment interventions
- Progress notes consistent with the presenting problems, history and diagnosis
- Assessment of risk for harm to self others
- Consents for release of information to coordinate care with other behavioral health providers and/or medical providers (PCP)
- Medications prescribed, including dosages and frequency, as applicable
- Collaboration with general medical care (PCP)
- An appropriate discharge plan established well in advance of termination of treatment

In addition to the above components, the treatment record should be:

- Organized and each patient should have his/her individual folder/chart
- Kept in a locked and secured location within the practitioner's office
- Available to the practitioner at the time of treatment
- Retained upon discharge in accordance with all state and federal laws

Providers must have formal policies and procedures for treatment record documentation and maintenance of records in compliance with state and federal confidentiality laws

COMPLAINTS

Complaint: A complaint is defined by as an expression of dissatisfaction regarding the organization's products or services.

PsycHealth takes complaints from both members and providers very seriously. Documentation of the substance of the complaint is gathered and distributed to the appropriate individual(s) in question for a response. All responses received are evaluated and action taken is documented. Complaints are categorized by the nature of the problem as clinical care issues or non-clinical (service) care issues. The protocol for each is delineated below.

Clinical Quality Issues and Corrective Action

Clinical issues may be identified through chart audits, utilization review or other QI processes. Treatment records will be made available to the Peer Review Committee for review. After review by the Peer Review Committee, the clinical members of the committee will decide is there is a potential quality of care issue.

Further information from the provider in question will be requested via certified return receipt mail. After review of additional information received, the Peer Review Committee will rank the identified quality of care issue utilizing the severity levels outlined below:

a. Rank 0 – No quality of care issue.
b. Rank 1 – Nonstandard or unusual treatment/practice that may endanger the patient without risk of substantial harm, but no detrimental effect realized.
c. Rank 2 - Nonstandard or unusual treatment/practice that may endanger the patient without risk of substantial harm, resulting in minor or short term detrimental effect.
d. Rank 3 - Nonstandard or unusual treatment/practice that results in exposure of imminent risk to the health, safety or well being of the patient.
e. Rank 4 – Life threatening quality of care violation. Violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety or well being of the patient.

Corrective action required is based on the severity level ranking and is determined by the Peer Review Committee:

a. Rank 0 – No action required.
b. Rank 1 or 2 – Letter to provider describing issue and determination by the committee.
c. Rank 3 or 4 – Counseling or meeting with provider to discuss issues – continuing education classes; Suspension, Termination. Provider notified via certified return receipt mail.

Copies of all decision letters to providers will be placed in the provider’s file. Terminations will be reported to the appropriate authorities.

Non-Clinical Quality Issues and Corrective Action

Non-clinical issues may be identified through site audits, member complaints, treatment record review or other QI processes. When a non-clinical issue is identified, a letter from the Quality Manager will be sent to the provider stating the area of non-compliance, the time-frame for becoming compliant and the date of follow up from PsycHealth, Ltd (no later than 6 months).

If the provider continues to be non-compliant upon PsycHealth follow up review, the matter will be brought to the Peer Review Committee. The provider may be invited to attend the Peer Review Committee to respond to the concerns presented. The Peer Review Committee may recommend corrective actions which may include but are not limited to:

a. Intensified review
b. Development of corrective action plan with follow-up timeframe
c. Financial sanctions
d. Suspension
e. Termination

Action Taken by the Peer Review Committee will be documented and placed in the provider’s file. The provider may appeal the decision.

PROTECTED HEALTH INFORMATION, PATIENT CONFIDENTIALITY AND REQUIRED CONSENTS

PsycHealth ensures that patient-specific information obtained during the process of utilization management be kept confidential in accordance with applicable laws and regulations. Patient-specific information released by PsycHealth to direct service providers is limited to the information necessary to initiate appropriate treatment and to complete forms for reimbursement for services provided as permitted by state and federal law. The patient-specific information released to PsycHealth by providers of services will be limited to the information necessary and will be used solely for the purposes of utilization management, quality improvement, discharge planning and for processing claims. With a consent for release of information form signed by the member (parent/guardian, if applicable), PsycHealth will release referral records to the party indicated on the form.

HIPAA Privacy Regulations and Protected Health Information (PHI)

PHI as defined as under HIPAA means protected health information. This would include any information that can identify a patient including demographic and/or treatment information. HIPAA regulations define health information as "any information, whether oral or recorded in any form or medium" that

- "is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse"; and
- "relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual."

While HIPAA's primary privacy concern is health information transmitted by or maintained in electronic media, the privacy rule also reaches to data "transmitted or maintained in any other form or medium" by covered entities. That includes paper records, fax documents, computer screen prints and all oral communications.

Documentation of Compliance with HIPAA Privacy Regulations

The following measures have been implemented by PsycHealth to ensure that the patient's right to have his/her personal health information kept confidential is protected:

- **Privacy Officer** – A designated staff person responsible for the development and implementation of the administrative policies and procedures in compliance with HIPAA guidelines. This is the responsibility of the Director of Compliance and Operations.

- **Contact Person** – A designated staff person responsible for receiving complaints and providing further information about the specifics of the privacy policy. This person is also responsible for facilitating a patient's request for an amendment to the record or documenting any limitations on the release of PHI requested by a patient. The Director of Compliance and Operations is responsible for these duties.

- **Staff Training** - All PsycHealth employees including salaried and non-salaried/consulting physicians or peer reviewers must be thoroughly trained in the requirements of HIPAA and all other applicable laws at a minimum frequency of every 2 years. All staff personnel are required to sign a Confidentiality Agreement indicating that they fully understand the patient privacy requirements, are aware of the penalties for violation and agree to comply with such requirements before being given access to any patient specific information.

- **Notice of Privacy Practices and Patient Rights** – PsycHealth and all its network providers must, by April 14th, 2003, post a notice of privacy practices and patients' right to have confidentiality information kept confidential. Any healthcare provider that has a direct treatment relationship with the patient must:

    1. Provide the Notice no later than the date of the first service delivery, including service delivered electronically.
    2. In an emergency treatment situation, as soon as reasonably practical after the emergency treatment situation has stabilized.
    3. Obtain written acknowledgement of receipt of the Notice.
    4. Have copies available for those who request them and post notice in a clear and prominent location in the office, where patients can see it.
    5. If the provider maintains a website the Notice must be on the website and available electronically from the website.
    6. The notice may be provided by email if the patient agrees to electronic notice.

A Notice of Privacy Practices and Patient Rights is available for download on our website at www.psychealthltd.com.

CLAIMS SUBMISSION & PAYMENT

PsycHealth processes claims in accordance with the guidelines of the state specific Prompt Pay Laws. Clean claims will be processed within 30 days of the date received. As of July 1, 2008 PsycHealth will no longer accept handwritten claims.

A Clean Claim is defined as: A claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment.

A Clean Claim must include the following information at a minimum:

- Member Name
- Member Identification Number
- Date of Birth
- Insurance Carrier
- Group, and Site Numbers
- Provider Name and Title
- Federal Tax Identification Number
- Location at which the services were provided
- Date(s) of Service
- Place of Service Code
- DSM Diagnosis
- CPT/HCPCS
- Revenue Code
- Rates/Charges
- Authorization number
- Group NPI number
- Provider NPI number

The following are additional requirements for claims submission to PsycHealth:

- All claims for services rendered must be submitted to PsycHealth on a completed CMS1500 Form or UB04 Form.
- ICD-10 Coding and CPT-IV Coding must be utilized.
- Claims must be received by the PsycHealth no more than ninety (90) days from the date the services were rendered (unless otherwise specified in Provider Agreement). Provider agrees that any claim received after the established timely filing limit may be rejected at PsycHealth's discretion.
- Hand written claims are not accepted.

Member co-payments are to be collected by the provider at the time of services rendered. PsycHealth will deduct co-payments from the rate of reimbursement when processing claims.

Under no circumstances is a member responsible for any payment beyond the specified plan deductible and/or co-payment.

It is not necessary to re-submit claims in less than a minimum of 30 days. Excessive, unnecessary resubmission of claims may interfere with PsycHealth's ability to accurately process claims in a timely fashion as required under CMS guidelines, state law, and PsycHealth billing policies and procedures.

All complaints and/or appeals concerning incorrect, denied or delayed payments or any other claim issues must be conveyed to PsycHealth in writing within ninety (90) days from the date of the initial payment or denial of the claim. Any complaints or appeals filed more than ninety (90) days from the date of the initial payment or denial will not be considered and will be rejected as an untimely appeal.

In the event that an overpayment occurs, provider agrees to notify PsycHealth within ten (10) days and return the overpayment to PsycHealth within 30 days from receipt of overpayment. At such time that PsycHealth would request a refund of an overpayment, Provider agrees to return payment within 30 days of the request for the refund. Any overpayments not returned within 30 days may be deducted from future payment at PsycHealth's discretion.

All claims may be reviewed by PsycHealth for use of proper coding and appropriate billing conventions. PsycHealth may employ technological means, methods, hardware and/or software to assure appropriate billing for services rendered, including software to detect and repair issues of improper bundling or unbundling of codes and appropriate coding in relation to the designated diagnosis codes.

If additional information and/or medical records are required by PsycHealth to properly adjudicate and process claims in accordance with the Provider Agreement, Provider shall provide such additional information and/or medical records at no cost to PsycHealth

Coordination of Benefits

In circumstances in which Provider becomes aware of any other third party payer, Provider shall notify PsycHealth and shall document such Coordination of Benefits (COB) information on a HCFA/CMS1500 (02- 12) form or UB04 form.

Provider shall refund PsycHealth any payment made by PsycHealth for services for which Provider has received payment from any primary third party payer. PsycHealth shall have the right to collect and shall retain, any funds available because of Coordination of Benefits provisions. Provider shall not be entitled to retain any amounts greater than that provided.

Payment for Retroactively Ineligible Members

PsycHealth, Ltd is not liable for payment of services rendered to members who it determines at a later date were not eligible to receive services on the date the services were rendered. In such instances, the therapist may bill the member directly on a fee-for service basis. This clause applies even if a PsycHealth, Ltd authorization was issued. If PsycHealth, Ltd has paid a claim for such a member it shall have the right to seek reimbursement of the payment from the therapist. In any case, such right shall not exceed twelve months.

Claims Submission and Status Inquiries

Providers are encouraged to submit all claims electronically via the QC portal.

Please submit all PsycHealth paper claims to the address below:

PsycHealth Care Management L.L.C.
Claims Processing Department

P.O. Box 5312
Evanston, IL 60201

Claims status inquiries can be obtained during normal business hours by calling:
(847) 864-4961 or (800) 753-5456

Appendix A: Credentialing Data Elements and Minimum Requirements

Credentialing Element and Requirement	Time Limit	Verification Source
State License/Certification	180 days	State licensing agency - oral, written or internet verification is acceptable.

Clinical privileges in good standing at the practitioner's primary admitting facility, including date of appointment, and restrictions on scope of privileges.	180 days	Credentialing department or medical records department of primary admitting facility - oral or written verification is acceptable.
Valid DEA/Drug Enforcement Agency certificate or (CDS Controlled Dangerous Substance certificate.)	None (180 days)	Copy of the DEA or CDS certificate is acceptable verification. The DEA certificate must be valid and current at the time or credentialing. (Whenever possible, the Controlled Substance certificate should be verified. Under this circumstance, oral, written, or internet verification is acceptable.)
Board Certification	None	Written confirmation from the appropriate specialty board; or AMA Physician Master File
Education and Training	None	Written verification of *only the highest level* of credentials is required. Verification of physician board certification is acceptable. If a physician is NOT board certified, written verification of completion of residency is confirmation. Confirmation from the medical school is required for physicians who have not completed a residency program. If the physician is not board certified, any fellowship programs must be verified along with the residency. Non-physician practitioners' education is verified directly from the professional school.
Work history from previous 5 years	None	Primary source verification is not required. Clarification of any gaps in work history of 30 days or more require written clarification.
Professional liability insurance	None	Copy of current coverage including effective dates and amount of coverage at time of credentialing decision. A minimum of $1,000,000 per occurrence/$3,000,000 aggregate is required.
Professional liability claims history for the past 5 years	180 days	For MDs and DOs, query the National Practitioner Data Bank. For non-physician practitioners, written confirmation from the insurance carrier.
Medicare/Medicaid Status	180 days	Department of Health and Human Services, Office of Inspector General, Office of Enforcement and Compliance Cumulative Sanction Report.
Current clinical competence	180 days	At least two (2) references.
Specialized training for nontraditional practitioners	None	Written verification from school or training program.