

**MANISTEE-BENZIE
COMMUNITY MENTAL HEALTH**

PROVIDER MANUAL

INTRODUCTION

IMPORTANT NOTICE

This manual explains many important aspect of Manistee-Benzie Community Mental Health. This Provider Manual in conjunction with the Provider Contract outlines the procedures and guidelines that providers must follow to be included in Manistee-Benzie Community Mental Health's provider network.

Manistee-Benzie Community Mental Health reserves the right to interpret any term or provision in this manual and to amend it at any time to the extent that there is an inconsistency between the manual and the provider contract. Manistee-Benzie Community Mental Health reserves the right to interpret such inconsistency. The interpretation shall be binding and final.

Provider Manual for Contracted Facilities

Introduction

Manistee-Benzie Community Mental Health has developed this Provider Manual to be better prepared to work with our network service providers.

As a network provider you are stakeholders with Manistee-Benzie Community Mental Health and the Customers in the successful service delivery of Behavioral Health to the residents of Manistee and Benzie Counties. We must work together in a cooperative manner to provide optimal care while being fiscally responsible.

This Provider Manual is an effort to develop the basis for a coordinated and consistent working relationship. As Manistee-Benzie Community Mental Health move into the role of payers for and managers of delivery of services we wish to establish clear expectations and reasonable guidelines for working together. We believe this second edition of the Provider Manual needs to be dynamic and to that end we are open to receiving your ideas for improvement. We are committed to communicate with you and continually enhance our working relationship.

In the age of managed care and financial constraints it is more important than ever to develop competent and qualified provider network credentialed to properly service our Customers. We view this Provider Manual as one small step in that direction. We look forward to continued dialogue and a successful relationship with each of you.

MANISTEE-BENZIE COMMUNITY MENTAL HEALTH SYSTEM

Strategic Direction Statements

MISSION STATEMENT

Enhancing Freedom for meaningful lives through quality mental health care, Leadership, and teamwork within our community.

VALUES GUIDING PRINCIPLES AND SHARED BELIEFS

Manistee-Benzie Community Mental Health seeks to operate in concert with the following values principles and shared beliefs:

CONTINUOUS IMPROVEMENT: Manistee-Benzie Community Mental Health believes in the importance of continuously assessing its performance and seeking pathways to enhance its operations and outcomes. Continuous improvement is viewed as a dynamic, never-ending process in the pursuit of excellence. Problems are viewed as opportunities for improvement, not blame. It is our belief that the best sources for ideas to enhance organizational performance and innovation come from CMH Customers, Providers, and CMH employees.

CUSTOMER CENTEREDNESS: All services and organizational operations are designed to be Customer-centered, easily accessible, and delivered in a culturally competent manner. At all times Customers must be treated with dignity and respect and their view's, insights, and suggestions sought out and responded to.

EMPOWERMENT: The existence of a positive work environment, one in which employees are empowered, respected and recognized, is essential to positive organizational performance. All CMH employees and providers should have the support freedom and authority necessary to perform as professionals to be a continuously improving and learning organization. CMH will provide opportunities to enhance the skills and knowledge of its network through continuing professional education and lending the concept of empowerment to those served by CMH. We believe it is vital that CMH Customers have a right to participate in determining the nature and course of any service provided. Services are designed in a way that capitalizes upon and increases the strengths, capacities and competencies of the individuals and families served, rather than to focus on the repair or control of their limitations.

FISCAL RESPONSIBILITY: Manistee-Benzie CMH values fiscal responsibility and believes its stakeholders must maintain a sensitivity to how financial and other resources are consumed. We believe it is important to use resources in a prudent, efficient, and responsible manner.

INCLUSION: Each citizen is a part of the community's mosaic, whether through work, school, residency, or leisure pursuits. Integration is being present in the community; inclusion is being an accepted and valued part of the community.

INFORMATION-DRIVEN DECISION MAKING: While doing the right thing needs to be guided by good intent, objective information must also be part of the decision making equation. Accordingly, Manistee-Benzie Community Mental Health believes in the importance of guiding operations based on the objective analysis of accurate, timely and accessible information. Insuring that we are an information-driven organization requires the creation and maintenance of a technologically progressive work force and work environment.

LEADERSHIP: Manistee-Benzie CMH will play a leading role in the community by identifying needs and, in turn, developing and delivering coordinated behavioral healthcare services that help meet those needs.

OUTCOME-FOCUSED PERFORMANCE: Manistee-Benzie CMH believes its services and products must meet Customer expectations and be based on defined standards of effectiveness, productivity, and quality. We value clinical interventions guided by a goal-oriented and behaviorally specific service plan. Customers and payors expect positive change and solutions to problems, not services, programs and professional processes. What we do is infinitely more important than what we say we intend to do.

PERSONAL RESPONSIBILITY: This is a companion value to empowerment. Individuals employed by and receiving services from Manistee-Benzie CMH should be

accountable for their actions and inactions. In a civilized society, empowerment and the privilege to live with broad authority and limited restrictions brings with it the requirement of personal responsibility.

PREVENTION: Manistee-Benzie CMH believes that the historic bias of health and human service entities for reacting to illness, injury, disease and social problems must be balanced by a commitment to address the conditions that underlie such behavioral health and social problems. Manistee-Benzie CMH values its leadership role in deploying talent and resources in support of this transformation.

SEAMLESS AND COORDINATED SERVICES: It is essential that all community Providers operate in harmony so that those who are served experience seamless and well-coordinated interventions within and across agency and professional service boundaries. Manistee-Benzie CMH values taking a leadership role in promoting the philosophy of Customer centered collaboration and service integration.

SOUND ASSESSMENT AS THE FOUNDATION TO SERVICE EXCELLENCE: In all dimensions of organizational performance we believe comprehensive assessment and needs determination should proceed interventions, assessing, planning, doing, and evaluating the results, in that sequence, are the critical stepping stones that lead to positive results with comprehensive and integrated assessment viewed as the most important.

TEAMWORK: Manistee-Benzie CMH believes a well performing organization requires teamwork, active collaboration, and clear open communication within and among organizational programs and units. Harmony can only occur when there is a clear sense of organizational purpose and a shared commitment to a set of core values and principles. We believe that continuously demonstrating respect, courtesy, and integrity is essential and that being accessible and responding to the needs of team members is vital. We value employees as organizational stakeholders.

CHARACTERISTICS OF A SUCCESSFUL HEALTHCARE ORGANIZATION

Manistee-Benzie CMH recognizes the presence of powerful forces which are impacting today's healthcare and human service environment: realities that must be addressed in shaping the way we conduct business. Success, perhaps even survival, will be awarded to organizations demonstrating all of the following characteristics:

- An understanding that excellence in the delivery of service must consistently be provided: excellence, that is, as defined by all stakeholders - the Customer, the payor of service, as well as the provider.
- A recognition that the customer and the payor drive the system.
- An understanding that customers/payors expect outcomes and value, not just good intent and hard work.
- A realization that being customer sensitive in all dimensions of organizational operations is an uncompromising necessity.
- A belief that progressive healthcare and human service organizations must focus on fostering customer empowerment and less on "controlling" persons with healthcare and other social/economic conditions.

- An unrelenting commitment to practice in concert with sound principles of business, while recognizing that adhering to an organization's social mission is likewise essential.
- A recognition that progressive organizational performance requires good information systems; that is, the capacity for all organizational stakeholders to know in a timely, unobtrusive and user-friendly manner what is and is not occurring as the result of operations.
- An organizational environment which empowers its human resources to realize the potential that exists in everyone.
- An organizational culture that fosters continuous quality improvement at all levels of the organization.

CODE OF ETHICS SUMMARY

The Code of Ethics is for members of the Manistee-Benzie Community Mental Health Organization and it's Provider Network and has been adopted to promote and maintain the highest standards of personal conduct and professional standards among its members. As a member of the organization, a member espouses this code, thereby assuring public confidence in the integrity and service of the Manistee-Benzie Community Mental Health organization.

As a member of the Manistee-Benzie CMH Provider Network, you pledge yourself and/or your organization to:

- Maintain the highest standards of professional and personal conduct.
- Support the organizational Mission and Values.
- Improve public understanding of Community Mental Health services.
- Strive for personal growth in the field of Community Mental Health.
- Uphold all laws and regulations pertaining to Community Mental Health services.
- Maintain the confidentiality of privileged information.
- Instill in those I serve, and the community, a sense of confidence about the conduct and intentions of the organization.
- Maintain loyalty to the organization and pursue its objectives in ways that are consistent with the public interest.
- Refrain from using my position to secure special privilege, gain, or benefits for myself.

IF YOU HAVE ANY QUESTIONS REGARDING THE CODE OF ETHICS OR IF YOU FEEL THAT AN AGENT OF MANISTEE-BENZIE COMMUNITY MENTAL HEALTH SYSTEM HAS CONMITTED AN ETHICAL VIOLATION PLEASE ASK TO SPEAK WITH A MEMBER OF OUR CUSTOMER AND PROVIDER SERVICES OFFICE AT 1-877-398-2013.

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INTRODUCTION AND MISSION

The mission of Manistee-Benzie Community Mental Health (MBCMH) is to help those affected by emotional difficulties, developmental disabilities or addictive disorders through quality mental health care, leadership and teamwork within our community by providing clinical, work, and assisted living services as determined by the persons served.

As a Provider for MBCMH, you join a team of professionals dedicated to the management and delivery of medically necessary services. Our mutual goal is to ensure that Customers have timely access to the most clinically appropriate and least restrictive care possible in the most caring, sensitive and confidential manner possible.

Services will be provided to all Customers by a network of professional staff credentialed to work with the identified populations. This includes individuals who are chronically mentally ill, developmentally disabled, or substance abusers. Network paneled providers will have demonstrated clinical competencies to serve all age ranges and all disabled groups. Regardless of provider location, all providers will be held to the same standards of service performance and customer care. MBCMH guarantees each Customer:

- Access to services 24 hours per day, 365 days per year
- Timely response to identified clinical needs
- Clinically appropriate service authorizations and reauthorizations
- Full participation in the Person Centered Planning process
- Confidential services in a caring environment
- Services with dignity and respect
- Services in a clean, comfortable and relaxing environment of care
- Claims payments to Network Providers
- Customer and stakeholder involvement
- Ongoing involvement in efforts to enhance the organization's social mission
- Health promotion initiatives and programs
- Ongoing improvements in access to public mental health, developmental disability, and community support services
- Ongoing improvements in resource management and appropriate utilization of available services through behavioral health best practice (critical service pathways, standardized treatment protocols) and utilization management guidelines
- Quality services assessed continually through clinical outcome data

The Provider Manual has been developed to provide a general introduction to Manistee-Benzie Community Mental Health and to provide specific information regarding access to care and care management of available mental health, developmental disabilities and substance abuse services.

After reviewing the Handbook, please call (877) 398-2013 if you have any additional questions or informational needs. Manistee-Benzie Community Mental Health staff is available to assist you.

Providers Access To The System

Customer and Provider Services Line

Manistee-Benzie Community Mental Health provides a toll free access line for Providers and Customers. Providers and Customers can call the toll free number of 1-877-398-2013 and the TDD is also the same (allow time for the operator to connect the machine).

The purpose of the Customer and Provider Services line is to provide access to the identified needs of providers and customers and connect them with the appropriate service or department to meet their needs.

The Customer and Provider Services line provides;

- authorization/reauthorization of behavioral healthcare services and supports,
- coordination with other providers,
- follow-up services
- coordination of appeals/second opinions of access system service recommendations and for coordination of inpatient screenings; and,
- exception authorizations for non-network providers and case finding.

The intent of the Customer and Provider Services line is to determine the most appropriate level of care required to address the customer's identified behavioral healthcare needs. The access document shall provide clear impressions of the customer's presenting problems, the customer's expectations from treatment, the urgency of the concern, medical necessity, referral source, substance abuse and psychiatric history, recommendations for referral and/or support services provided by network providers and other organizations will also follow a referral. Follow-up services are an important function the Customer and Provider Services line it helps to link customers with services and to educate customer's on the Manistee-Benzie CMH system. The Customer and Provider Services line provides customers and referral sources with easy and timely access to services.

Services are available for Emergency services 24 hours 7 days a week.

Provider Services and Managed Care Operations Department
Phone: (877) 398-2013 and Fax (231) 882-2195

Representatives are available Monday through Friday from 8:00 a.m. until 5:00 p.m. (EST) and are responsible for:

- Screening for Intake assignment
- Follow up services, education, and prevention
- Pre-certification for all applicable services
- Authorization and Reauthorization of all covered services
- Concurrent utilization management
- Verification of covered person's eligibility
- Verification of covered person's authorization status
- Provider applications
- Network monitoring/management
- Provider relations/education
- Consultation with Providers
- Claims inquiries
- Written inquiries
- Benefit explanations
- Contractual negotiation

Information Needs

One of the priorities of the Customer and Provider Services (CAPS) is to meet the information demands of Customers and Providers. Specifically, they provide information regarding demographics, covered benefits, non-clinical utilization, CAPS staff answers eligibility verification, and other miscellaneous issues. Customers and Providers can access this information by calling a toll free number 1-877-398-2013 and a TTY is available. A clinician is available to speak with someone 24 hours a day. Voice Mail is also available 24 hours per day, seven days per week.

How to Access Care:

Providers can access care for Customers 24 hours per day, seven days per week, by calling the Customer and Providers Services line at 1-(877)-398-2013 a TTY is available.

Customer and Provider Services team authorize medically necessary care that is most clinically appropriate to the needs of each Customer as determined by a face to face clinical assessment. Medical necessity criteria are based on contract, national standards, and accepted professional practice. Medically necessary services must meet the following criteria:

1. Mental health (and/or substance abuse) services are authorized for the following purposes:
 - Assessment services to determine the presence and severity of a mental illness or substance abuse disorder; and/or,
 - Identification and evaluation of a mental illness or substance disorder that is inferred or suspected: and/or,
 - Intention to treat, ameliorate, diminish or stabilize the symptoms of mental illness (or substance abuse) including impairment in functioning: and/or,
 - Expectation to arrest or delay the progression of a mental illness (or substance abuse) disorder and to forestall or delay relapse: and/or,

- Provision of rehabilitation for the customer to attain or maintain an adequate level of functioning
2. The determination of a medically necessary service must be based upon a person-centered planning process.
 3. Services selected based upon medical necessity criteria should be:
 - Delivered in a timely manner, with an immediate response in emergencies, in a location that is accessible to the Customer.
 - Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner.
 - Provided in the least restrictive appropriate setting: (inpatient and residential treatment shall be used when less restrictive levels of treatment have been unsuccessful or cannot be safely provided).
 - Delivered consistent with national standards of practice including standards of practice in community psychiatry, psychiatric rehabilitation, developmentally disabled habilitation/rehabilitation, and substance abuse. This is defined by standard clinical references, and generally accepted professional practice guidelines, and is based on empirical professional experience/research; and
 - Provided in sufficient amount, duration, and scope to reasonably achieve their purpose.
 4. Using criteria for medical necessity, a CMHSP may:
 - Deny services that (a) are deemed ineffective for a given condition based upon professional and scientifically recognized and accepted standards of care; (b) are experimental or investigational in nature; or (c) services for which there exists an appropriate, efficacious, less-restrictive and cost effective alternative, setting or support, that otherwise satisfies the standards for medically necessary services;
 - Not to deny services solely based on preset limits on the duration of services; instead, reviews of the continued need for services shall be conducted on an individualized basis; and
 - Employ various methods to determine medical necessity, including prior authorization for certain services, concurrent utilization reviews, assessment and referral, protocols and guidelines.
 5. All determinations regarding medically necessary services shall be made in a timely fashion, by appropriately trained mental health (or substance abuse) professionals with sufficient clinical experience.

Customer and Provider Services authorizes therapeutically appropriate services that are most clinically appropriate to the needs of each Customer as determined via the intake process. Therapeutically appropriate criteria are based on national standards and accepted professional practice. Appropriate services must meet this criteria. They must be:

1. Medically necessary;
2. Provided at the appropriate level of care;
3. Provided by an appropriate credentialed and privileged provider;
4. Provided in a frequency required to meet the customers need;
5. Provided in the most appropriate location to meet the customers need;
6. Meeting the customers treatment needs (customer is making progress toward their treatment goals);
7. Provided in the least restrictive, most normalizing environment, and;
8. Satisfying the customer's standards of quality care.

Level of Care Criteria

Customer and Provider Services (CAPS) has established criteria to identify the intensity of Customer needs. The intensity criteria are matched with the above medical necessity and therapeutically appropriate criteria to determine the most appropriate level and setting for treatment services and care. Listed below is a summary of these intensity criteria.

CAPS Level of Care Criteria (LOC) standard is included in the Service Selection Guideline appendix section of this Manual (Attachment II). The LOC standards contain specific clinical guidelines for each level of care including the following:

- Description of the Service
- Expected Outcomes
- Admission Criteria
- Continued Stay Criteria
- Exclusionary Criteria
- Discharge Criteria
- Treatment Activities

CAPS will utilize the LOC to determine the appropriateness of all authorization and reauthorization requests.

Diagnostic Treatment Protocol

CAPS Vermont Clinical Practice Guidelines are included in the Attachment section of this Manual (Attachment III). This document represents the practice guidelines of Manistee-Benzie Community Mental Health delivery system. The purpose is to provide direction to the clinical practices of network providers based on industry standards and regulations. These guidelines are not meant to be an absolute standard a textbook or a cookbook in the evaluation, placement, care, and/or treatment of a Customer. Rather, they are intended to provide the clinician with a framework upon which to assess, achieve a diagnostic understanding, and assist the customer in building an effective and efficient Person Centered Plan. Clinicians are expected to use the guidelines to focus treatment/services/supports and to coordinate and keep consistent services approaches across the network.

During the course of treatment providers are to utilize Manistee-Benzie Community Mental Health's Person Centered Planning Practice Guidelines (Attachment IV).

These guidelines are subject to continuous quality improvement and adaptation based on research and national standards of care.

Customer Intensity Needs

CAPS defines Customer intensity of need as emergent, urgent, or routine and defines these as follows:

Emergent Need is a life threatening condition in which the Customer is actively psychotic; displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others; and/or is displaying vegetative signs and is unable to care for self. CAPS staff can refer the Customer to a MBCMH Crisis Worker who can authorize emergency care.

Urgent Need is a condition in which the Customer is not actively harmful to self or others, denies having a plan or intent to harm self or others, means or intent for harm but expresses feelings of hopelessness, helplessness, or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention will progress to the need for emergency services and care. CAPS staff will call the Provider's office to alert the Provider of the urgent referral and as needed help connect the Customer to the Provider. Providers are required to see the Customer within 72 hours of a request for an urgent appointment.

Routine Need is a condition in which the Customer describes signs and symptoms which are resulting in impairment and functioning of life tasks; impact the Customer's ability to participate in daily living; and/or have markedly decreased the Customer's quality of life. CAPS staff will schedule an appointment for the Customer with an appropriate provider. Providers are asked to see the Customer within 5 days of a request for a routine appointment.

Referrals for Internal and External Providers

Internal Provider Referrals

1. CAPS completes the initial Access to Care form and determines the appropriate provider based on presenting need. CAPS then authorizes an intake to the provider.
2. CAPS schedules the customer for an appointment with the provider. The most appropriate clinician to work with the customer and their identified need and the provider who is credentialed will most likely be assigned the case.
3. The provider clinician completes the assessment and plan of care, utilizing a standard assessment instrument provided by Manistee-Benzie Community Mental Health. This document will help to determine the diagnosis and recommended course of treatment. This will lead to the development of a standardized single initial Person Centered Plan (PCP). There is no therapy contract with the customer at his point.
4. Within 72 hours of submission of recommendations to CAPS, CAPS will

authorize services to the provider or disapprove services based on the provider recommendation.

5. Services are not approved by the provider if medical necessity is not established or if services are not deemed therapeutically appropriate.

If services are not medically necessary, the provider will, within 72 hours send a letter to the customer explaining the decision, outlining the appeal process and reminding them of the 24 hour emergency number.

If services are not therapeutically appropriate, the Provider will, within 72 hours send a letter to the customer explaining the decision. This letter will outline the appeal process and remind the customer of the 24-hour emergency number.

6. Services are approved if medical necessity is established or if services are deemed as therapeutically appropriate. CAPS will, within 72 hours of receipt of the information from the provider authorize the services. The Provider is required to notify the Customer.

7. CAPS via the Quality Improvement Process, use of the Service Selection Guidelines, and the Vermont Best Practice Guideline will monitor providers for medical necessity and therapeutic appropriateness.

External Provider Referrals

1. CAPS completes the initial Access to Care form and determines the appropriate provider based on presenting need. CAPS then authorizes an intake.

2. CAPS contacts the provider to schedule the customer for an appointment with the provider. This provider will be the most appropriate credentialed clinician that will most likely work with the customer and their identified need.

3. The provider clinician completes the assessment and initial Person Centered Plan (PCP) utilizing a standard Assessment instrument provided by Manistee-Benzie Community Mental Health. This document is to help determine the diagnosis and recommended course of treatment, leading ultimately to the development of a standardized single Initial Person Centered Plan (PCP). The Initial Person Centered Plan of Care submission standard is forty-eight (48) hours after completion of the Assessment appointment.

4. Within 72 hours of submission of recommendations to CAPS, CAPS will authorize services to the provider or disapprove services based on the provider recommendation.

5. Services are not approved by the provider if medical necessity is not established or if services are not deemed therapeutically appropriate.

If services are not medically necessary, the provider will, within 72 hours send a letter to the customer explaining the decision, outlining the appeal process and reminding them of the 24 hour emergency number.

If services are not therapeutically appropriate, the Provider will, within 72 hours send a letter to the customer explaining the decision. This letter will outline the appeal process and remind the customer of the 24-hour emergency number.

6. Services are approved if medical necessity is established or if services are deemed as therapeutically appropriate. CAPS will, within 72 hours of receipt of the information from the provider authorize the services. The Provider is required to notify the Customer.

7. CAPS via the Quality Improvement Process, use of the Service Selection Guidelines, and the Vermont Best Practice Guideline will monitor providers for medical necessity and therapeutic appropriateness.

Alternative Access Points for Care

Customers are encouraged to access all access to care functions through the local number in Manistee County 1-(231)-723-6228 and in Benzie County at 1-(231) 882-2100. A toll free number of 1-877-398-2013 and a TTY is available. This is considered the single point of access; however, for when treatment, services, and care are accessed through other avenues. These avenues may include:

Hospital Facility Emergency Rooms
Walk - In at any Manistee-Benzie Community Mental Health Location
Physicians Offices
Schools
Law Enforcement Departments
Community Mental Health Center Provider Offices

When this occurs, it is the responsibility of the treating Provider and/or utilization review staff to call 1-(877)-1-398-2013 to seek an authorization for treatment, services, and/or a referral to a clinically appropriate Provider.

Authorization for care must be received prior to the rendering of care for all treatment or services of care (except in the case of a medical necessity Emergency). Emergency care can be authorized up to 24 hours after the rendering of services. Unauthorized care will not be paid.

Eligibility Verification

The following information should be obtained before the first visit

1. Confirmation of Customer's name, date of birth, and social security number.
2. Name of Customer's employer and/or health plan insurer.
3. Information about who referred the Customer for services.
4. Clinical information and benefit data as per usual contractual procedure.

First Appointment Requirement: During the first visit, the Provider will initiate the following services;

1. Utilize a standard Assessment instrument provided by Manistee-Benzie Community Mental Health to determine the diagnosis and recommended course of treatment, leading ultimately to the development of a standardized single Initial Person Centered Plan (PCP).

2. Complete intake forms provided by CAPS which may include:
 - a. Assessment of Level of Eligibility (including the CAFAS, Pre-CAFAS, ICD-9, or BASIS32)
 - b. Consent To Treatment
 - c. Release of Information
 - d. Fee forms including Ability to pay
 - e. Background information
 - f. Consumer handbook

The Provider will maintain a copy of each instrument/form in an appropriate Medical Record consistent with standards developed by Manistee-Benzie Community Mental Health. A copy of each instrument/form will be provided to CAPS within 72 hours by mail, courier delivery, electronic mail, or fax.

About Our Staff

CAPS is comprised of individuals who have the education, training and expertise to:

- help determine the needs of Customers;
- help determine medical necessity;
- assist in matching the Customer's needs with the most clinically appropriate level and setting of care; and, assist the Customer in any means available to access appropriate care.

List Of Available Services

Listed below are the Levels of Care, which are available to each Customer through Manistee-Benzie Community Mental Health. For a complete review of the Services available under each Level of Care (please see attachment II):

Mentally Ill Adults (MIA) and Children (MIC)

- High Acuity
- Enhanced
- Enhanced Nursing Home Monitoring (Adults only)
- Enhanced - Therapeutic Stabilization Services (TSS)
- Moderate - Brief Outpatient
- Prevention

Developmentally Disabled Adults and Children

- High Acuity
- Enhanced
- Enhanced - Therapeutic Stabilization Services
- Moderate - Brief Outpatient
- Prevention

AUTHORIZATION RE-AUTHORIZATION STANDARDS

In the appendix section of this Manual is a copy of the Service Selection Guidelines. This details the description of the service, expected outcomes, admission criteria, continued stay criteria, exclusionary criteria, discharge

criteria, and treatment activities. Based on input from the Provider, all Authorizations and Re-Authorizations will be issued by CAPS staff within the service limits of these standards. These standards will be reviewed and modified by CAPS from time to time. Therefore, please request a current copy of the standards from CAPS.

The reauthorization process;

1. The provider must be proactive in the reauthorizations process. Re-authorizations must be requested within two (2) sessions or two (2) weeks, which ever comes first, of the expiration of the current authorization.
2. The provider clinician submits documentation requesting re-authorization and demonstrating continued need for services. This may be in the form of a quarterly report, monthly report, or similar format.
3. Within 72 hours of submission to CAPS, CAPS will either approve and authorize services to the provider or disapprove services based on provider input.
4. Within 72 hours of submission of recommendations to CAPS, CAPS will authorize services to the provider or disapprove services based on the provider recommendation.
5. Services are not approved if medical necessity is not established or if services are not deemed therapeutically appropriate.

If services are not medically necessary, the provider will, within 72 hours send a letter to the customer explaining the decision, outlining the appeal process and reminding them of the 24 hour emergency number.

If services are not therapeutically appropriate, the Provider will, within 72 hours send a letter to the customer explaining the decision. This letter will outline the appeal process and remind the customer of the 24-hour emergency number.

6. Services are approved if medical necessity is established or if services are deemed as therapeutically appropriate. CAPS will, within 72 hours of receipt of the information from the provider reauthorize the services. The Provider is required to notify the Customer.
7. CAPS via the Quality Improvement Process, use of the Service Selection Guidelines, and the Vermont Best Practice Guideline will monitor providers for medical necessity and therapeutic appropriateness.

Utilization Management Procedures

Utilization management reviews are conducted for all levels of care with all in-and-out-of Network Providers. The goal is to formally review the Customer's clinical record to ensure quality behavioral health services are being provided at the most appropriate level of care, in the most clinically appropriate setting, in the least restrictive environment, by the most appropriate provider in the most cost effective manner possible.

An authorization decision (authorization or denial of authorization) will occur:

1. With the initial request for care from the Customer (or from the Provider if the Customer is unable to call the Access line);
2. When further care is requested based upon a review of medical necessity therapeutic appropriateness and the Person Centered Plan;
3. Significant change in Diagnosis or Level of Functioning;
4. Upon review of an emergency admission to an acute care facility; or
5. Before admission to Detox/Rehab/Crisis Stabilization facility/partial hospital program or intensive outpatient program.

Emergency Direct Admissions

1. Pre-authorization of inpatient emergency care must be obtained by calling the Manistee-Benzie Community Mental Health prior to admission to an inpatient facility.
2. Emergency admissions will be authorized for 72 hours of treatment if the Customers situation meets emergency hospitalization criteria. After that period, Providers must follow the in-patient concurrent review process outlined below;

Psychiatric Evaluation in an Inpatient Medical Unit

Psychiatric evaluations performed through an in-patient medical unit require pre-authorization by Manistee-Benzie Community Mental Health staff.

Inpatient Care

All inpatient and alternative levels of care must be pre-authorized. This can be done through the 24-hour emergency on-call clinician a telephonic review between the Provider and Manistee-Benzie CMH and/or through a face to face review process.

Inpatient Reviews

1. Pre-Authorization of inpatient care requires a telephone review between the Provider and Manistee-Benzie staff and can be initiated by calling the CAPS line.
2. If a customer is admitted to an inpatient unit the responsible case manager must contact the customer and the unit within 71 hours after the admission.
3. To perform the review, Manistee-Benzie CMH staff must have detailed documentation concerning the Customer's need for continuing care and a realistic detailed discharge plan (i.e., treatment and discharge plans, any additional services).

Normally, psychiatric admissions do not qualify as emergencies. In order to qualify as emergencies, the Customer must meet all of the following criteria:

1. The medical record must clearly justify that the Customer was, at the time of admission, at immediate risk of serious harm to self or others. The emergency on-call clinician or other qualified mental health professional with Manistee-Benzie Community Mental Health must do an evaluation before the admission. The medical record must include the Customer's immediate

intent to commit harm and the method and opportunity to carry out the intended harm.

2. Medical documentation must show that the Customer requires immediate and continuous skilled observation and treatment at the acute psychiatric level of care. The medical record must document an unsuccessful attempt at crisis intervention prior to admission.
3. Providers must contact the Manistee-Benzie CMH staff as soon as possible, but no later than within 24 hours of an emergency admission, If it is determined that a true emergency existed and notification within 24 hours occurred, benefits will be approved from the date of admission. In contrast, if the Customer's condition is determined not to be emergent, but is medically necessary, benefits will be approved from the date of receipt of the pre-authorization request.
4. If a customer is admitted to an inpatient unit, the responsible case manager must have follow-up with the customer on the unit within 71 hours after the admission and fax to CAPS the detailed discharge plan.

Outpatient Reviews

1. Pre-authorization of outpatient care requires a telephone review between the Provider and CAPS staff, and can be initiated by calling CAPS.
2. If a customer is seen on an emergency basis, the responsible case manager must contact the MBCMH within 23 hours after the contact.
3. If ongoing services are needed and there is no authorization, a review CAPS/Utilization Management staff must have detailed documentation concerning the Customer's need for continuing care and a realistic detailed discharge plan (i.e., treatment and discharge plans, any additional services).

Normally, Outpatient Customers do not have emergencies. In order for an Outpatient Customer to qualify as emergent, he/she must meet all of the following criteria:

1. The medical record must clearly justify that the Customer was reporting an emergency.
2. Medical documentation must show the description of the Customer problem, the clinician's clinical impression, and their recommendation and plan for follow up. The medical record must document a successful attempt at crisis intervention.
3. Providers must contact CAPS staff as soon as possible, but no later than within 71 hours of an emergency contact. If the Customer's condition is determined not to be an emergency at that time, no payment will be rendered.
4. If a customer has an emergency contact, the responsible case manager must have follow-up with the customer within 71 hours after the expression of emergent need,

Complaints and Grievances

It is the policy of Manistee-Benzie Community Mental Health that all recipients have the right to a fair and efficient process for resolving disagreements regarding their services and supports managed or delivered by MBCMH or their provider network.

Recipients shall not be denied services and supports for arbitrary or capricious reasons, but do need to meet the definitions and criteria of medical and clinical necessity.

All recipients are to be informed of the grievance process orally and in writing at the time of initial service and the subsequent avenues available if they are not satisfied with decisions regarding services and supports received.

Please refer to Attachment V Labeled Appeal and Grievance Procedure to review the protocol for denials in:

Initial Community Mental Health Services
Denial, Reduction, Suspension, or Termination of existing services.
Denial of Hospitalization
Denial of Family Support Subsidy
PAS/ARR Level II Assessments

Filing An Appeal of Non-Authorization of Services

In the event that the Customer's request for a specific service(s) is not authorized by Manistee-Benzie CMH, you will receive telephone and written notification for emergent and urgent care placements and written notification for routine placements. The written notice will provide a detailed explanation of the medical necessity criteria utilized by MBCMH to make the determination of non-authorization. Listed below is a portion of the non-authorization letter that will be sent;

The proposed treatment requested has been reviewed by Manistee-Benzie Community Mental Health. Based on these reviews MBCMH has determined that the requested authorization should be denied for the following reason(s):

Care not deemed medically necessary.

Current Access and Authorization regulations do not allow for Customers referred by CAPS to be held responsible or billed for any denied services until the day following receipt of this notice. Therefore, the Customer cannot be held responsible for payment of any denied services until the day following the date on which the Customer signs a statement from the Provider (facility) outlining the specific non-covered services.

If you do not agree with the stated reason(s) for the non-authorization of services determination, you have the right to appeal this decision based on the aforementioned Appeal and Grievance procedures.

Appeal Procedure

CAPS is committed to providing Customers with the highest quality, confidential, mental health, developmental disabilities, and substance abuse services.

Providers can appeal denials of authorization to the CAPS Director. Providers need to give the CAPS Director any additional information to help with the first level of appeal. If the authorization is not approved, then a rational is

written by the CAPS Director. If the provider wishes to submit a second level of appeal then notify the CAPS Director in writing who will forward the first level appeal information and subsequent correspondence to the MBCMH CEO or his/her designee who reviews the information in a second level of appeal. If authorization is not approved, the customer and the provider are contacted.

Provider Practice Requirements

Access and Provider Availability

All Providers (in and out of Network) should be available for appointments according to the following availability standards;

- * Routine: Within 5 days of a request
- * Urgent: Within 48 hours of a request
- * Acute/Emergency: Within 24 hours of a request

All Providers (in and out of Network) should be available to handle their customer's emergencies.

All Providers (in and out of Network) are to insure that they do not put the customer between MBCMH and them themselves.

All providers (in and out of Network) will be proactive with their requests for authorizations.

COLLECTION OF CO-PAYMENTS/DEDUCTIBLES

A Provider may only collect applicable deductibles, co-insurance and/or co-payments from the Customer at the time of service. Providers shall use the Ability to Pay guidelines as outlines in the Michigan Community Mental Health Code Chapter 8 Section 818 - 819 (NOTE: Additional payments or co-payments of any kind are not allowed for Medicaid only covered Customers). CAPS will reimburse the Provider the balance up to the fee schedule maximum or negotiated per diem upon receipt of a claim form and compliance with CAPS policies and procedures. Coordination of benefits, co-payments, and deductibles vary by contract. A Provider will give the Customer a published fee schedule at the first session. When a Provider expects a Customer to pay for missed appointments, the Provider is expected to charge an amount congruent with the Provider's contracted fee schedule.

QUALITY IMPROVEMENT

The Quality Improvement (QI) program monitors and systematically evaluates the case management process as well as the care delivered by Providers. The approach is clinically directed as it focuses on the appropriateness and quality of care. The goal is to ensure that cost-effective quality care is provided to all those accessing services.

The Quality Improvement program is located in the Customer and Provider Services Department, which coordinates the review and evaluation of all aspects in delivering of care, Components include:

- Problem-focused studies
- Continuous monitoring of key indicators
- Medical records review
- Assessment of access and availability

- Customer satisfaction surveys
- Provider satisfaction surveys
- Accreditation Reviews

QI assessment and summary reports are made to the Quality Improvement Committee, Medical Director, senior management, and Providers (when appropriate) in order to identify problems, develop resolutions, and provide adequate follow-up.

STAKEHOLDER MEETINGS

Customer and Provider Services will have stakeholder meetings with providers on the network panel. The purpose of the meetings are to have a collaborative discussion regarding treatment of Customers in like contracted services. Stakeholders include representation from contracted providers, Customers/guardians, providers and Customer and Provider Services. Data is to be published and shared.

Data is to be collected and published for the stakeholders. Due to the public nature of our business, Data is available to others under the Freedom of Information Act. Data is collected on agreed upon performance indicators. Some potential indicators may include, Customer Satisfaction, Utilization, and Coordination Performance Outcomes. Data is to be examined at face value. The Quality Improvement Committee will review data and suggestions. Provider profiles will be considered as part of the contract selection for Network Provider Panel. The underlying Goals of Stakeholder meetings is to increase competition among stakeholders, enhance overall provider performance, and resolve Provider panel issues.

PROVIDER REVIEWS

Provider reviews are a summary of certain measurements of performance. It is a segment of data and is not designed to make value judgments. Provider reviews are used to compare results across a peer group or to set a standard or expectation. It can be used as part of the selection and retention guidelines of provider network. Reviews are used in decisions about referrals and as an indicator for intensity of utilization or quality review. Customer and Provider Services will use data as a consideration in rate negotiation and as a tool to focus quality improvement efforts and related training/development.

Some of the Profile Elements may include:

Cost of care

- per case
- Per admission

Care Access Elements

- Timeliness
- Hours of availability
- Related communication/notifications

Denials

- Types of denials
- Denial disposition

Customer diagnosis and acuity

- Severity of illness indicators
- Demonstrated competencies for authorization of care

Customer satisfaction elements

- Complaints
- Survey ratings

- Documentation quality control elements
 - Timeliness of required components
 - Required data elements
 - Clinical pertinence of content
- Other quality elements
 - Performance on key quality indicators
 - Compliance to Standards of Care
 - Outcome performance measurements
- Volume of activity
- Source and disposition of referrals and discharges
- Utilization management interface
 - Adherence to policies and procedures
 - Complaints
- Billing practices
 - Timeliness/frequency
 - Accuracy
 - Completeness

STATEMENT OF CONFIDENTIALITY

CAPS is committed to keeping all Customer information; documents disclosures and data confidential. Access to any Customer files will be exclusively limited to the MBCMH staff and those who are under contract to perform appeal reviews.

CAPS is committed to keeping all Provider information, documents disclosures, and data confidential. Due to the public nature of our business, data collected and published for the stakeholders' meetings is available to others under the Freedom of Information Act. This information will be presented in summary form only with no identification of individual customers.

Network Monitoring

Customer and Provider Services (CAPS) is responsible for monitoring all aspects of the Provider Network. This includes, but is not limited to, Provider changes and updates, re-credentialing, staff competencies (documentation of training as well as the determination of current competencies), utilization of person centered planning principles, environment of care, recipient rights, geographic and specialty access, and Provider relations activities. CAPS is responsible for monitoring the providers' compliance to care standards and outcome performance measurements.

To keep CAPS files current, the Provider is responsible to provide recredentialing and competency, accreditation, licensing, liability insurance, inspection reports, and plan of correction information within the defined timelines. When CAPS receives the new information, they will update the data system and add the documentation to the Provider's file. Failure to submit current copies of expired items may result in termination of benefit payments until the current Credentialing documentation is received.

Providers can help keep files current by notifying network operations of new practice affiliations, changes in address or licensure, and facility or program Involvement. Information can be submitted by faxing or by writing.

Out-of-Network providers are required to meet with the above standards if payment for services to be authorized.

Provider Terminations

Voluntary

If a Provider chooses to terminate membership in the Provider Network, a written request should be submitted to CAPS offices 90 days prior to termination.

Involuntary

Non-adherence to performance standards or criteria may result in termination as an approved Provider Critical areas monitored include:

- Adherence to contract stipulations
- Professional liability claims/disposition involving direct Customer care.
- Patterns of practice contrary to procedural standards
- Patterns of service delivery
- Billing fraud
- Unsatisfactory Medical Records Compliance Audit
- Refusal of accepting referrals
- Inability to service Customers within specified time lines

If performance standards are questioned the Provider will be contacted by phone whenever possible or by certified mail to alert the Provider to the issue(s) and review the appropriate documentation in compliance with due process/fundamental fairness procedures.

Billing For Services

Getting Your Claim Paid

1. Check the validity of the authorization. If further care or authorization is needed you can call CAPS.
2. Verify that you are the approved Provider. The Provider named on the claim form should match the Provider specified on the authorization.
3. Verify eligibility. If a Customer becomes ineligible for care before the number of sessions or units of care have been exhausted or the time period has expired, then the authorization becomes invalid.
4. Use the correct claim format. Providers are required to file their claims in an invoice format.
5. When approved by CAPS, submit claims to all insurance companies with which the Customer carries coverage. The notification of the decision from that insurance company should be attached to the claim form that is submitted.
6. When approved by CAPS, bill the customer per his/her Ability to Pay the amount after all insurance and all other funding sources have been paid, should be billed to CAPS. The notification of the decision from that insurance company and the amount billed to the Customer for his/her ability to pay should be attached to the claim form that is submitted.
7. Claims will not be accepted past sixty (60) days from the date services are provided, unless delayed as a result of billing other insurance's.

8. All claims submitted must include a copy of the authorization.

Billing the Customer

1. Providers may only bill (When approved specifically by contract/agreement)
 - For applicable deductibles, co-insurance, and/or co-payments from the Customer at the time of service.
 - According to the Ability to Pay guidelines as outlined in the Michigan Community Mental Health Code Chapter 8 Section 818 - 819
2. Providers may not bill:
 - Non-authorized services
 - Amounts above fee schedule/per diem
 - Additional payments or co-payments

Coordination of Benefits

Coordination of benefits will be conducted with a Customer's primary health insurance carrier. Please send a copy of the primary carriers Explanation Of Benefits (EOB) with each claim submitted as well as the amount paid on the Customers Ability to Pay. If the necessary information is not attached the claim will be returned, thus delaying the claim payment. The Provider has up to 60 days from the date of receipt of the primary insurance carrier's EOB to submit the claim.

Additional Paperwork with Claims

Providers do need to submit copies of their clinical documentation either electronically or in paper format each time a claim is submitted until written notice of release of this obligation is received C.A.P.S. staff. Although authorization is a prerequisite to reimbursement the authorization (both initially and throughout treatment) is entered into the central database system. Your claim may be processed quicker if the authorization number is on the bill claim form.

Time Limit

Provided all necessary information is received to process the claim, it is the goal of C.A.P.S. for all claims to be paid within 30 days of receipt.

Claims Submission

Please send claims to:
Manistee-Benzie Community Mental Health
Customer and Provider Services
Suite 800
6051 Frankfort Hwy.
Benzonia, MI 49616

*NOTE: Claims will not be accepted sixty (60) days past the date of services unless it has to be billed to primary insurance first In this case the claims will not be accepted sixty (60) days from date of EOB notice It is the Provider's responsibility to provide timely submission of all claims.

The Rights of a Customer

A Customer has the right to:

- Receive prompt access to care for mental health, developmental disabilities and alcohol/drug treatment needs.
- Receive information about Network Providers including their individual qualifications experience and specialty(s).
- Be treated with respect and dignity.
- Be provided privacy and confidentiality regarding Customer's treatment needs.
- Be provided care in a nondiscrimination environment.
- Ask for a different Provider if the Customer is not satisfied with the current Provider.
- Have a reasonable opportunity to choose the Provider.
- Ask questions and receive complete information about the Customer's treatment services, the Customer's medical status, and treatment options.
- Access the Customer's medical records in compliance with Federal and State laws.
- Have an opportunity to express concerns, grievances, and appeals regarding the timeliness and appropriateness of care, the authorization or non-authorization of payment for the Customer's care and any other issue that causes the Customer concern about receiving care through the C.A.P.S. access to care system.
- Receive prompt responses to Customer's concerns, grievances, and appeals.

A Customer has specific rights regarding receiving treatment Services, He/she has the right to:

- Consent to treatment or to refuse treatment
- Actively participate in the planning process for treatment (PCP)
- Be involved in the development of a treatment plan, which provides the Customer the opportunity to help make decisions regarding the services, Needed.
- Participate in the development of a personal crisis plan which helps the Customer prevent medical, family and psychiatric crises.
- Receive emergency services when required.
- Receive available, community-based, self-help services that the Customer feels are required to help in his/her in recovery from mental illness, developmental disabilities, and/or alcohol/drug abuse.
- Receive medically necessary services to meet the Customer's needs.
- Receive services in the least restrictive and least costly settings possible.
- Receive services that are culturally appropriate and that promote Customer satisfaction with the care received.

Customers Responsibilities

A Customer also has certain responsibilities. The customer is responsible for:

- Reviewing the Guide Handbook so that the Customer can fully participate in and receive benefits from C.A.P.S. authorized services and care.

- Abiding by the policies and procedures of Manistee-Benzie Community Mental Health.
- Participating as a full Customer in the Manistee-Benzie Community Mental Health authorized services and care. This means that the Customer will need to learn about and understand his/her rights as a Customer.
- Having the Customers Provider call (877) 398-2013 for authorization of services before services begin (except in the event that emergency services are immediately required which will allow the Provider to call within 24 hours after services begin).
- Sharing information about his/her mental health developmental disability or alcohol/drug abuse needs with the care Provider(s) in order to provide full information to assist in a team effort to develop treatment options.
- Actively participating in the treatment planning and service delivery process. This means the Customer will need to make personal choices about his/her care and take actions to improve his /her health and quality of life regarding the identified treatment needs.
- Providing clear and correct information about his/herself to the case manager/therapist.
- Communicating to his/her case manager/therapist about his/her perceptions of the most appropriate treatment.
- Arriving for scheduled appointments on time and telephoning the agency if for any reason he/she is not able to keep the appointment. This will allow us to reschedule for another day and time.
- Following the treatment plan exactly as it has been created by the Customer and case manager/therapist. This includes taking all prescribed medications correctly and at the time(s) directed.
- Asking questions of West Michigan Community Mental Health System if something is not clear to you.
- Being considerate of the rights of other customers and agency staff members.
- Be clean and free of illicit drugs.
- Abide by weapons restrictions at Manistee Benzie Community Mental Health and Provider sites.
- Informing the case manager/therapists of any changes in the Customer's life that may have an effect on the established course of treatment,

Glossary of Terms

Crisis Intervention - A method of addressing a person in crisis when seeking phone access/assistance to services Crisis is defined as a time-limited period of psychological disequilibrium which is precipitated by a sudden and significant change in the person's environment. This change demands an internal and external adjustment and expression. During this adjustment time the person is often rendered incapable of self-motivation. A loss or a threat of a loss, or a challenge coming usually precipitates the crisis in the shape of a hazardous, threatening event, threat of an individual need, and/or inability to cope. The goal of the Crisis Intervention is to reduce symptoms by labeling feelings and sources of feelings and to plug the person into resources of support, be it internal or external. This may also include helping the person take action on own behalf by exploring alternatives and consequences of those alternatives and identity personal strengths and past effective problem solving methods.

Triage - The process of choosing, selecting, or sorting; the immediate sorting out and classification of psychiatric casualties so that customers may be routed to and referred to appropriate treatment needed services.

Emergency Services - A service that is performed by a network provider for persons with presenting problems that cannot be adequately addressed by telephone crisis intervention. Direct face to face assessment and intervention is needed to process the emergency, contain, de-escalate and stabilize the crisis, coordinate and triage care services with others which may include family, law enforcement and medical providers. Various legal statutes or professional practice standards may come into play, such as "duty to restrain," "duty of due care," or legal reporting requirements such as "duty to warn," child/adult abuse/neglect, etc. Preauthorization for this service may not always be necessary since we anticipate multiple points of access/demand. Persons/clients assessed and found in need of covered behavioral health services and/or support would require MBCMH authorization. Network providers must have 24 hour (during business and non-business hours) emergency resources availability.

Initial Customer Screening - Screening includes the precipitating event, presenting symptoms, relevant history, substance use, present level of functioning, availability of support system, determination of need for second level review.

Intake Assessment - Comprehensive customer Assessment - The completion of a comprehensive bio-psychosocial assessment to determine clinical/medical necessity and level of care. Authorization of other differential diagnostic assessments at the network provider level may be sought if needed for clinical/medical necessity and level of care determination.

Reassessment and Periodic Review - Assessing an enrollee response to service and service outcome at a predetermined interval. Review of Customer's response to services and progress toward predetermined discharge criteria or desired outcomes. This review activity may be scheduled/unscheduled and be direct/indirect. Focused periodic reviews may be directed at certain target populations with network provider/programs that are serving high volume/high risk or high cost Customers.

Determination of Level of Care - The determination of eligibility

and clinical/medical necessity for Medicaid, public funded, or third party fee for service behavioral healthcare services and supports guided by clinical assessments, level of care protocols, examination/determination of benefit plan eligibility/coverage and/or code defined eligibility criteria. Also included are Person Centered Planning guidelines and linkages with community supports for those found ineligible, but requiring preventative or maintenance support.

Access to Care Sheet - A single entry sheet including Data would have date of request, client name, D/B, Medicaid or SS#, address and county, presenting problem, disposition data, program assignment, follow-up data. Data can be used for utilization management and performance improvement monitoring and reporting activities

C.A.P.S. Director - MA level clinician responsible for the overall operation of C.A.P.S. and supervision of CAPS staff.

Authorization/Reauthorization of Behavioral Healthcare Services and Supports - A Function performed by CAPS. The process is supported by the establishment and use of standardized clinical assessments, evaluations and level of care protocols matched to services and supports available through a network of service providers. Based on these clinical criteria and coverage of an enrollee's benefit plan, persons are matched (given authorization) to access a level of care which may include a bundle/package of predetermined services and supports, for a specific time frame or # of sessions, with stated expected outcomes. This process will include follow up with referral sources/service providers, concurrent reviews, access to an appeals process/system, coordination activities with other involved providers, monitoring and tracking of service provision and outcome with the provider and clients served.

Follow up - Contact with the enrollee following a complete/incomplete episode of care, A standardized questionnaire may be used. The intent is to determine care outcome and satisfaction. Customers may be encouraged to participate in prevention activities that promote wellness, prevention, and support. Some customers may be referred to a network provider for reassessment if behavioral healthcare services appear to be needed.

Coordination with other Providers - The basic intent is to ensure the continuity and non-duplication of care and supports. CAPS staff may identify a coordination concern during the initial screening. These concerns will be shared with the network provider when authorization is given for an Assessment/Intake. The process of the Assessment/Intake may need to further clarify issues of needed service coordination and consultation.

Inpatient Preadmission Screenings - The authorization of payment for inpatient psychiatric hospitalization, partial hospitalization or crisis residential services. The actual preadmission screening may be completed by an emergency service clinician serving the Customer's geographical area, then seeking authorization following the completion of an emergency service assessment

Capturing and Reporting Community Needs Information - CAPS staff aggregating service request data identifying trends or demands for service, especially gaps in care and reporting such data to the CAPS Director in the assessment of community service needs.

The Use of Utilization Data - The CAPS system of receiving and using data, such as Customer's satisfaction, program level outcomes studies, current

service reviews, the clinical accuracy of level of care protocol usage by network providers, program level length of stay data in contrast with population groups and diagnoses, recidivism rates, all for the purpose of determining CAPS and provider performance/standards compliance. Collectively, data can assist access in better linking Customers to a network provider program.

Receiving Cost-effective Care Data - Receiving utilization management data detailing provider network (program) outcome performance in contrast with cost of care, by program, population group and diagnostic categories.

Outcome - The clinical result or health improvement expected or planned from the provision of care.

Provider Network Panel - Listing of all provider network programs, including assigned clinical staff by location, discipline, and expertise/privileges.

Appeals/Second Opinion - A contract provider/Customer may request an appeal if payment or services are denied/unauthorized. Customers may disagree with the recommendations as determined by our Intake Provider. Customers will be informed of their right to a second opinion at the time of the screening/intake. CAPS staff and/or Recipient Rights will facilitate the Customer's concerns and will provide an opportunity to receive timely responses. A customer may request a second opinion if there is a denial of service. The customer notifies CMH within five (5) working days of the completed screening of their desire to request a second opinion. C.A.P.S. Director will clarify the customer's dissatisfaction with the findings/recommendations and will complete the review. There are two types of denials, which may trigger a second opinion following an inpatient screening and /or following an initial request for CMH services.

Eligibility Determination - The determination of all benefits a Customer seeking help has at their disposal for behavioral healthcare services. Determining if any costs may be born by the Customer seeking care. CAPS may need to contact insurance carriers, etc., to explore and determine benefit coverage. Enrollee benefit eligibility/or customer behavioral healthcare benefits are to be determined prior to referral to a network provider for assessment/care services

Claims Management/Review - Assisting MBCMH in claims processing, by providing authorized/reauthorized services data with internal/external care providers. This process may trigger a need for a retrospective review or an appeal

Care Coordination with HMO/QHP - Significant coordination will be necessary with qualified healthcare plans (contracted HMOs with DCH), to differentiate between medical benefits and behavioral healthcare benefits and plan responsibility for payment of disputed care.

Exception Authorization for Non-Network Providers - Negotiation of Rates of providers for a service when the enrollee is out of the catchment area; Customer is hospitalized while on vacation, CAPS must be able to negotiate a rate for the service. CAPS may have an established rate ceiling for all behavioral healthcare services to assist CAPS in rate negotiation with non-network providers.

Maintain Population Health - Being proactive vs. reactive

Recipient of Record - An Customer requesting or currently receiving CMH services, or a third party, such as law enforcement, a guardian, custodial parent of a minor, a family member, or a representative from a foster home, hospital or nursing facility requesting CMH services for a person in its care.

Informed Consent for CMH Services - Consent is implied when the Customer makes the first call to CAPS. At the provider level, written authorization of a customer, or a parent of a minor or guardian, authorizing the customer's participation in CMH assessment services based upon:

- Competency, which is the ability to rationally understand what is being proposed;
- knowledge, which is adequate information to permit an informed consent; and
- Voluntaries, which means no element of force, fraud, deceit, or coercion used to obtain the written informed consent.

Consultation - An exchange of information with another identified entity on behalf of the customer, which may include customer history, assessment information, diagnostic impression and recommendations. Consultation requires an informed written consent by the customer or the customer's court appointed guardian or custodial parent of a minor, and a written authorization to exchange information with the identified consultation entity. CMH staff members shall verbally inform the person (or parent of a minor or empowered guardian) who is the subject of the requested consultation of the following:

- Who (community agency/service provider) requested the consultation;
- The identified reason for the requested consultation,
- CMH policy regarding confidentiality and disclosure of customer related information; and
- The time frame or period in which the information is to be exchanged.

In emergency situations where a Customer is refusing to allow CMH to share specific client related information with other services providers to access appropriate substance abuse, psychiatric, or medical care, the CMH staff person shall exercise and document professional judgement as to the sharing of Customer information required to meet the Customer's emergency needs to the extent allowed under Public Act 258, of 1974, as amended, or as required by other related legal acts or professional reporting requirements.

Custodial Parent - A person with legal authority for the care and custody of a minor.

Guardian - A person with legal authority for the care and custody of an individual pursuant to an order of the Probate or Circuit Court, or a person who possess the legal rights and powers of a full guardian of the person, or the estate, or both, pursuant to an order of the Probate Court.

Minor - A person who is less than 18 years of age and has not been emancipated by a court of law.

Referral - The process of referring an individual to an appropriate service provider as determined by screening, with consent of individual, parent, or empowered guardian.

Duty of Due Care - An unwritten legal responsibility of mental health professionals to arrange and/or provide (either directly or indirectly), mental health services which are appropriate to the Customer's condition. For instance, a Customer found to be suicidal, psychotic, and/or violent requires access to treatment intervention/services initiated/implemented by CMH, which are clinically appropriate/equivalent to the Customer's condition.

Person-Centered Planning - The Customer shall be given the opportunities to express his or her needs or desired outcomes, potential support and/or treatment options to meet the expressed needs. The Customer shall be given ongoing opportunities to discuss and express his/her preferences and to make choices. Customers are provided with the opportunity to provide feedback on how they feel about services, treatment, and /or support they are receiving and their progress toward attaining valued outcomes.

Episode of Care - The period of time the Customer presented with specific symptoms and desired outcomes and the treatment/supports used to help achieve the desired outcome.

PROVIDER FORMS