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**CARDINAL HEALTH ALLIANCE BEHAVIORAL HEALTH
PROVIDER MANUAL**

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INTRODUCTION

Dear Behavioral Health Providers:

Cardinal Health Alliance is pleased to welcome you into our panel of providers. The manual has been developed to assist you with the necessary information to aid in the delivery of care to our members. This will be updated, as changes are evident.

You are a provider for Cardinal Health Alliance, a managed care company that holds contracts with Advantage Health Plans. CHA has a goal of providing cost effective, high quality mental health and substance abuse services for our members. Cardinal Health Alliance is responsible for managing and reviewing all mental health and substance abuse services for CHS employees, which are offered by Advantage Health. This may include prior authorization for inpatient and outpatient care, concurrent reviews, and coordination of services with the primary care physician and/or the development of new programs to meet the needs of our members. Other employers use the CHA network but CHA does not do the authorizations for the Mental Health Issues unless they are employed by Cardinal Health Systems. Call the number listed on the back of their cards for Mental Health authorization of services.

It is our intent to have a cooperative working relationship with our network providers. If there are any questions or concerns that you have about the procedures identified in this Manual, please call Cardinal Health Alliance at 765-286-2150

I. PURPOSE

This Provider Manual is intended to be a tool to assist contracted Providers in understanding what Cardinal Health Alliance requires for a smooth delivery of services. This manual should help you with claims payment issues, authorization requirements and other important procedures. Providers have contracted to follow the procedures listed in this manual. The Manual may be amended from time to time to improve delivery of services, or to comply with insurance or legislative requirements. CHA will notify you of any such changes.

II. DEVELOPMENT OF NETWORK SERVICES

In developing a network of providers in each area, Cardinal Health Alliance is responsible for development of a broad spectrum of services for contracted members. Therefore, the provider network typically consists of professionals from the disciplines of psychiatry, psychology, and clinical social workers. Primary credentialing criteria are listed below. Limitations to the network may be imposed by the limited number of individuals for whom CHA is responsible in this geographic area or for any other reasons determined by Cardinal Health Alliance.

1. Provider must successfully complete the application process.
2. Provider must possess an appropriate degree obtained from an accredited college or university
3. Provider must possess an appropriate license and/or certification for independent practice by the state of Indiana, without restrictions or past suspensions.
4. Provider must demonstrate competencies in his/her specialty in adolescent, and/or adult behavioral health or in substance abuse.
5. Provider must maintain professional liability coverage within specified limits.
6. Provider must have an excellent community reputation and have no ethical or malpractice complaints.

7. Provider must be quality conscious and have a problem-focused, **BRIEF** therapy treatment philosophy, which is congruent with Cardinal Health Alliance.
8. Provider must keep up-to-date with his/her field as evidenced by attendance at workshops, conferences, and/or clinical supervision.
9. Provider must agree to follow both policy and treatment guidelines established by Cardinal Health Alliance.
10. Provider must agree to treat patients in the least restrictive environment at the most appropriate level of care. Urgent needs must be met within 6 hours of a call request urgent care or member must be sent to BMH ER. A routine office visit must occur within 10 business days of a call requesting routine services.

Each Contracted provider completes a CHA Provider Application form before participation in the Cardinal Health Alliance network CHA network providers are recredentialed every 2 years. Cardinal Health Alliance monitors the providers for adherence to NCQA standards. Upon acceptance into the network, a provider's name and office location may be used in directories or other listings.

In addition to the termination provisions in the Provider's contract with CHA, a provider may be terminated from the network effective upon written notice from Cardinal Health Alliance and based upon the following criteria:

1. Provider has been rejected for participation in the network by the Benefit plan or Cardinal Health Alliance previously within twelve-month period of time at the time of the application to the network.
2. Provider has been terminated by the Benefit plan or CHA due to failure to comply with protocols.
3. Provider's general area of practice, treatment philosophy or specialty is incompatible with managed behavioral health care.
4. Provider fails to offer an after hour crisis service to the Benefit Plan members referred to the provider by CHA.

5. Provider has made a misrepresentation or knowingly misstated a fact or a matter on the information submitted to the Benefit plan or Cardinal Health Alliance.
6. Provider's general area of practice, treatment style, or specialty is such that in CHA's judgment, the provider network is represented by a sufficient number of participating providers the same or similar services to its members.

Information on the appeal process for a terminated provider can be obtained from Cardinal Health Alliance by calling 765-286-2150

III. AUTHORIZATION PROCESS

A. Eligibility Verification

Participating providers may check with CHA Medical Management/ Utilization Review department at 1-800-394-5234 or 1-800-553-0865 for eligibility or call the insurance company. The information needed to verify eligibility is as follows: subscribers name and date of birth, patient name, date of birth, Benefit group plan number and the employer.

B. Outpatient Prior Authorization

Participating Physician/ Psychologist/ Psychiatrist providers should prepare a treatment plan after they have seen the patient for intake and 5 sessions. A treatment plan must be filled out within the areas stated on the standardized treatment form (Appendix B) for prior approval of the next 6 sessions. No Physician referral is necessary, for the intake and the first 5 sessions. If Psychological testing is undertaken, prior approval must be requested, for the evaluation. The intake and 5 sessions with prior approval are intended for psychotherapy only.

If the member needs to see a specialized Psychiatrist for further evaluation and treatment, i.e. PPD/Autism the Psychiatrist or referring Physician must send a care plan or call Cardinal Health Alliance (CHA) to start the authorization for sessions. CHA has developed a step letter to follow to determine the suspected diagnosis of PDD/Autism if it is not known at the time of referral by the Primary Care Physician and/or the parent to follow in order to obtain treatment. Updated treatment plans are required for each 6 sessions requested by the Psychologist.

Treatment plans must be completed prior to the beginning of additional treatment services outside the previous authorization. Authorizations for the outpatient services are typically provided in blocks of 4-6 sessions. No more than 6 sessions per request are to be authorized for Psychologist. All therapy services will be specifically reviewed. Testing is not approved without prior approval.

- c. Offer the Release of Information Form to the member after the initial evaluation has been completed. After the form has been signed, send the information to the Primary Care Physician to promote coordination of care between the behavioral health and the primary care physicians. (Appendix A).

A. Inpatient Services

All inpatient admissions (**OUT OF NETWORK**) during business hours must be prior authorized by Cardinal Health Alliance case managers. After business hours you can call the following number below and give brief description of why the member is out of network or call the following day with all clinical information to 1-800-394-5234

Utilizations Review Quality Management case managers for Cardinal Health Systems must authorize all network inpatient admissions, within 1 business day of the admission to a network hospital through Midas.

B. Psychological Evaluations

All Psychological testing must be authorized for outpatients. The specific need for psychological testing must be identified to Cardinal Health Alliance before initiation of any psychological testing procedure. Authorization from CHA will be limited to Psychological assessments needed for development of treatment plans and authorization of Cardinal Health Alliance services.

Psychological testing for school evaluations, learning disabilities, developmental delays, admissions to organizations, and for judicial reasons are not covered benefits. Neuropsychological assessments typically will be channeled through a network neurologist for initial evaluation prior to any outpatient psychological testing for neuropsychological assessments.

If you have any questions regarding coverage for psychological evaluations, please contact Cardinal Health Alliance.

IV. UTILIZATION REVIEW

A. Outpatient Utilization Review

A review of outpatient services will be conducted after each block of 6 outpatient visits that have been authorized through Cardinal Health Alliance Behavioral Health Practitioner. Participating providers are required to complete the Outpatient Summary Form and submit the form with request for additional authorization. CHA has an expectation of approximately 8 visits for the average length of outpatient therapy. A request for coverage will be carefully reviewed and the Behavioral Health Director may initiate conversations directly with the participating provider to review a case in more detail. InterQual criterion is used by Cardinal Health Alliance to determine severity of illness and intensity of service.

At the completion of all outpatient services, a Termination Summary Form should be completed or a copy of the discharge summary provided to the Primary Care Physician whenever appropriate.

B. Inpatient Utilization Review

Services provided to patients on an inpatient psychiatric unit would be reviewed within 1 business day of admission. Quality Management/ UR Case Managers at Ball Memorial Hospital would authorize or deny the stay depending on clinical information and the diagnosis. The review will be put into a computer for the initial admission information, further concurrent review and discharge needs, which will be for CHA Case Managers to consider retrospectively.

InterQual criteria will be utilized by both CHA and BMH to determine if the member meets severity of illness and intensity of services. If member does not meet the InterQual criteria Cardinal Health Alliance case managers will be notified by QM/UR department at BMH. The case will be pended and appropriate Behavioral Health Practitioner, in regards to appropriate settings of care, will conduct further review. Direct conversation with the admitting counselors and /or with the attending Psychiatrist may be necessary to determine medical necessity. The case managers for both CHA and BMH will work with the inpatient staff to develop alternative treatment modalities for appropriate care for patients when there is non-authorization of continued stay coverage.

The Behavioral Health Director, or designee, is involved in all determination for any situation where the clinical information presented by a provider does not meet medical necessity for the requested intensity level of care. Definitive aspects of clinical appropriateness and medical necessity that result in an authorization of benefit coverage being denied are the responsibility of the Behavioral Health designee.

When continuation of an inpatient stay is not authorized, the Health Plan may indicate that the patient may be billed for these services. In any non-authorization situations, CHA will attempt to notify the patient of this situation. For minors or patients under custodial care, CHA will attempt to notify the appropriate custodian. In addition, notification will be made directly to the hospital QM/UR department regarding nonauthorization of the patient's continued stay on the inpatient unit.

Non-authorizations of admissions may be appealed through the appeal process identified under Section VI. In all cases of non-authorizations, it is important for you to understand that what is not authorized is Benefit plan coverage of the proposed care. The decision regarding a patient's care is your and the patient's responsibility. When a non-authorization is issued, the appropriate CHA case manager and the hospital case manager can work with you to attempt to develop an alternative treatment intervention for the patient.

Emergency, life-threatening conditions do warrant after hours, emergency admissions. Under these circumstances, the expectation is to notify the CHA medical management number at 751-3064 or 751-3060 during business hours. A Case Manager is on call 24/7 for Mental Health issues and can be reached at the same number listed above.

Conditions that warrant emergency admissions are situations in which there is a clear suicide risk for the patient, the patient is actively psychotic and is in danger of harming him/herself or others, or the patient needs an acute Medical stabilization. Requests for an initiation of routine inpatient substance abuse treatments are not considered emergencies and can be evaluated during the next business day.

C. Appeals Process

At the time of any non-authorization the provider or treating facility will be instructed regarding the appeals process. Failure to exercise the right to the appeals process cannot be used as a justification for request for payment later. Under most circumstances, a request for concurrent appeal will be heard by a psychologist or psychiatrist who has not been directly involved previously with the case. Behavioral Health designee will make a decision on a request for an expedited appeal the same day if all clinical information is available. For urgent concurrent review, a decision will be made within 24 hours of receiving all clinical information. For urgent pre-service request, decisions will be made within 72 hours of receiving all clinical information. For non-urgent pre-service request, decisions will be made within 15 calendar days and within two days of receiving all clinical information. For all post-service requests, decisions will be made within 30 calendar days and within 2 days of receiving all clinical information.

Under no circumstances will the appeal process be used to question or modify the criteria for admission or continued stay. Additional appeal is open to providers through the appropriate Benefit plans. If so interested, please contact Cardinal Health Alliance medical management department to request information in this regard. You can call the number on the back of the card and ask for the appeals area also.

V. CLAIMS PROCESSING

A. Fee Schedule

As a part of becoming a CHA participating provider, providers must sign a Participation Agreement, which outlines many of the expectations of participating provider, as well as the fee schedule for their services. Please consult the Participation Agreement to review the fee schedule for all services. In some cases, the fee schedule may also contain fee maximums as set by appropriate health plans. Except for co-payments and deductibles, patients cannot be held financially responsible for any balance due in excess of these fee schedules.

B. Co-payments and Deductibles

In most benefit plans members are required to contribute to the cost of Behavioral Health services by paying a co-payment and/or a deductible for the cost of services. The co-payment required is usually found on the member's card. If this is not plain as to what the co-pay is you can call for benefits and the number to call is on the card. Some plans do not require co-pays from the member. It is your responsibility to collect the co-payment at the time of service. CHA strongly encourages you to require payment at the time of service in order to avoid any bad debt. Members are not required to pay in excess of the co-payment/or deductibles.

C. Claim Forms

Submission of claims to CHA for payment should be made using the HCFA-1500 billing format, which includes itemized information such as diagnosis (ICD9 and current version of DMS), patient and subscriber names, patient and subscriber Dates of birth. Groups plan numbers, dates of service, type and duration of service (CPT-4), name of the provider (I.e., individual who actually provides the service)

credentials, and tax I.D. number of the provider. We ask that you submit claims which reflect your “usual and customary” or standard rates. The Health Plan will reimburse you according to the negotiated fee schedule. The address to submit your claim to is on the back of the member card.

VI. QUALITY ASSURANCE PROCEDURES

Quality Assurance standards begin with appropriate selection of providers to the Cardinal Health Alliance provider network. Use of credentialing criteria is a necessary first step for development of high quality, cost effective care.

Maintaining these standards is necessary to protect you, your network colleagues, and CHA with regard to reputation and standing in the professional community. After this initial selection process, the following procedures are implemented as part of Quality Assurance system.

A. Recredentialing

During the recredentialing process that occurs every 2 years, you will be required to respond to the recredentialing questionnaire, report malpractice cases, and furnish proof of licensure and malpractice insurance coverage.

As a part of the recredentialing, site visits will be performed at Behavioral Health provider offices, where Cardinal Health Alliance will perform a medical record audit. Site visits will be arranged at a time convenient to you and to CHA. You will be informed of the number and types of medical records that will be reviewed. Providers are expected to maintain adequate medical records on all clients, in accordance with legal standards.

B. Patient Satisfaction Surveys

On a regular basis Cardinal Health Alliance conducts patient satisfaction surveys to Benefit plan members.

C. Utilization Management Monitor

On a regular basis CHA conducts an evaluation of key utilization management indicators for Health plan members receiving services coordinated and/or managed by CHA

D. Utilization Profile

On a quarterly basis, each provider is reviewed and information is available in regards to his or her average length of therapy, and the network average length of therapy. Cardinal Health will attempt to break this down to child, adolescent, adult services for both inpatient and outpatient if requested. In addition, use of psychological testing also is evaluated from time to time. This information is used to evaluate overall performance by that provider concerning over and under utilization of treatment services.