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For the most current CBHA forms please see our website at www.cbhallc.com

GENERAL INFORMATION

Forward

This manual is a reference and source document for network mental health and substance abuse providers and facilities participating in the CBHA program. It contains all relevant program policies and procedures and accompanying explanations and exhibits.

CHBA views your continued independence, clinical freedom and success as essential to the program's effectiveness. The better each network provider understands the program and the way it is designed, the greater the likelihood of success. This manual is intended to help maximize the value of the program for you and your patients.

This manual is updated as experience with the program, enrollees and network providers dictate. Quality issues are continuously monitored to determine areas needing improvement.

This manual is designed to clarify the various provisions of the ***Network Professional Agreement*** you have already signed. It is considered to be a part of that agreement and to operate as a unified whole and does not create new or different requirements. In the event that a conflict is ever found to exist between the provisions of this manual and the agreement, the agreement shall take precedence.

About Carolina Behavioral Health Alliance (CBHA)

Carolina Behavioral Health Alliance (CBHA) is a managed behavioral health organization based in Winston-Salem, North Carolina and is owned by three North Carolina medical schools—East Carolina University, University of North Carolina Chapel Hill, and Wake Forest University. The mission of CBHA is to assure access and exceptional value in behavioral health services and benefits for its clients. Reflecting the best tradition of academic medicine, we seek effective outcomes provided in a dignified and confidential manner. Our goal is to facilitate and ensure that our members receive the most efficient and effective mental health and chemical dependency treatment available and that their benefits are used wisely. This treatment is facilitated through CBHA's extensive statewide network of community and academic behavioral health providers and facilities.

CBHA Service Delivery…A Commitment to Quality

CBHA is proud of the reputation it has earned in the healthcare community as an organization dedicated to providing superior service to its customers. Amongst enrollees, providers, and benefit administrators, CBHA is known for being one of the friendliest and easiest health plans to work with. This accomplishment is due in large part to:

Simplified, provider-friendly utilization management procedures;
A comprehensive, statewide provider network;
The CBHA commitment is to provide customers with prompt and personal service.

CBHA is a licensed TPA and meets or exceeds all regulatory and NCQA requirements for utilization management. A clinician is available for emergencies 24-hours a day, 7 days a week through a simple call in process to 1-800-475-7900. Enrollees and providers always reach a live person when they contact CBHA; there is never a need to follow a telephone menu or wait through excessive holding times.

CBHA Mission Statement

The mission of Carolina Behavioral Health Alliance is to assure access and exceptional value in behavioral health services and benefits for its clients. Reflecting the best tradition of academic medicine, we seek effective outcomes provided in a dignified and confidential manner.

CBHA Program Goal and Objectives

The goal of Carolina Behavioral Health Alliance is to facilitate and ensure that our members receive the most efficient and effective mental health and chemical dependency treatment available and that their benefits are used wisely.

Patient Objectives

- Provide outstanding customer service
- Quality of care at the most appropriate level
- Easy access
- Rapid Assessment
- Emergency services available 24/7
- Timely outpatient appointments
- Access to focused and goal-oriented treatment
- Crisis stabilization
- Access to multi-disciplinary care
- Responsiveness to individual needs and confidentiality
- Ongoing treatment outcomes monitoring
- Preventive measures and educational programs
- Ongoing monitoring of enrollee satisfaction

Health Plan Objectives

- Ease of access to a broad network of highest quality providers
- Fiduciary responsibility through correct application of benefits
- Highest degree of enrollee/provider satisfaction
- Competitive Fees
- Co-ordination of services with the medical carrier
- Accountability through accurate and timely reporting mechanisms

Provider Objectives

- Referrals matched to provider practice goals
- Fair, prompt payment for services rendered
- Guidelines based upon recognized, published best practices
- Administrative procedures that are considerate of provider time and effort
- Ease of communication and adjudication of appeals
- Fair and consistent credentialing process

- Ongoing provider feedback and communication through newsletters, satisfaction surveys, and provider representation on the credentialing/quality improvement committee.

Website

Registered CBHA providers can log on our website at www.cbhallc.com to review enrollee eligibility, benefits and claims information. To obtain a provider log on and password, just go to the section of the website labeled "Provider Tools" in the upper right hand corner of the website. You may call us at (800) 475-7900 if you have any questions.

CBHA provides detailed information on our website for our providers and enrollees at www.cbhallc.com. Information on the website is updated on a regular basis to provide current information about behavioral health services. The website includes a Provider Search feature that allows our enrollees to locate providers by name, location and specialty. Documentation forms, such as the "Psych Testing Request" form, and the provider manual are located on the website under the Provider section.

Telephone Contacts

For pre certification, eligibility or benefit information	1-800-475-7900
For psychological testing requests	fax 1-888-908-7140
For professional relations, claims questions and filing information complaints, grievances and appeals	1-800-475-7900

The toll free line is answered by a live person and is staffed after hours for emergencies. Authorizations and questions are addressed during normal business hours.

Mailing Address

All claims and correspondence should be mailed to:

CBHA
PO Box 571137
Winston Salem, NC 27157-1137

Provider Frequently Asked Questions

1. What services require pre-registration?

Services other than standard outpatient psychotherapy and medication management require pre-registration. This includes: psychological and neuropsychological testing; EMDR; outpatient consultations; ECT (both outpatient and inpatient); behavioral health home visits; Gastric Bypass Evaluations and Vagus Nerve Stimulators (VNS). Additionally, all intensive levels of services (i.e., inpatient, partial and intensive outpatient programs) must be pre-registered. Call 1-800-475-7900 to speak with a clinical case manager to obtain registration for these services.

2. What is the process for registering outpatient sessions?

For authorization of specialized services, call CBHA at (800) 475-7900 to talk to a clinical care manager. Some services may require special documentation, while other services, such as gastric bypass evaluations, may be able to be authorized over the phone. If specific documentation is required, you may send that to us one of two ways:

Fax-888-908-7140

Mail: _ PO Box 571137
Winston-Salem, NC 27157

3. How do I obtain authorization for psychological and/or neuropsychological testing?

Call CBHA to obtain authorization for consult visits so an evaluation can be done in order to determine what type of testing will be necessary. Prior to administering any testing, the provider should access the CBHA website,www.cbhallc.com, and obtain a copy of the "Psych Testing Request" form which can be located by clicking on, "Providers," then "Provider Forms." The form should then be submitted via fax (888-908-7140), or via mail (PO Box 571137, Winston-Salem, NC 27157).

Upon receipt of the testing request form, a clinical case manager submits it to our consulting psychologist for review, and the psychologist renders a decision to the CCM within three business days of the request. Most requests for testing are granted based upon a need to clarify a clinical issue or a need to provide direction for treatment planning. Please keep in mind, testing for Learning and Developmental Disabilities are generally not eligible under the behavioral health plan; call to obtain details of specific health plans managed by CBHA.

4. Will CBHA authorize group therapy? –OR—Is group therapy covered under an outpatient psychotherapy registration?

CBHA recognizes that group therapy programs can be beneficial and is willing to authorize these services. We ask providers who conduct group therapy programs to submit a written description of the group(s). It is preferred that groups have defined time limits and are open to newcomers. Health plans managed by CBHA do not cover support groups that are not facilitated by a licensed therapist.

Authorization of group therapy is only required if the member is seeing a different therapists for individual and group therapy. If the same provider is seeing the member for both services, a separate authorization is not required.

5. Can an enrollee see a provider more than once in one day?

We will not cover two sessions in one day for the same therapist. A provider may utilize add on codes, as appropriate, to describe services rendered.

6. Can a patient see his/her therapist and a psychiatrist in the same day?

An enrollee may see his/her therapist and psychiatrist in the same day and receive insurance reimbursement if both providers have prior registration.

7. Will CBHA allow for more than one family member to be seen by the same therapist?

If it is clinically appropriate for more than one member of a family to be seen by the same therapist, CBHA will support this plan. If several members of the same family require treatment, family therapy may be indicated. If several members of the same family are seeing different therapists, CBHA will likely request clarification why this is necessary and whether the participating providers are collaborating on the case.

8. Is marital therapy a covered benefit?

Treatment of relationship problems where no other diagnosis exists is not covered by CBHA managed benefits.

9. **Do CBHA managed benefits cover VNS and rTMS therapies?**

CBHA managed health plans do cover Vagus Nerve Stimulators (VNS) and Repetitive Transcranial Magnetic Stimulation (rTMS) for treatment of certain mental health conditions. You will need to obtain separate approval for these treatments. Call CBHA at (800) 475-7900 for details.

10. If a network provider fails to obtain authorization prior to providing services that require authorization, will CBHA backdate that authorization?

CBHA will not backdate for services requiring pre-authorization that is not obtained prior to the provision of services. Remember, the patient cannot be held liable for the payment of services for lack of authorization; enrollees are only responsible for their co-pay or coinsurance. If a provider is unable to obtain pre-authorization due to extenuating circumstances, they may contact CBHA to discuss the issue. CBHA does allow a five business-day grace period to obtain authorization of care for outpatient services that require prior approval.

11. How long does CBHA take to reimburse claims?

CBHA pays all clean claims well within thirty (30) days of receipt. If providers have any concerns/complaints regarding claims payment, they should contact the CBHA Claims Department Manager. CBHA is committed to maintaining a good relationship with its provider network and welcomes information about provider's concerns.

12. If an enrollee has specific confidentiality concerns, how is this handled by CBHA?

Enrollee confidentiality is very important to CBHA. Enrollee information is held in strict confidence by CBHA staff and enrollee records are kept in a secure location and accessible only to those who have "a need to know". If an enrollee needs additional confidentiality protection, they must put their requests in writing to CBHA. CBHA will consider all such requests, especially where member safety is an issue.

STATEMENT OF ENROLLEE RIGHTS AND RESPONSIBILITIES

Enrollee Rights

Enrollees whose behavioral health benefits are managed by Carolina Behavioral Health Alliance (CBHA) have the right to:

1. Be treated with courtesy, respect and dignity without regard to race, gender, cultural background, religion or other protected classifications.

2. A clear and understandable explanation of benefit plans and how to access behavioral health services.

3. Request and receive information about CBHA and its services.

4. Request and receive information about how CBHA determines medical necessity and authorizes behavioral health services.

5. Request access to inspect and copy your protected health information and to request that health information be amended if you have reason to believe it is inaccurate or incomplete.

6. Request that CBHA communicate with them through alternate means or locations if use of the standard communications process would endanger an enrollee or others.

7. Privacy and confidentiality regarding your clinical information, including your diagnoses; information shall be kept in strict confidence and shall not be shared with anyone without the enrollee's written permission, except as permitted or required by law.

8. Request restrictions on uses and disclosures of protected health information.

9. Access to services and CBHA providers within timeframes that meet the needs of the current situation, including immediate access in case of emergency.

10. Be informed about CBHA providers, including location, office hours and specialties.

11. Participate with practitioners in decision-making regarding treatment planning, including a clear explanation of diagnoses and treatment options, regardless of cost or benefit coverage, and, in cases where medication is prescribed, a clear explanation of the medication(s), including any possible side effects.

12. Be informed of all facts about any charges and bills received, regardless of who is responsible for payment.

13. Be provided with information about how to file a complaint, grievance or appeal; to file a complaint or grievance; to appeal any denial of services in accordance with CBHA policies and applicable law.

14. Receive a copy of your rights and responsibilities and make recommendations on CBHA's member rights and responsibilities policy.

Enrollee Responsibilities

Enrollees whose behavioral health benefits are managed by Carolina Behavioral Health Alliance (CBHA), have the responsibility to:

1. Read and adhere to the guidelines of the health plan as they appear in the ***Certificate of Coverage***, benefit booklet or other benefits materials.

2. Present your ID card before receiving each service and to pay the appropriate co-payment at the time of the service. Protect your ID card from unauthorized use.

3. Provide CBHA and its providers accurate and relevant information regarding current and past health condition(s) to ensure appropriate care and treatment; this includes granting a release of information and helping to obtain medical records from former providers of care, if applicable.

4. Actively participate with providers in the development of treatment plans, to cooperate with agreed upon treatment goals, instructions and guidelines and to discuss progress or lack of progress with your providers.

5. Inform your providers of care of any changes in your health care benefits.

6. Report concerns about fraud, abuse or quality of care.

7. Make and keep appointments for non-emergency behavioral care, to adhere to the treatment plan and to take medications as prescribed. If it is necessary to cancel an appointment, you have a responsibility to give the provider's office adequate notice.

8. Inform providers of any changes in medication prescribed by other practitioners.

9. Notify your group administrator and CBHA if you have any additional coverage; notify the group administrator of any changes regarding dependents and marital status as soon as possible.

10. Be considerate and courteous to CBHA providers, their staff and CBHA representatives.

If you have any questions, please feel free to call CBHA at 1-800-475-7900 or write to us at: P.O. Box 571137, Winston-Salem, NC 27517-1137.

UTILIZATION REVIEW

CBHA Authorization and Referral Procedure

The enrollee or network provider shall call **1-800-475-7900** to initiate authorization for treatment. If the enrollee requests a specific network provider, or the call is from the network provider's office, a CBHA Customer Service Representative or Clinical Case Manager will verify enrollee eligibility and benefits and will complete an initial Authorization, if required.

If the enrollee needs a referral to a network provider, the CBHA Clinical Case Manager will conduct a brief telephone assessment, in order to match the patient with the most appropriate provider to assure the patient receives the right care at the right time by the right provider.

If it is determined that an emergent situation exists, the enrollee/provider shall be directed to the nearest facility equipped to handle the crisis/emergency.

If the patient is seeking outpatient treatment and no crisis exists, the enrollee is given a choice of at least three appropriate in-network providers or the enrollee may request a specific network provider. Authorization would only be required for certain services outside of standard outpatient psychotherapy and medication management.

While standard psychotherapy and medication management do not require prior approval, certain specialized procedures do require pre-authorization, so long as they are not considered emergent

services. Emergency services must be authorized within 48 hours or the next business day, whichever is later, following the beginning of services.

Except for emergencies, failure to obtain pre-authorization of services will result in the provider not being reimbursed.

Services Requiring Prior Authorization

All intensive levels of services (inpatient, partial hospitalization, intensive outpatient programs) require prior authorization as well as the following outpatient services:

Psychological and Neuropsychological Testing

Behavioral Health Home Visits

Outpatient and Inpatient ECT

Outpatient Consultations

Gastric Bypass Evaluations

***Please note that individual health Plans continue to have behavioral health exclusions. If you have questions regarding these exclusions, please call CBHA at 800-475-7900.**

Access and Triage

CBHA is committed to ensuring that its network includes sufficient numbers of providers representing the full range of disciplines, and that geographic distributions are adequate to the needs of its enrollees.

The National Committee for Quality Assurance (NCQA) has established the following accessibility standards; all CBHA network providers are expected to meet these standards:

- Immediate access upon referral for life-threatening emergent cases;
- Emergent appointments within 4 hours;
- Urgent appointments within 24 hours;
- Routine appointments within 5 to 10 business days.

Network providers are required to immediately notify CBHA if they are unable to meet the accessibility standards listed above.

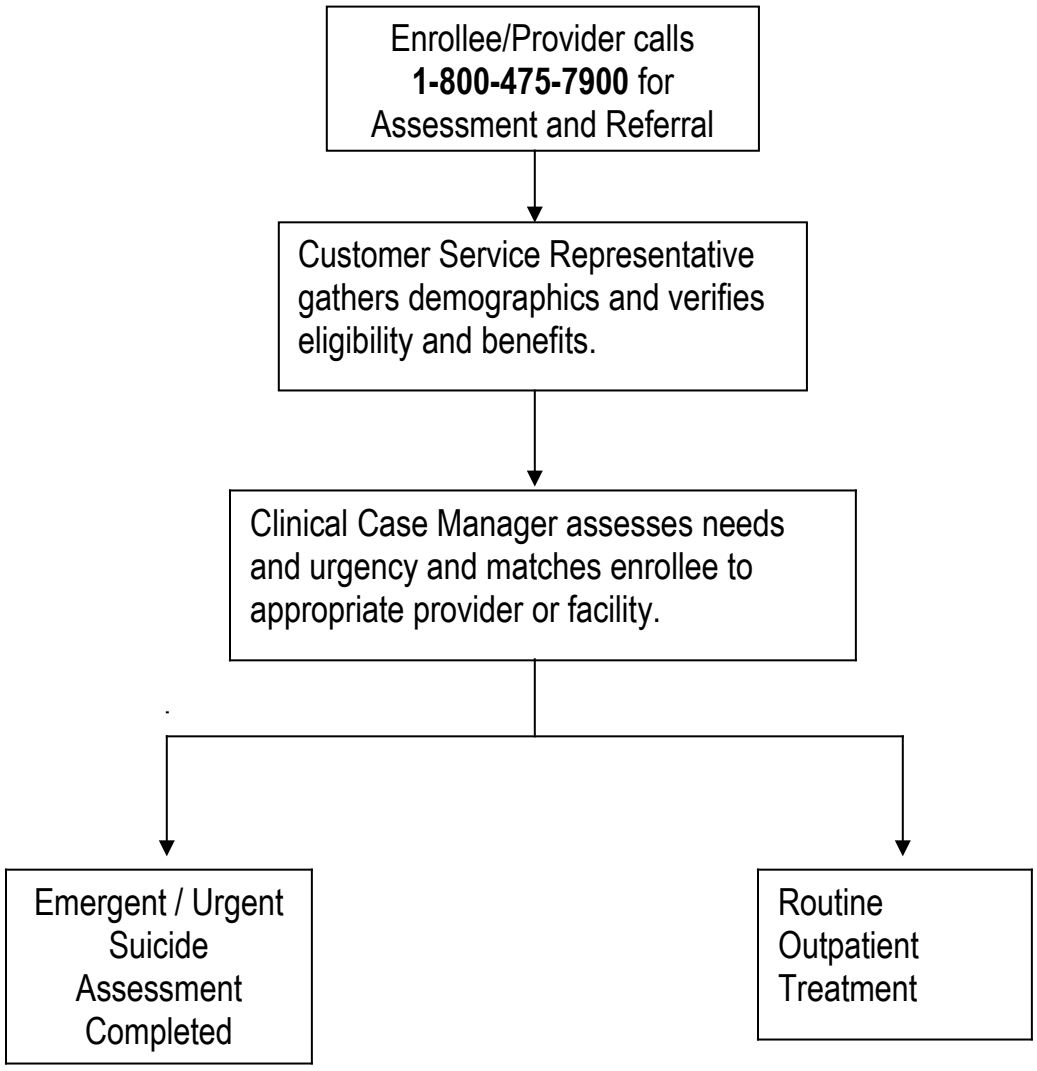
All network providers are required to have an emergency on-call system to assure that their patients have access to care 24-hours a day, 7 days a week.

A CBHA clinician is available for emergencies 24-hours a day, 7 days a week through a call-in process at **1-800-475-7900**. The Clinical Case Manager will complete a telephone triage, refer the enrollee to the appropriate level of treatment and authorize initial treatment. A 23-hour observation bed inpatient admission may be authorized for some patients until a more complete assessment is completed and a treatment plan is formulated.

Access & Triage

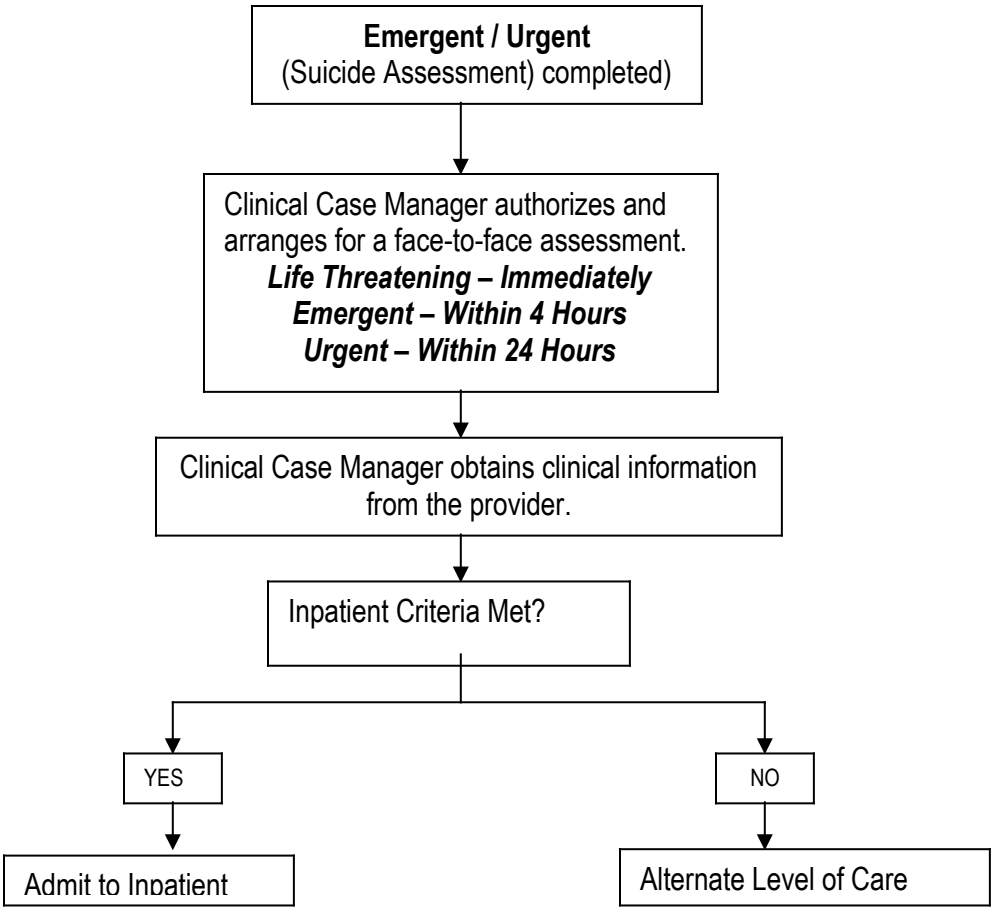
Carolina Behavioral Health Alliance, LLC

Access/Triage Model



Carolina Behavioral Health Alliance, LLC

Emergent Situations



Definitions:

Emergency services are medically or psychologically necessary services furnished or required to screen or treat an emergency mental health or substance abuse condition until the condition is stabilized.

An emergency mental health or substance abuse condition is the sudden or unexpected onset of a mental health or substance abuse condition requiring immediate treatment which an enrollee secures after the onset of such condition and, in the absence of immediate medical attention, could reasonably be expected by a prudent layperson possessing an average knowledge of health and medicine, to result in any of the following: 1) Serious physical impairment or death; 2) Serious or permanent dysfunction of the enrollee's mental health; or 3) the enrollee's or a third party's health is placed in serious jeopardy.

Determination of Medical Necessity

The CBHA authorization process is designed to ensure a timely response to requests for service. CBHA uses seven core criteria in determining medical necessity for any given level of service:

1. Services are necessary and appropriate for the diagnosis, evaluation or treatment of a mental health or substance abuse condition or illness other than mental retardation, with a distinct diagnosis as given in the most recently-published edition of the Diagnostic & Statistical Manual of Mental Disorders.
2. Services can reasonably be expected to improve the enrollee's condition or level of functioning or at least prevent further deterioration.
3. The services are provided at the level of care appropriate to the severity of the enrollee's illness and capacity to respond to professionally provided treatment.
4. The services are consistent with generally accepted standards of behavioral health professional practice in the community.
5. The services are provided within the professional competence of the provider.
6. The services are not for experimental, investigational or cosmetic purposes.
7. The services are not solely for the convenience of the enrollee, enrollee's family or the provider.

If the presence of medical necessity is in doubt, the CBHA Medical Director or Assistant Medical Director will be consulted.

Carolina Behavioral Health Alliance Responsibilities

CBHA has the responsibility to:

- Obtain all information required to make the clinical case management decision including pertinent clinical information.
- Provide enrollees and their network providers with toll-free telephone access to clinical case management staff twenty-four hours per day/seven days per week for required pre-authorization.
- Limit information requests to information necessary to certify the service in question.
- Provide notification of clinical case management decisions within 72 hours of receipt of all necessary information (authorizations communicated to network providers; non-certifications communicated to network providers; written or electronic confirmation communicated to the enrollee).

Non-Authorizations for Concurrent Inpatient Reviews: In instances where a non-authorization determination is made, CBHA remains responsible for covered behavioral health services until the network provider and/or the enrollee has been notified of the non-authorization. Notification to the enrollee may be through hospital staff, physician or CBHA's clinical case management staff.

Non-Authorization of Continued Services: A non-authorization letter is initiated in the following cases:

1. Failure to meet medical necessity;
2. The enrollee already has an authorization for another provider for the same level of care /service;
3. The requested service is not a covered benefit;

The non-authorization letter is sent to the provider and the enrollee within 72 hours of receipt of clinical information; this letter specifies the reason(s) services could not be authorized. The appeal process is available only for non-authorizations for failure to meet medical necessity, and the letter will identify the appeal process. The other reasons listed above for non-authorization are not eligible for the appeal process. The CBHA Medical Director or Assistant Medical Director makes all non-authorization decisions for failure to meet medical necessity criteria.

Lack of Information: When clinical information is received that has minor information missing that can be clarified by telephone; a CBHA Clinical Case Manager may contact the provider and obtain the needed information.

Enhanced Case Management

CBHA enrollees who are seriously and persistently mentally ill may be monitored closely as part of CBHA's commitment to quality, cost-effective delivery of behavioral health care for all enrollees in the health plan. CBHA has established an Enhanced Case Management program in order to provide follow-up for individuals who meet certain clinical criteria. In the Enhanced Case Management process, the CBHA case manager will follow up with the member and the provider to assure that the member is accessing needed services and making appropriate progress.

Individuals with a Primary DSM (most recently-published edition) diagnosis and at least one of the following criteria may be selected to participate in this program:

- Demonstrated need for assistance in obtaining and coordinating treatment, rehabilitation and social services;
- More than one inpatient hospitalization within a year;
- History of non-compliance with treatment programs;
- High Utilization of the outpatient benefit for the benefit year;
- Disability status due to a behavioral health condition
- History of psychiatric hospitalization (s)

The Clinical Case Manager works in conjunction with the network provider to identify resources and community support systems for long-term maintenance.

FACILITIES

Facility-Based Initial Authorization Request

Pre-Authorization is required for **all** inpatient, partial hospitalization and intensive outpatient services.

Emergency Inpatient Admissions: The only exception to this rule is for emergency cases where it is not possible to obtain pre-authorization due to critical or possible life-threatening circumstances Emergency circumstances are situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: 1) placing the health of an individual in serious jeopardy; 2) serious impairments to bodily functions; 3) serious dysfunction of any bodily organ or part, or; 4) death. In those instances, the provider must notify CBHA as soon as possible, but in all cases within 48 hours of the provision of emergency services or by the end of the first business day following the rendering of such services, whichever is later. Retroactive authorization may be granted if the situation meets the criteria for emergency admission. In instances where the facility does not obtain pre-certification and there is no emergency justification, the facility will be administratively sanctioned for the period prior to the initial request for certification.

Facilities are to call 1-800-475-7900 to pre-authorize all admissions 24 hours a day, 7 days a week. A CBHA clinician will gather and document information necessary to determine the appropriate level of care based upon medical necessity criteria and to verify the enrollee's eligibility and benefit structure as provided by the affiliated health plan. Required information includes, but is not limited to the following:

1. Attending physician – for In-Network benefit, attending must be an in-network provider;
2. Demographic information;
3. Precipitants/stressors just prior to admission;
4. Degree of dangerousness to self or others;
5. Judgment impairment or decreased functioning level;
6. Baseline urine drug sample/blood alcohol levels for chemical dependency patients;
7. Detox protocol (and rationale if deviating from symptom-based medication protocol), if applicable;
8. DSM(most recently published edition) Diagnoses.

Note: Initial reviews after hours or on weekends or holidays will require a follow-up review for the next business day to verify eligibility. If the enrollee is not covered, CBHA staff will notify the facility of the lack of benefit within 24-hours or the next business day.

CBHA Clinical Case Managers may authorize a 23-hour observation bed to provide an opportunity for a more extensive evaluation and formulation of a treatment plan for an inpatient request.

In cases where the Clinical Case Manager is unable to determine whether medical necessity criteria are met, the facility will be notified and a peer to peer review will be conducted by the CBHA Medical Director or Assistant Medical Director. This review will be conducted within 24 hours of the request or by the next business day. If the review determines the presence of medical necessity criteria, an authorization will be issued. If the review indicates no medical necessity, the clinical case manager will immediately notify the facility via telephone, informing the facility of the right to file an appeal, and will issue a ***Notice of Services Not Certified*** to the provider and the enrollee.

Facility-Based Authorizations - Concurrent Reviews

When an initial/previous request has been authorized and a concurrent review is due, it is the facility's responsibility to contact CBHA to obtain additional authorization. The following information is required from the facility:

1. DSM (most recently-published edition) Diagnoses;;
2. Symptoms that support continued medical necessity for the level of care requested;
3. Medication regimen;
4. Patient's participation in program;
5. Current treatment plan and transition plan to the next level of treatment;
6. History of previous treatment, both inpatient and outpatient;
7. Supportive family or friends and dates of any scheduled family sessions and outcomes;
8. Living arrangements or other issues that may cause delays in the discharge date or prevent discharge to a less intensive level of care;
9. Proposed aftercare plan.

Once information is provided that justifies medical necessity for the level of care, the Clinical Case Manager will authorize additional days as indicated.

In cases where the Clinical Case Manager is unable to determine whether medical necessity criteria are met, the facility will be notified and a peer to peer review will be conducted by the CBHA Medical Director or Assistant Medical Director. This review will be conducted within 24 hours of the request or by the next business day. If the review determines the presence of medical necessity criteria, an authorization will be issued. If the review indicates no medical necessity, the clinical case manager will immediately notify the

facility via telephone, informing the facility of the right to file an appeal, and will issue a ***Notice of Services Not Certified*** to the provider and the enrollee.

Non-Authorizations for Concurrent Inpatient Reviews: In instances where a non-authorization determination is made, CBHA remains responsible for covered behavioral health services until the network provider and/or the enrollee has been notified of the non-authorization. Notification to the enrollee may be through hospital staff, physician or CBHA's clinical case management staff

Discharge Review Process

Facilities are responsible to contact CBHA to report a discharge on the date it occurs and to supply the following information:

1. Details of the aftercare plan, including the name of the network provider or other aftercare program where the enrollee is being referred and the date and time of the first scheduled appointment and proposed frequency of visits;
2. Information about where the enrollee will be residing;
3. Information about support systems available to the enrollee within the family and community;
4. Discharge medications.

An Authorization for Services letter will be sent within 72 hours of the notification of discharge.

Inpatient Discharges to Partial Hospitalization or Intensive Outpatient Programs:

In instances where an individual is being discharged from an inpatient setting to a partial hospitalization or intensive outpatient program, the clinical case manager documents the above discharge information, along with information documenting medical necessity for the partial hospital or intensive outpatient program. The authorization for the new level of care may not begin until the next working day after discharge.

BENEFIT ADMINISTRATION

Benefit Plans

CBHA authorizes services for enrollees with various benefit plans. Services covered, co-payments, co-insurances as well as annual and lifetime limits vary among health plans. Please contact CBHA to confirm benefit parameters.

While CBHA makes a good faith effort to provide the most recent benefit information, CBHA does not guarantee coverage in the absence of eligibility. Enrollees should be encouraged to become informed about the limits and exclusions of their policies.

PROVIDER PARTICIPATION REQUIREMENTS

Member Notification Requirements

Network providers should educate enrollees whose care is managed by CBHA about the treatment process and encourage enrollees to be familiar with procedures required by their plan. The following contains information that should be discussed with enrollees at the beginning of their treatment program:

- *Patients' Rights and Responsibilities*;
- Fees and co-payments;
- Benefit plan coverage;
- After-hour procedure for contact and/or procedures to follow if a clinical emergency occurs;
- Confidentiality issues;
- Treatment options available;
- Medication risks and potential side effects, if applicable;
- Communication with the primary care physician and other relevant health care providers.

Administrative Sanction

Definition: CBHA defines an administrative sanction as a denial of payment as a result of a network provider's failure to obtain one or more of the following:

Pre-certification of an inpatient admission, except in the case of an emergency admission. In those cases the facility must notify CBHA within 48 hours or by close of the first business day after care is rendered. Clinical case managers are responsible to ascertain whether the admission is a true emergency as defined in the ***Certificate of Coverage***.

Emergency Definition: An emergency mental health or substance abuse condition means the sudden or unexpected onset of a mental or substance abuse condition requiring immediate mental health or substance abuse treatment which an enrollee secures after the onset of such condition, and in the absence of immediate medical attention it could reasonably be expected by a prudent layperson, possessing an average knowledge of health and medicine, to result in any of the following: 1) serious physical impairment or death; 2) serious permanent dysfunction of the enrollee's mental health; or 3) enrollee's or a third party's health placed in serious jeopardy.

Pre-certification of partial hospitalization or intensive outpatient treatment prior to the end of the first day of service;
Concurrent review to obtain certification for an ongoing inpatient, partial hospitalization or intensive outpatient treatment;

An administrative sanction is enforced when there is failure to adhere to the terms of the provider contract with CBHA; an administrative sanction is not related to medical necessity criteria.

Network providers and providers who have signed a single case contract, and have an administrative sanction imposed upon them, may not balance bill or impose any surcharge upon an enrollee or individuals responsible for the enrollee's care.

Clinical Case Managers are responsible to identify situations requiring an administrative sanction, to inform the provider and to enter a note into the electronic record documenting the date(s) and reason(s) for the sanction. Clinical Case Managers are also responsible to notify the QI Manager of the sanction prior to the end of the current workday.

The Director of Quality Improvement and Clinical Operations is responsible to send an ***Administrative Sanction Letter*** to the provider within 72 hours of the decision to impose the sanction. The letter identifies the enrollee, level of care, dates of service that have been sanctioned and the reason for the sanction.

Obligation to Report Abuse

Network providers must comply with all applicable state and federal child abuse, elder abuse and other emergency reporting laws. It is the provider's responsibility to understand and comply with the professional and legal requirements of the state where s/he practices.

Duty to Warn

The duty to warn may override an enrollee's usual right to confidentiality when confiding in a clinician. A CBHA network provider may release relevant clinical data or history information if a life-threatening situation exists. In instances where the provider feels that an enrollee represents a threat to others; s/he must attempt to warn the potential victim(s) in a timely manner, preferably by contacting local law enforcement.

American With Disabilities Act (ADA)

Network providers are required to comply with all provisions of The American With Disabilities Act that are applicable to the provision of care to CBHA enrollees.

Provider Sanctions

In the event CBHA becomes aware of a breach of contract by a specific provider, efforts will be made to assist the provider to correct the situation. The provider is notified, in writing, of the specific breach of contract related to a sanction. Written notification includes the following:

1. The reason for the notice;
2. The specific breach of contract;
3. The steps necessary to correct the breach;
4. Review date.

A review is scheduled to determine if corrective action has been taken; this review may include an on-site visit by CBHA staff. In the event correction has not been made at the time the review takes place, CBHA will:

1. Suspend new patient referrals to the provider for a period of six months;
2. Present the issue(s) to the Behavioral Health Quality Improvement Committee (BQIC) for a review of the provider's status;
3. Notify the provider of any recommendations made by the BQIC prior to the end of the suspension.

If the BQIC recommends approval for the provider to remain on panel pending correction of the breach, the provider will be notified of the next review date. If the BQIC recommends termination from the panel, the provider will be notified that the contract is terminated.

Termination of Providers

Providers may be terminated from the CBHA provider network in accordance with the terms outlined in the provider contract. Providers are given notification of termination in writing. Criteria for termination of a provider contract with CBHA include, but are not limited to:

1. Suspension, revocation or limitation of license, DEA certificate or practice privileges; probation, reprimand or otherwise disciplined or restricted by any state agency;
2. Suspension, censure, exclusion or disqualification by Medicare or Medicaid;
3. Submission of false or incomplete information on the application form or in the re-credentialing process;
4. Failure to return the re-credentialing application;
5. Failure to comply with any aspect of the provider contract, including failure to comply with Utilization Review procedures or BQIC recommendations;
6. Submission of erroneous, false or incomplete claims information or claims that are in violation of the provider agreement, including rendering services outside the scope of the provider's professional license;
7. Indictment or conviction of a felony or any criminal charge related to the practice of psychiatry or related health services;
8. Termination or material suspension of privileges at a network facility or another hospital where the provider has privileges, where the provider for business or other purposes did not initiate such termination not related to avoiding disciplinary action.
9. Failure of the provider to meet the credentialing standards of CBHA.

Appeal of Termination: Providers who have been terminated from the provider network for reasons related to the provider's competency and/or professional conduct would be afforded an opportunity to appeal the decision. The provider shall have the following rights in an appeal:

1. The right to represent him/herself in an appeals hearing;
2. The right to have a record made of the proceedings; copies of which may be obtained upon payment of any reasonable charges associated with preparation thereof;
3. The right to present evidence determined to be relevant to the panel, regardless of its admissibility in a court of law;
4. The right to submit a written statement at the close of the hearing.

Appeal Procedures: Network providers are given thirty (30) days from the date of the ***Notice of Termination*** to request a hearing; the request must be made in writing. A hearing date shall be scheduled not less than thirty (30) days or more than sixty (60) days after the provider's request for a hearing is received.

The hearing shall be held before a panel of individuals appointed by CBHA; panel members shall gain no direct financial benefit from the outcome and shall not have acted as accusers, investigators, fact finders, and initial decision makers or otherwise have actively participated in consideration of the matter leading up to the recommendation or action. The provider shall be entitled to a reasonable opportunity to question and challenge the impartiality of hearing panel members. Once approved, the panel members shall select a chairperson among themselves.

The provider has a right 1) to counsel; 2) to have a record made; 3) to call, examine and cross-examine witnesses, 4) to a copy of the written recommendation from the panel that includes its basis for the recommendation and, 5) to a copy of the written decision of the BQIC, including a statement of the basis for the decision if the BQIC does not adopt the hearing panel's recommendations.

The BQIC/Credentialing Committee is responsible to make a written disposition with respect to the termination within thirty (30) days after the hearing. The provider is to be notified in writing of the panel's decision within fifteen (15) days of the decision.

If, based upon facts presented at the hearing, a decision is made to reverse the termination, the termination shall be cancelled and the provider reinstated to the network.

If the BQIC/Credentialing Committee decides, based upon facts presented at the hearing, that the termination is justified and the termination is relative to the provider's professional competency and/or professional conduct, the termination is upheld and the findings are submitted to the appropriate licensing/certifying board and/or the National Practitioner's Data Bank (NPDB).

Provider Satisfaction Survey

CBHA sends an annual survey to all network providers to determine network providers' satisfaction. (See below.) This survey is structured to obtain network providers' opinions regarding all departments within CBHA; additional space is provided for comments. Identified areas of concern are addressed via the CBHA Quality Improvement Program.

***Carolina Behavioral Health Alliance, LLC* – Provider Satisfaction Survey**

You may fax your completed survey to 336-499-4006 or mail to CBHA, PO Box 571137, Winston-Salem. NC 27157-1137.

Please rate your satisfaction with CBHA.	Strongly Agree	Agree Somewhat	Disagree	Strongly Disagree	NA
CUSTOMER SERVICE:					
1) My calls are answered promptly.					
2) Information from customer service is accurate.					
3) Customer service staff is courteous and professional in dealing with you.					
UTILIZATION REVIEW:					
1) UM staff is easily accessible to discuss utilization management issues.					
2) UM staff demonstrates sound clinical judgment in responding to inquiries.					
3) Authorization request for treatment are processed expediently.					
CLAIMS PROCESSING AND PAYMENT:					
1) Claims are processed in a timely manner.					
2) Claims are processed accurately.					
3) Claims staff is accessible to address your claims issues/concerns.					
PROVIDER RELATIONS:					
1) The credentialing/re-credentialing process is easy to follow.					
2) The professional relations staff is accessible to discuss your issues/concerns.					
QUALITY IMPROVEMENT:					

1) Complaints, grievances and appeals are handled in a timely manner.					
OVERALL SATISFACTION					
1) Compared to working with other Managed Behavioral Health Organizations, working with CBHA is a positive experience.					
In the past year I have provided services to: Comments:		**1 – 5 CBHA Members**	**6–10 CBHA Members**	**11–20 CBHA Members**	**20+ CBHA Members**

Please share any additional thoughts or suggestions you may have to help us improve services to providers and patients.

_____

_____

_____

Contact Professional Relations at (800) 475-7900 if you have questions.

QUALITY IMPROVEMENT

CBHA Quality Improvement Program

Carolina Behavioral Health Alliance, LLC, is committed to ensuring that network providers and enrollees receive the highest quality services possible. The CBHA Quality Improvement Program is designed to provide a framework for continuous assessment and ongoing performance improvement of all organizational functions to assure that treatment is efficient and effective and services are provided in a dignified and confidential manner. CBHA integrates generally accepted recommendations from the behavioral health community into its Quality Improvement Program to help identify areas of behavioral health practice where there are opportunities to promote an improved standard of care.

The CBHA Medical Director has the overall responsibility to ensure quality of care. The CBHA QI Manager is responsible for coordination of the operational components of the QI Program under the direction of the Medical Director. This program ensures the review and ongoing evaluation of all aspects of patient care. The CBHA QI process includes, but is not limited to:

A. Development, implementation and annual review of organization policies and procedures;
B. Development and implementation of a consistent performance improvement process;
C. Identification of key monitors and indicators;
D. Risk Management;
E. Utilization Management;
F. Credentialing and re-credentialing;
G. Preventive Behavioral Health;
H. Members/Enrollees rights and responsibilities;
I. Enrollee satisfaction;
J. Provider satisfaction;
K. Program Evaluation;
L. Treatment records, and
M. Regulatory compliance.

Behavioral Health Quality Improvement Committee (BQIC)

The CBHA Medical Director and Behavioral Health Quality Improvement Committee (BQIC) are responsible for the functions of the Quality Improvement Program. The BQIC is an action body and conducts comprehensive review and approval of the Quality Improvement Program and the annual Quality Improvement Work Plan. This committee also approves organizational policies and procedures and provides guidance for all QI activities. The Quality Improvement Program and QI Work Plan are also presented to the Board of Directors upon request.

CBHA contracts with facilities and individuals for the provision of services to its enrollees. CBHA has the following expectations of its providers and facilities relative to quality improvement:

- To maintain the confidentiality of enrollee information;
- To provide CBHA with copies of enrollees' medical records upon request;
- To accept phone calls from CBHA and to return calls concerning QI issues;
- To cooperate with clinical practice guidelines distributed by CBHA and other clinical outcome monitoring activities as requested by CBHA.

Enrollee Satisfaction

CBHA utilizes a survey instrument to assess enrollee satisfaction relative to behavioral health providers, programs and services. CBHA distributes the survey to adult enrollees seen by network providers utilizing generally accepted sampling methods to ensure an appropriate number and mix of enrollees is reached. Survey data is gathered, organized and analyzed at least annually to produce comprehensive reports of findings. Individual responses are reviewed as they are received to identify specific problem areas that may need immediate attention.

Carolina Behavioral Health Alliance, LLC **– Enrollee Satisfaction Survey**

Dear Enrollee: Carolina Behavioral Health Alliance (CBHA) currently manages your behavioral health benefit. We answer the 1-800 number, make referrals and benefit authorizations, process claims and payments, and monitor the activities of network providers who are dedicated to serving you. We want to do a good job and we need your help to identify ways we can provide a better service. Please take sixty seconds to complete the following survey questions, then fold on the dotted lines and seal so the CBHA address and stamp are on the outside. Thank you for your participation!

Please rate your satisfaction with CBHA over the past year.	Strongly Agree	Agree Somewhat	Disagree	Strongly Disagree	Does Not Apply
Phone calls to CBHA were answered promptly & directed appropriately.	O	O	O	O	O
CBHA staff returned calls to you as promised.	O	O	O	O	O
CBHA staff answered all of your benefit questions.	O	O	O	O	O
You received your authorization letter in a timely manner.	O	O	O	O	O
The Claims Department staff helped you resolve any billing issues.	O	O	O	O	O
Please rate your satisfaction with your behavioral health provider.	Strongly Agree	Agree Somewhat	Disagree	Strongly Disagree	Does Not Apply
You are able to get appointments with your provider within a reasonable time frame.	O	O	O	O	O

Your provider's office is conveniently located, has adequate parking **or** is near public transportation, etc.	O	O	O	O	O
The time you wait in your provider's waiting room is generally reasonable.	O	O	O	O	O
Your provider shows understanding and concern for you.	O	O	O	O	O
You have confidence in your provider's ability.	O	O	O	O	O
Your treating physician explained your medication, why you need to take it and any side effects.	O	O	O	O	O
You have noted improvement as a result of the treatment you are receiving.	O	O	O	O	O

Comments: Please share any additional thoughts you may have. _____
_____
_____
_____

If you have had a particular experience with the CBHA office or your provider that you wish to discuss further, please feel free to call us at 1-800-475-7900 and ask for the Quality Improvement Manager. All contacts are confidential. This survey also may be found on the CBHA interactive website – www.cbhallc.com.

Complaint & Grievance Procedures

CBHA responds to all complaints and grievances in a timely and efficient manner that meets all regulatory and accrediting body requirements. The intent is to resolve most concerns or complaints in an informal manner to the mutual satisfaction of all involved within a very short time frame.

Complaint: A complaint is a verbal/telephone report of concern expressed by an enrollee, representative or provider relative to services received, billing/claims issues or overall satisfaction with CBHA. The majority of complaints can be resolved informally within one business day. Complainants will be advised of the formal grievance process in cases where the issue cannot be resolved on an informal basis.

Grievance: A grievance is a written report of a concern by an enrollee, representative or provider regarding any of the following:

- CBHA decisions, policies or actions related to availability, delivery or quality of behavioral health services;
- Claims payment or handling; or reimbursement for services;
- The contractual relationship between the enrollee and the insurer;
- The outcome of an appeal of a non-certification.

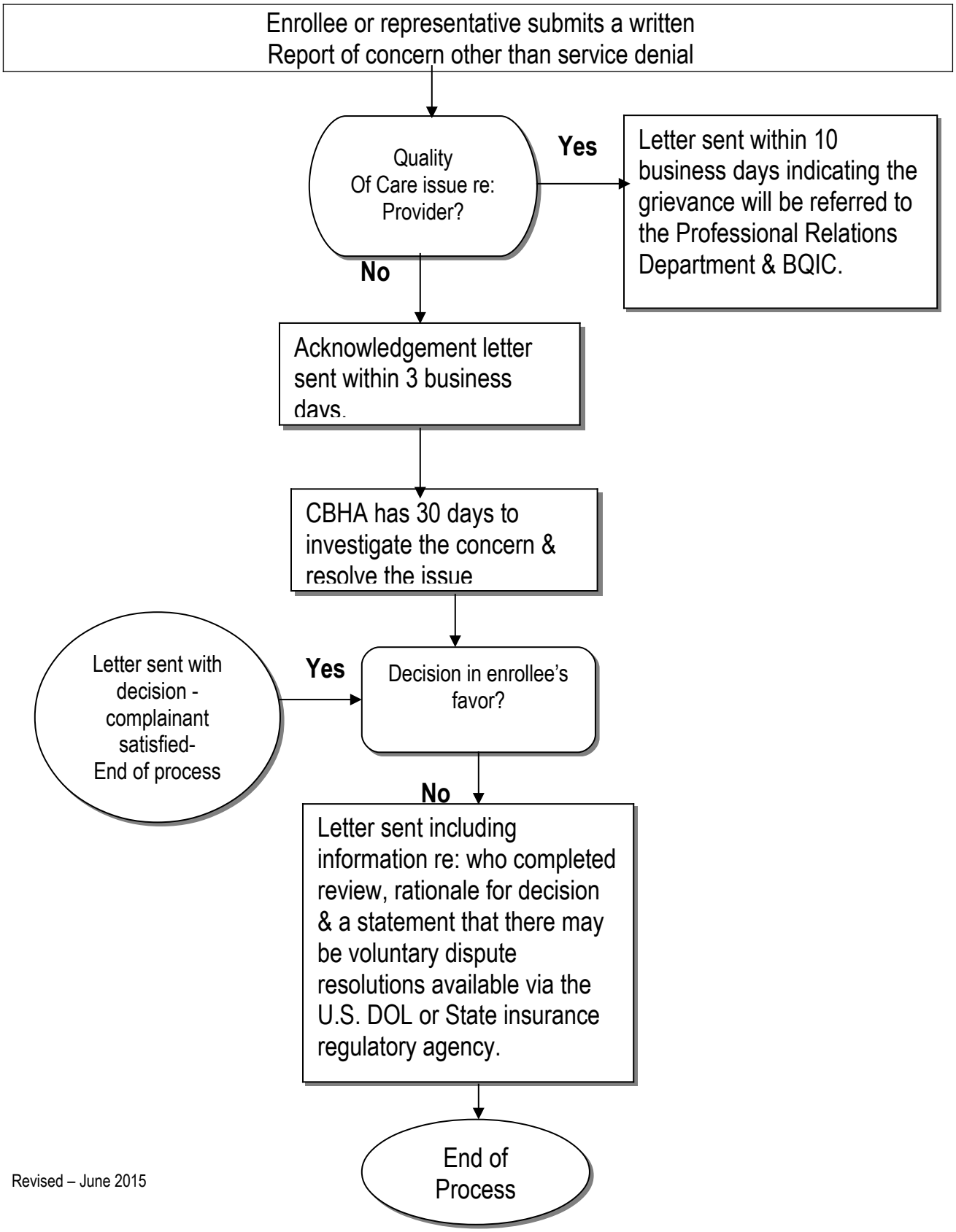
First Level Grievance Review: An enrollee, representative or a provider acting on an enrollee's behalf may submit a grievance to:

Grievance/Appeals Manager
Carolina Behavioral Health Alliance, LLC
P.O. Box 571137
Winston-Salem, NC 27157-1137

CBHA has thirty days to investigate a grievance and prepare a written response to the complainant. Grievances concerning quality of care provided by a provider are referred to the CBHA Medical Director, the

CBHA Professional Relations Department, and the Behavioral Health Quality Improvement Committee for review and consideration of any appropriate action against a provider.

CBHA GRIEVANCE PROCESS



Appeals Procedure

Appeal: An appeal is a challenge by an enrollee, representative or provider acting on behalf of an enrollee, of a non-certification determination made by CBHA relative to an admission, availability of care, continued stay or other behavioral health service that had been reviewed and denied, reduced or terminated based upon CBHA's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness.

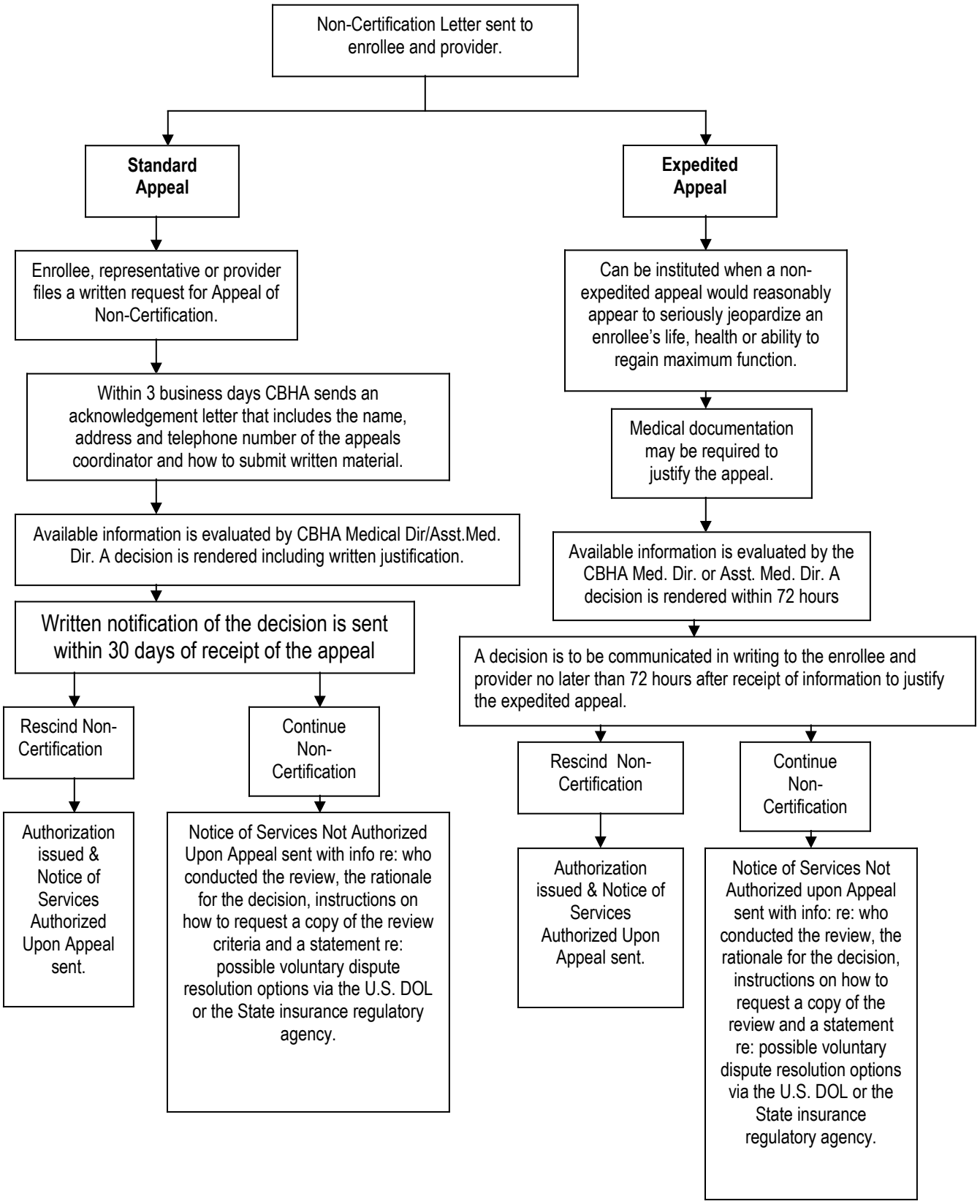
First Level Appeal: An enrollee, representative or a provider acting on an enrollee's behalf may submit a formal written appeal within one hundred eighty (180) days of a non-certification; additional clinical information may be submitted, if available. Appeals should be addressed to:

Grievance/Appeals Manager
Carolina Behavioral Health Alliance, LLC
P.O. Box 571137
Winston-Salem, NC 27157-1137

CBHA has thirty (30) days to review the appeal and develop a written response. If the decision is not in favor of the enrollee, the decision shall include the professional qualifications and licensure of the individual conducting the review; a statement of the reviewer's understanding of what is being appealed; the reviewer's decision including criteria used, instructions for requesting a written copy of the criteria and a description of the procedure for submitting a second level review.

Expedited Appeal: An expedited appeal may be requested by an enrollee, representative or provider acting on an enrollee's behalf when a non-expedited appeal would reasonably appear to seriously jeopardize an enrollee's life, health or ability to maintain maximum function. Medical documentation may be required to justify the appeal. A written decision will be delivered to the enrollee no later than 72 hours after receiving information to justify an expedited appeal.

CBHA – Appeals Process Flow Chart



CREDENTIALING AND RE-CREDENTIALING

Credentialing/Re-credentialing Process

CBHA credentials and contracts with providers to deliver treatment to CBHA covered enrollees. The CBHA network includes licensed professionals who:

- Demonstrate current competence;
- Continuously meet and satisfy the regulatory qualifications, standards and requirements set forth in this document;
- Practice in a geographic area determined by CBHA to be advantageous to its enrollees;
- Maintain the physical and mental health to provide quality managed behavioral health care.

Qualifications for Membership on the CBHA Provider Network

. **Psychiatrist**: (MD, DO)

- Required Education: Graduate of an approved Medical or Osteopathic School and completed one year of internship or its equivalent;
- Board certified or board eligible in psychiatry; child psychiatrists shall be additionally board certified or board eligible in child psychiatry;
- Licensure/Certification: Current valid license to practice as a medical doctor in the state in which he/she practices
- Clinical privileges in good standing at primary admitting facility (if applicable);
- Valid DEA number;
- Complete work history for the past five (5) years;
- Current, adequate malpractice insurance.

Licensed Clinical Psychologist: (Psychologist)

- Required Education: Ph.D. in psychology or equivalent;
- Licensure/Certification: Current valid Health Services Provider Licensure (HSP-P) issued by the North Carolina Psychology Board, if applicable; or in the state in which he/she practices practice
- Current, adequate malpractice insurance.

Licensed Psychological Associate: (LPA)

- Required Education: Master's degree in psychology or a specialist degree in psychology with two years post graduate experience;
- Licensure/Certification: Current valid Health Services Provider Licensure (HSP-PA) issued by the North Carolina Psychology Board;
- Current, adequate malpractice insurance.

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Licensed Clinical Social Worker (LCSW) (LISW in South Carolina):

- Required Education: MSW, DSW or PhD in Social Work from a Council on Social Work Education accredited school or equivalent;
- Licensure/Certification: Current valid licensure which allows for independent clinical social work practice in the state in which he/she practices;
- Current, adequate malpractice insurance.

Clinical Specialist in Adult Psychiatry and Mental Health Nursing: (CNS)

- Required Education: Graduate of a master's degree program in psychiatric nursing which confers an MSN (Master of Science in Nursing), MN (Master in Nursing), or MS (Master of Science) and is accredited by the National League for Nursing/American Nursing Association, or is approved by the state board granting licensure/certification in nursing in the state(s) in which the applicant is to provide care.
- Licensure/Certification: 1) Current valid North Carolina license in nursing or licensed by the Board of Nursing in the state in which he/she practices, 2) Licensed as a CNS by the NC Medical Board, or by the Medical Board in the state in which he/she practices, and 3) Certified as a Clinical Nurse Specialist in Psychiatry; by the AANC.
- Current, adequate malpractice insurance.

Licensed Marriage and Family Therapist (LMFT):

- Required Education: Masters degree from an accredited marriage and family therapy program or equivalent;
- Licensure/Certification: Current valid license from the state in which he/she practices to be an independent practitioner;
- Current, adequate malpractice insurance.

Certified Fee-Based Practicing Pastoral Counselor: (CFBPPC)

- Required Education: Masters of Divinity or higher or equivalent; Masters or doctoral degree in pastoral counseling or its equivalent & one unit of full-time clinical pastoral education in a accredited program;
- Licensure/Certification: Certification by North Carolina Board of Fee-Based Practicing Pastoral Counselors;
- Current, adequate malpractice insurance.

Licensed Professional Counselor: (LPC)

- Required Education: Master of counseling or equivalent;
- Licensure/Certification: Current valid license from the state in which he/she practices to practice independently;
- Current, adequate malpractice insurance.

Licensed Clinical Addictions Specialist: (LCAS)

- Required Education: A minimum of a master's degree with a clinical application in a human services field from an accredited college or university;
- Licensure/Certification: Current valid certification by the North Carolina Substance Abuse Professional Certification Board;
- Current, adequate malpractice insurance.

Certified Substance Abuse Counselor (CSAC):

- Required Education: A master's degree in a counseling related area;
- Licensure/Certification: Current valid certification by the North Carolina Substance Abuse Professional Certification Board;
- Current, adequate malpractice insurance.

Family Nurse Practitioner (FNP)

- Required Education: Certificate or diploma indicating completion of an accredited Nurse Practitioner Program.
- Licensure/Certification: 1) Current valid North Carolina license in nursing or licensed by the Nursing Board in the state in which he/she practices, 2) Licensed as a FNP by the NC Medical Board, or by the Medical Board in the state in which he/she practices, 3) and is Certified as a Family Nurse Practitioner by the AANC.
- Employed in an office in which a Psychiatrist is also practicing; and Supervisor of record on the NC Medical Board must be a Psychiatrist or licensed as a Psychiatrist in the state in which he/she practices.
- Current, adequate malpractice insurance.

Physician's Assistant (PA)

- Required Education: Certificate or diploma indicating completion of an accredited Physician's Assistant Program.
- Licensure/Certification: Current valid license as a Physician' Assistant by the Medical Board in the state in which he/she practices.
- Employed in an office in which a Psychiatrist is also practicing; and
- Supervisor of record on the state Medical Board must be a Psychiatrist or licensed as a Psychiatrist in the state in which he/she practices.
- Current, adequate malpractice insurance.

General Requirements for Credentialing/Re-Credentialing

Formal applications to CBHA's provider network shall be in writing, submitted on prescribed forms (***North Carolina Department of Insurance – Uniform Application to Participate as a Health Care Practitioner***) and signed by the applicant. The applicant bears the burden of producing adequate information in a timely manner for the credentialing evaluation. By applying for appointment to the CBHA network, the applicant: 1) authorizes CBHA and/or its designee to consult with others who may have information bearing on competence and qualifications; 2) authorizes those consulted to provide such information; 3) consents to inspection by CBHA or designee of all records and documents that may be material to an evaluation of professional qualifications, professional ethics, physical and mental health and emotional stability; and 4) releases from liability without malice all CBHA representatives for acts performed in connection with evaluating the applicant's qualifications.

Each application must include:

- A copy of the applicant's current professional license/certification;
- A copy of the applicant's DEA (Drug Enforcement Agency) registration (narcotic license), if applicable;
- A copy of the face sheet of the current professional liability insurance certificate of coverage including the effective date and expiration date, policy number, limits and names of individuals covered;
- Documentation of board or professional certification;

- Current curriculum vitae with dates and summary of work history
- Social Security Number or ***W-9*** form identifying formal name filed with the IRS or ***Tax Identification Number (TIN)***
- A copy of the **National Practitioner Identification Number (NPI);.**
- Any explanatory statements related to the application.

The application must also include a current and signed attestation by the applicant regarding the following:

- The reasons for any inability to perform the essential functions of the position, with or without accommodation*;
- Lack of present illegal drug use;
- History of loss of license and/or felony convictions;
- History of loss or limitation of privileges or disciplinary activity;
- Current malpractice insurance coverage; and
- The correctness and completeness of the application.

* The exact statement or inquiry may vary depending upon applicable legal requirements such as the Americans with Disabilities Act (ADA).

Applicants are responsible to submit a complete application, including supporting documents, to the CBHA Professional Relations Department. Applications are reviewed for completeness and to ensure the applicant meets the minimal requirements for membership on the CBHA network. In instances where the application form is incomplete or there are missing supporting documents, CBHA Professional Relations staff will notify the applicant in writing within fifteen (15) days of receipt of the application. If missing information or supporting documents have not been received within sixty (60) days after the initial receipt of the application, or if date-sensitive information has expired, CBHA will close the application or delay final review pending receipt of the necessary information. The applicant will be sent written notification of this action.

In instances where the application verifies the applicant does not meet minimum requirements for membership, a letter is sent to the applicant indicating requirements have not been met and the applicant will not be considered.

Applicants for Re-Credentialing: Network providers are re-credentailed every three years. Pre-populated application forms are sent to network providers four months prior to the credentialing expiration date to ensure that information on file is no older than 180 days at the time of re-credentialing. Applicants are responsible to submit a completed application, including requested supporting documents within thirty calendar days of receipt of the application form. If an incomplete application is received, CBHA will notify the applicant in writing of all missing or incomplete information or supporting documents within fifteen (15) days of receipt of the application. The notification will include the CBHA contact for the applicant. Approximately, one month prior to the credentialing date, if the re-credentailing application has not been received, a follow-up telephone call will be placed by the Professional Relations Manager to encourage the provider to return the application. If an applicant for re-credentialing fails to return a completed application form within thirty (30) calendar days, the provider's status will be changed to "non-participating" and the effective date noted. The provider will be notified in writing that he/she has been terminated from the panel. In addition, the Enrollees being treated by the provider during the past year will also be notified of the provider's status change and will be encouraged to contact CBHA to make arrangements for treatment with another provider. After termination for failing to return a re-credentialing application, the provider may re-apply to for network status if CBHA is recruiting providers within their geographical area or if the provider has a specialty that is not being met by the current network.

Failure of Primary Sources to Respond: Applicants for credentialing or re-credentialing will be notified of any failure of others to respond to requests for credentialing information within a reasonable time frame. After such notification the applicant is responsible to obtain responses to requests for information. If information collection and verification remain incomplete for 180 days, the file will be closed and the applicant will be notified by mail.

Conflicting Data/Discrepancies: Providers will be notified by telephone or in writing of any primary source verification that varies substantially from information submitted by the provider. The provider has thirty days to address and correct any erroneous information submitted by another party.

Note: Contracted Credentialing Services: CBHA reserves the right to contract out the investigative function of the credentialing process to an accredited credentialing service. In such event, the contracted credentialing verification organization (CVO) is required to investigate each application, including primary source verification of education and licensure/certification.

Site Visit: Once information collection and verification is complete, the CBHA Professional Relations Manager may contact the applicant and arrange for a site visit, if there are issues regarding standards of quality, safety, accessibility or record keeping per CBHA credentialing policy.

Provider Profiling Data for Re-Credentialing: The following sources of information regarding providers seeking to be re-credentialed may be used to aid in the decision-making process:
Utilization patterns;
Treatment record reviews;
Site visits;
Peer reviews;
Enrollee satisfaction/complaints;
Corrective action plans
Other relevant information.

The Professional Relations Manager and Quality Improvement staff are responsible for gathering relevant information for inclusion in provider files and forwards this information to the CBHA Medical Director for review whenever there is an issue identified that may warrant further investigation and response from the BQIC/Credentialing Committee.

Credentialing Committee Review

Applications for credentialing/re-credentialing are presented to the CBHA Behavioral Health Quality Improvement Committee (BQIC) on a monthly basis for review and final decision relative to inclusion on the CBHA provider network. This committee is composed of six to twelve members representing a cross-section of the provider network. All are required to sign a confidentiality statement agreeing to maintain strict confidentiality of all information and a conflict of interest statement agreeing not to participate in any decision where there may be a personal involvement or where the reviewer's judgment may be compromised.

The CBHA Medical Director presents any discrepancies and/or concerns regarding providers' responses to the committee for discussion and review. The following courses of action may be taken:

1. Application approved;
2. Application approved with exception(s) noted;

3. Application on hold, pending more information;
4. Application denied, with specific reason(s) noted.

Notice of the final decision is documented in writing in the applicant's file; the applicant is notified of the decision of the BQIC in writing.

On-Site Visits

CBHA staff will perform site visits on all providers for whom there is a serious complaint related to physical accessibility, physical appearance, adequacy of waiting room and examining room space, as well as other safety or quality reasons.

CBHA staff will conduct a site review if it receives a Level 1 or Level 2 complaint (see below for details) regarding the provider.

1. Level 1 Complaint: A complaint concerning a situation or event that will have an immediate impact on the member's health or safety.
2. Level 2 Complaint: A complaint concerning a situation or event that has the potential to impact the member's health or safety.
3. Level 3 Complaint: A complaint concerning a situation or event that has no impact on the member's health or safety

Each site visit includes a review of the physical space that is designed to evaluate the following: (See attached form.)

- Physical accessibility;
- Physical appearance;
- Adequacy of waiting and treatment room space;
- Availability of appointments.

CBHA will make the provider practice aware of the CBHA standards for record-keeping and will discuss the forms and methods that the practice uses to keep the information in a consistent manner, as well as how the practice will ensure medical record confidentiality.
CBHA will assess treatment records for orderliness of record and documentation practices, as well as look for appropriate documentation of quality of care. These standards are outlined below.

Documentation Standards: CBHA has adopted the following standards for documentation in treatment records:

General Treatment Criteria
Record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, or guardianship information.
Consents obtained for Managed care company
Consents obtained for Primary Care Physician and/or Referring agent
All entries in treatment records include patient name, and are legible, typed or written in ink, dated, and signed by the responsible clinician.
Indication that HIPAA policy has been reviewed with the enrollee.

Initial Evaluation

An initial evaluation is completed and includes

The presenting problem
A medical and psychiatric history
Medications prescribed and medication allergies, if appropriate
Family history of mental illness
Substance abuse history
A complete mental status evaluation
A full scale DSM-IV diagnosis
Initial Treatment Plan including long term and short term treatment goals

Special Situations

Special status situations, such as imminent risk of harm, suicidal ideations are prominently noted.
The record reflects follow-up relative to self-harm/harm to others from one session to another.
Patients who become homicidal, suicidal or unable to conduct activities of daily living are promptly referred to the appropriate level of care.

Providers Who Prescribe Medications

Each record indicates what medications have been prescribed by the provider, the dosages of each and dates of the initial prescription or refills.
Allergies and or lack of known allergies and sensitivities to pharmaceuticals and other substances are prominently noted.
Provider has discussed the benefits and risks of medication prescribed.
Laboratory tests ordered by the provider and/or consultation reports with other providers are evident and the record reflects discussion with the patient and f/u for abnormal findings.

For Children and Adolescents

A complete developmental history

Treatment Goals and Progress Reports

A plan of treatment is developed that is consistent with diagnoses and symptoms
There is evidence of patient participation in the development of treatment goals and objectives
A progress note is in place for each treatment visit.
The focus of treatment interventions, as documented in progress notes, is consistent with the goals and objectives of the plan of treatment.

Continuity of Care and Discharge

The treatment record documents referral to preventive services, when appropriate (e.g. relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).

The treatment record reflects continuity and coordination of care between the primary clinician and other heath care providers, and referral sources.

The treatment record documents dates of follow-up appointments and, as appropriate, a discharge plan.

Availability of Treatment Records

Treatment records are to be stored in a secure, centralized location that is readily available to the practitioner and authorized personnel only.

Practice sites will be evaluated according to the following standards:

90 to 100	- Compliant
80 to 89	- Partial compliance – revisit in one year
0 to 79	- Non-compliant

Sites with a score of less than 90% will receive feedback with recommendations for improvements. Any site with a score of less than 80% will be reviewed by the Behavioral Health Quality Improvement Committee, which may deem that the deficiencies are such that the practice will no longer be on the CBHA provider panel. If the BQIC committee recommends retaining the practice, it will be revisited as frequently as BQIC recommends but at least annually until the 90% threshold is met.

If the practice is removed from network membership by the BQIC committee, the practice will be notified by the CBHA medical director in writing of CBHA's decision and the reason for CBHA's decision. The letter is sent via certified mail to ensure receipt by the provider/practice.

Provider Name:	ID#:
Group Practice Name:	
Address:	
City/State/Zip:	
Phone Number:	
Date:	Reviewer:

(A) Physical Accessibility	Yes	No	N/A
Handicap Parking			
Handicap entrance, restrooms and walkway			
Elevators, ramps, stairway			
Ample Parking			

(B) Adequacy of Waiting Area	Yes	No	N/A
Sufficient Seats Available			
Viewing/Reading Material Available			
Staff Available at Reception Area			
Neat and Clutter Free			

(C) Adequacy of Treatment Room Space	Yes	No	N/A
Clean and Sanitary			
Affords Privacy			
Credentials Displayed via Diploma, Certifications, State License			
Adequate Medical Record Filing System			
Patient Discussions cannot be heard in reception area?			
Basic first aid supplies available?			
Pharmaceuticals stored in a secured area?			

(D) Availability of Appointments

	Yes	No	N/A
Are scheduled routine care appointments available within 2 weeks?			
Are urgent, non-emergency appointments seen within 4 hours?			
Are emergency visits seen immediately?			
Are walk-in patients seen within 4 hours or sent to the emergency room if necessary?			
Does the office utilize an answering service and/or answering machine when the office is closed?			
Is there always clinician after-hour coverage?			

Provider Name: Date:	Y	N	N/A
Each page in the treatment record contains the patient's name or identification number.			
Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, or guardianship info.			
All entries in the treatment record include the responsible clinician's name, professional degree.			
Initial Assessment Completed within 2 weeks of initial visit.			
Consents obtained for: a) Managed care company			
All entries are dated.			
The record is legible and either written in ink or typed.			
Relevant medical conditions are listed, prominently identified and revised.			
Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status, are documented.			
Special status situation, such as imminent risk of harm, suicidal ideation, are prominently noted.			
Record reflects follow-up relative to self-harm/harm to others from one session to another.			
Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.			
Allergies or a lack of known allergies and sensitivities to pharmaceuticals and other substances is prominently noted.			
A medical and psychiatric history is documented, including previous treatment dates and provider identification, results of laboratory tests, and consultation reports.			
Laboratory tests and/or consultation reports with other providers are evident and the record reflects discussion w/ the patient and f/u for abnormal findings.			
For children & adolescents, prenatal and perinatal events are documented w/ a complete developmental history (physical, psychological, social, intellectual, and academic).			
History of family mental illness/substance abuse issues and relevant family information are documented.			
For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.			
A mental status evaluation documents the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory and impulse control.			
A DSM (most recently-published edition) full-scale diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.			
Treatment plans are consistent with diagnoses and symptoms and have both objective and measurable goals and include timeframes for goal attainment.			
The focus of treatment interventions is consistent with the treatment plan goals and objectives.			
There is evidence of patient participation in treatment plan development.			
Informed consent for medication and the patient's understanding of the medications prescribed, including any potential side effects are documented.			
Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives.			
Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.			
The treatment record documents preventive svcs, as appropriate (e.g. relapse prevention, stress mgmt, wellness programs, lifestyle changes, and referrals to community resources).			
The treatment record reflects continuity and coordination of care between the primary clinician, consultants, ancillary providers and health care institutions.			
The treatment record documents dates of follow-up apts or, as appropriate, a d/c plan.			

Specific Chart Deficiencies Noted:

Organizational Credentialing

CBHA enters into contracts with facilities for the provision of behavioral health services. These contracts are automatically renewed annually unless terminated by either party. CBHA ensures that network facilities are in good standing with regulatory bodies and fully accredited by appropriate accrediting bodies as part of the contract approval process:

- Verification that a facility is a duly licensed acute care hospital or other facility providing inpatient or other mental health or substance abuse services;
- Confirmation that the facility is fully accredited by a recognized accrediting body and is qualified under Medicare and Medicaid programs, if applicable. Accrediting bodies include, but are not limited to, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF).
- Confirmation via the ***Network Facility Agreement*** that the facility represents and warrants that it has complied and will comply during the term of the agreement with all applicable federal, state and local statutes, ordinances, rules and regulations.
- Confirmation that the facility has an approved credentialing process for professionals who are allowed staff privileges to ensure all are licensed in the state and appropriately credentialed. Under the agreement, CBHA has the right to review and audit network facilities' credentialing files at reasonable intervals.
- Practitioners who are not exclusively practicing within a network facility and wish to be included in the provider network must go through the CBHA credentialing process for independent practitioners unless there is an agreement to delegate those services to the facility.

Professional Liability Insurance: Network facilities must be able to show proof of professional liability coverage of not less than one (1) million dollars per claim and three (3) million dollars per annual aggregate.

Re-credentialing: CBHA will confirm all network facilities remain in good standing with state and federal regulatory bodies and are currently fully accredited by an appropriate accrediting body as part of the re-credentialing process. Facilities are required to complete and submit a ***Facility Information Form*** to apply for re-credentialing on a tri-annual basis. Forms will be sent to facilities for their use.

Delegated Credentialing

CBHA shall have a signed agreement in place prior to delegating the credentialing process; this agreement shall specifically outline responsibilities of the delegate and CBHA. CBHA Professional Relations staff periodically reviews the credentialing policies and procedures and credentialing files of each delegated entity that completes any portion of the credentialing process for provider(s) rendering care and treatment to CBHA enrollees. CBHA retains the right to approve or deny a provider from participating in the CBHA network, regardless of his/her participation with a delegated entity.

Providers must meet all criteria for the identified clinical discipline and all verifications and credentialing processes must be performed in compliance with CBHA credentialing policies and procedures.

CBHA staff shall review all credentialing policies and procedures of the delegated entity to ensure compliance.

CBHA staff shall complete an initial audit of the delegate's credentialing files and an annual audit thereafter; the lesser of 5% or 50 files shall be reviewed.

Should any deficiencies be identified during an audit, the delegated entity shall be required to submit a written corrective action plan that identifies specific steps to be taken to correct the deficiencies. If the concerns are adequately addressed in the corrective action plan, CBHA staff will conduct the next audit at the regular annual review. CBHA may exercise its discretion in requesting a re-audit prior to the annual review if the identified deficiencies raise concerns about the delegate's ability to carry out required credentialing functions. Failure to correct identified deficiencies may result in revocation of the delegation agreement.

BILLING

CBHA Claims Procedures

CBHA network providers are required to submit claims for services rendered on the ***HCFA – 1500 Claim Form.*** Standard HCFA – 1500 guidelines should be followed; providers are responsible to complete all applicable sections of the form.

- Claims for behavioral health services will not be processed without a DSM (most recently-published edition) diagnosis.
- Clean claims with correct information must be received within 180 days of the date of service to be eligible for reimbursement. Claims filed beyond the time limit are denied and the patient may be billed for any deductible, co pay and/or coinsurance amount only.

Remittance Advice*:** Network providers will receive a written statement explaining how benefits were applied that includes a ***Remittance Summary) and payment, if payment is due. Network providers having questions regarding their ***Remittance Advice*** should contact the CBHA Claims Department at 1-800-475-7900.

Anyone having questions regarding claims procedures or the status of a claim should contact the CBHA Claims Department at 1-800-475-7900.

Coordination of Benefits

CBHA will coordinate benefits in instances where an enrollee is covered under another plan in addition to the CBHA Plan (the Plan). When the Plan is considered primary, the Plan will reimburse the full extent of covered behavioral health services, which is the network provider's billed charges or the CBHA allowed amount (less any co-payment, co-insurance or deductible and with-hold), whichever is less. When the Plan is secondary, it will reimburse the provider for covered services in conjunction with the primary plan so that the two plans do not exceed the lowest amount, which the provider would be entitled to receive as a participant in either plan. If the enrollee does not have a legal obligation to pay all or part of the provider's billed charges, the Plan, as secondary payer, will also have no obligation to pay that portion of the provider's billed charges.

The claims should first be filed to the primary carrier as determined by the rules above. If the Plan is determined to be secondary, claims should be submitted within sixty (60) days of receipt of payment from the primary carrier along with a copy of the ***Explanation of Benefit*** (EOB). If the Plan receives a claim and has information that the enrollee has other coverage, the claim will be pended for further investigation. Release of payment for that claim will not be made until CBHA receives proof of primary payment or denial. If the enrollee does not have other coverage, it is his/her responsibility to contact the Plan directly to update his/her records; information relative to other coverage will not be accepted from a provider's office.

Note: If the Plan is secondary, the rules for the primary carrier should apply; therefore, the Plan's co-payment is not to be collected for the office visit. However, providers must still procure pre-authorization in order for the Plan to pay as secondary.

Determination of Primary Payor:

- **No Coordination of Benefits Provision**: When there are two plans and the other plan does not contain a written coordination of benefits provision, the plan without the provision will be the primary.

- **Employee Versus Dependent Status**: When a patient is covered as an employee under one plan and a dependent under the other, the plan under which the person is covered as an employee is the primary.

- **Dependent Children (Birth Date Rule)**: When a dependent child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in the year will be primary. If the parents are divorced or separated, the following guidelines apply:

    1. When a parent has financial responsibility for the child's health care expenses by court decree, his/her plan is primary.
    2. When financial responsibility has not been established, the health plan of the parent with legal custody of the child of is primary.
    3. When financial responsibility laws have not been established and the parent with legal custody remarries and the child's step-parent's plan also covers the child as a dependent, the order of primacy is as follows:
        - The health plan of the parent with legal custody;
        - The health plan of the step-parent;
        - The health plan of the parent without legal custody.

- **Active and Retirement Plans**: If one health plan is a retirement plan and the other is the Plan where a person is actively employed (the active plan); the active plan is primary and the retirement plan is secondary.

- **Workers Compensation, Medicare and Other Employer Liability Laws**: If benefits are available as primary benefits to an enrollee or his/her covered spouse or covered dependents under Medicare or any Workers Compensation Laws, Occupational Disease Laws or Employer Liability Laws, those benefits will be primary.

- If none of the rules for order of payment apply, then the plan under which the enrollee has been enrolled the longest is the primary plan.

Any questions concerning primary insurance may be referred to the CBHA Claims Department.

Refunds and Recovery of Overpayments

In the event a claim is mistakenly underpaid, CBHA will promptly make an adjustment and issue the corrected amount on the next claims payment to the provider. If for any reason the Plan has mistakenly paid or overpaid a claim, CBHA will deduct the overpayment from the provider's next claims payment. This adjustment will be

noted on the ***Remittance Advice*** as a negative amount and shall include a "Remark Code" indicating the reason the adjustment was made. All recoupments are clearly identified on the remittance summary and no single overpayment is recouped partially and carried over to the next claims payment.

Appeal/Grievance of Claims Denial

Most administrative issues such as delay in claims reimbursement can be resolved quickly and informally through verbal discussions between the provider and the CBHA Claims Department staff. Providers having an issue regarding claims payment should contact a claims staff member for further discussion. Written requests for reconsideration of denied claims must be submitted no later than one hundred eighty (180) days after the date of the denial. The request should state the reasons for the request, including supporting documentation and any new or additional information that will help CBHA make a decision. An acknowledgment letter will be sent within three (3) business days of receipt of the appeal. The letter will include the name, address and phone number of the appeals coordinator and will provide instruction for submitting written material. CBHA has thirty (30) days to review an appeal and prepare a written decision. Providers have a right to review pertinent documents and submit issues and comments to CBHA within the one hundred eighty (180) day period after receipt of the written notice of denial. (See the Complaints and Grievances and Appeals Section of this manual.)

CLINICAL PRACTICE GUIDELINES

CBHA recognizes the importance of utilizing consistent approaches to treatment that meet established industry standards and has established a method for adopting nationally recognized clinical practice guidelines to ensure individuals included in its enrollee population with identified diagnoses receive treatment within those guidelines. All guidelines adopted by CBHA are initially reviewed and approved by the BQIC and are re-reviewed every two years or at any time a change occurs. Clinical practice guidelines are disseminated to providers through direct mailings, e-mail or the Internet. Relevant portions or versions of adopted guidelines may be distributed to affected enrollees upon request.

Providers are audited for adherence to guidelines through review of medical records and treatment plans. Information is evaluated to determine whether the treatment provided to enrollees follows the adopted guideline.

Alcohol Detoxification

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA – Ar)

Many qualification instruments have been developed for monitoring alcohol withdrawal (Guthrie, 1989; Sullivan et al., 1989; Sellers & Naranjo, 1983). No single instrument is significantly superior to others. What is clear is that there are significant clinical advantages to quantifying the alcohol withdrawal syndrome. Quantification is key to preventing excess morbidity and mortality in a group of patients who are at risk for alcohol withdrawal. Such instruments help clinical personnel recognize the process of withdrawal before it progresses to more advanced stages, such as *delirium tremens*. By intervening with appropriate pharmacotherapy in those patients who require it, while sparing the majority of patients whose syndromes do not progress to that point, the clinician can prevent over and under treatment of the alcohol withdrawal syndrome. Finally, quantifying and monitoring the withdrawal process can modify the treatment regimen modified as needed.

The best known and most extensively studied scale is the Clinical Institute Withdrawal Assessment – Alcohol (CIWA – A) and a shortened version, the CIWA – A revised (CIWA – Ar). This scale has well-documented reliability, reproducibility and validity, based on comparison to ratings by expert clinicians (Knott, et al., 1981; Wiehl, et al., 1994; Sullivan, et al., 1989). From 30 signs and symptoms, the scale has been carefully refined to a list of 10 signs and symptoms in the CIWA – Ar (Wiehl, et al., 1994). It is thus easy to use and has been shown to be feasible to use in a variety of clinical settings, including detoxification units (Naranjo, et al., 1983; Hoey, et al., 1994), psychiatry units (Heinala, et al., 1990), and general medical/surgical wards (Young, et al., 1987; Katta, 1991). The CIWA – Ar has added usefulness because high scores, in addition to indicating severe withdrawal, are also predictive of the development of seizures and delirium (Naranjo, et al., 1983; Young, et al., 1987).

Copied from: ASAM Patient Placement Criteria, Second Edition - Revised

CLINICAL PRACTICE GUIDELINES: ALCOHOL DETOXIFICATION

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA - Ar)

What it Measures: The **CIWA – Ar** can measure 10 symptoms. Scores of less than 8 to 10 indicate minimal to mild withdrawal. Scores of 8 to 15 indicate moderate withdrawal (marked autonomic arousal); and scores of 15 or more indicate severe withdrawal. The assessment requires 2 minutes to perform (Sullivan, et al, 1989).

CIWA – Ar categories, with the range of scores in each category, are as follows:

Agitation	(0 – 7)
Anxiety	(0 – 7)
Auditory Disturbances	(0 – 7)
Clouding of Sensorium	(0 – 4)
Headache	(0 – 7)
Nausea/Vomiting	(0 – 7)
Paroxysmal Sweats	(0 – 7)
Tactile Disturbances	(0 – 7)
Tremor	(0 – 7)
Visual Disturbances	(0 – 7)

A study of the revised version of the CIWA predicted that those with a score of >15 were at increased risk for severe alcohol withdrawal (RR 3.72; 95% confidence interval 2.82 – 4.85) the higher the score the greater the risk. Some patients (6.4%) still suffered complications, despite low scores, if left untreated (Foy, et al., 1988).

EXAMPLE - ALCOHOL DETOXIFICATION PROTOCOL The following is an example of a protocol developed around the use of the CIWA – Ar in an alcohol detoxification program:

1. CIWA to be completed on admission and q 8 hours for a period of 24 hours.
2. Determine and record blood alcohol concentration (BAC) by breathalyzer on admission.
3. Vital signs: pulse rate and BP q 4 hours. **Call physician if patient has HR > 110mmHg, DBP > 120 mmHg, or SBP > 180 mmHg.**
4. Obtain serum glucose, HFP (hepatic function profile), CMEP (comprehensive metabolic panel, CBC w/DIFF and urine for drug screen.
5. Give Thiamine 100 mg IM now, and then Thiamine 100 mg PO bid times 3 days.
6. If CIWA score is > 0 but ≤ 8 and vital signs are stable, no medication is required. Repeat vital signs q 4 hours and the CIWA q 8 hours. (May repeat CIWA and vital signs as needed.)
7. If CIWA is > 8 but < 15, give Lorazepam (Ativan) 2 mg PO/IM and repeat vital signs q 2 hours and the CIWA q 4 hours.
8. If CIWA is ≥15 or DBP > 110 mmHg, give Lorazepam (Ativan) 2 mg PO/IM q 1 hour until patient has a CIWA of < 15 or DBP < 110 mmHg (CIWA and vital signs checked q 1 hour until patient's CIWA is < 15 and DBP < 110 mmHg.) When CIWA is between 8 and 15, give Lorazepam (Ativan) 2 mg PO/IM and resume vital signs q 2 hours and the CIWA q 4 hours.
9. **CALL MD IF PATIENT REQUIRES ≥ 6 mg OF LORAZEPAM (ATIVAN) IN THREE HOURS.**
10. May awaken patient to complete CIWA and vital signs.
11. When CIWA is ≤ 8 for 3 consecutive 8-hour increments, d/c CIWA protocol.

Addiction Research Foundation
Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA – Ar)

Patient: _____ Pulse or heart rate, take for 1 minute: _____

Date: _____ Time: _____ Blood Pressure: _____

Nausea and Vomiting: Ask, "Do you feel sick to your stomach? Have you vomited?" Observation: 0 No nausea and no vomiting 1 Mild nausea and no vomiting 2 3 4 Intermittent nausea with dry heaves 5 6 7 Constant nausea, frequent dry heaves and vomiting.	**Tactile Disturbance:** Ask, "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling under your skin?" Observation: 0 None 1 Very mild itching, pins and needles, burning or numbness 2 Mild itching, pins and needles, burning or numbness 3 Moderate itching, pins and needles, burning or numbness 4 Moderate severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations
Tremor: Arms extended and fingers spread apart. Observation: 0 No tremor 1 Not visible but can be felt fingertip to fingertip 2 3 4 Moderate, with patient's arm extended 5 6 7 Severe, even with arms not extended	**Auditory Disturbances:** Ask, "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation: 0 Not present 1 Very mild harshness or ability to frighten 2 Mild harshness or ability to frighten 3 Moderate harshness or ability to frighten 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations
Paroxysmal Sweats: Observation: 0 No sweat visible 1 2 3 4 Beads of sweat obvious on forehead 5 6 7 Drenching sweats	**Visual Disturbances:** Ask, "Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation: 0 Not present 1 Very mild sensitivity 2 Mild sensitivity 3 Moderate sensitivity 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations

Addiction Research Foundation

Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA – Ar)

Patient: _____ Pulse or heart rate, take for 1 minute: _____

Date: _____ Time: _____ Blood Pressure: _____

Anxiety: Ask, "Do you feel nervous?" Observation:

0 No anxiety, at ease
1 Mildly anxious
2
3
4 Moderately anxious, or guarded, so anxiety is inferred
5
6
7 Equivalent to acute panic states, as seen in severe delirium or acute schizophrenic reactions

Agitation: Observation

0 Normal activity
1 Somewhat more than normal activity
2
3
4 Moderately fidgety and restless
5
6
7 Paces back and forth during most of the interview, or constantly thrashes about

Headache, Fullness in Head: Ask, "Does your head feel different? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness. Otherwise, rate severity.

0 Not present
1 Very mild
2 Mild
3 Moderate
4 Moderately severe
5 Severe
6 Very severe
7 Extremely severe

Orientation and Clouding of Sensorium: Ask, "What day is this? Where are you? Who am I?" Observation:

0 Oriented and can do serial additions
1 Cannot do serial additions or is uncertain about date
2 Disoriented for date by no more than 2 calendar days
3 Disoriented for date by more than 2 calendar days
4 Disoriented for place and/or person

Total **CIWA – Ar** Score _____
(maximum possible score = 67)

Rater's Initials _____

Patients scoring less than 10 do not usually need additional medication for withdrawal.

Note: The CIWA – Ar is not copyrighted and may be used freely. Source: Sullivan JT, Sykora K, Schneiderman J, Naranjo CA & Sellers EM (1989) Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA – Ar) British *Journal of Addiction 84:1353 – 1357*

CLINICAL PRACTICE GUIDELINES: ATTENTION DEFICIT/HYPERACTIVITY DISORDER

AACAP Official Action:

OUTLINE OF PRACTICE PARAMETERS FOR THE ASSESSMENT AND TREATMENT OF CHILDREN, ADOLESCENTS, AND ADULTS WITH ADHD

Reprinted with permission from: J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY, 36.10 SUPPLEMENT, OCTOBER 1997

CHILDREN AGED 6 TO 12 YEARS

I. Initial evaluation (a complete psychiatric assessment is indicated; see Practice Parameters for the Psychiatric Assessment of Children and Adolescents [American Academy of Child and Adolescent Psychiatry, 1995]).

1. Interview with parents.
    a) Child's history.
        (1) Developmental history.
        (2) DSM (most recently-published edition) symptoms of ADHD
            (a) Presence or absence (may use symptom or criterion checklist).
            (b) Development and context of symptoms and resulting impairment, including school (learning, academic productivity, and behavior), family and peers.
        (3) DSM (most recently-published edition) symptoms of possible alternate or co-morbid psychiatric diagnosis.
        (4) History of psychiatric, psychological, pediatric, or neurological treatment for ADHD; details of medication trials.
        (5) Areas of relative strength (e.g., talents and abilities).
        (6) Medical History.
            (a) Medical or neurological primary diagnosis (e.g., phenobarbital, antihistimines, theophylline, sympathomimetics, steroids).
            (b) Medications that could cause symptoms (e.g., phenobarbital, antihistimines, theophylline, sympathomimetics, steroids).
    b) Family history:
        (1) ADHD, tic disorders, substance-use disorders, CD, personality disorders, mood disorders, obsessive-compulsive disorder and other anxiety disorders, schizophrenia.
        (2) Developmental and learning disorders.
        (3) Family coping style, level of organization, and resources.
        (4) Past and present family stressors, crises, changes in family constellation.
        (5) Abuse or neglect.
2. Standardized rating scales completed by parents.
3. School information from as many current and past teachers as possible.
    a) Standardized rating scales.
    b) Verbal reports of learning, academic productivity, and behavior.
    c) Testing reports (e.g., standardized group achievement tests, individual evaluations).
    d) Grade and attendance records.
    e) Individual educational plan (IEP), if applicable.
    f) Observations at school if feasible and if case is complex.
4. Child diagnostic interview: history and mental status examination.
    a) Symptoms of ADHD (note: may not be observable during interview and may be denied by child).
    b) Oppositional behavior.
    c) Aggressive behavior.
    d) Mood and affect.
    e) Anxiety.
    f) Obsessions or compulsions.
    g) Form, content, and logic of thinking and perception.
    h) Fine and gross motor coordination.
    i) Tics, stereotypes, or mannerisms.
    j) Speech and language abilities.

k) Clinical estimate of intelligence.

5. Family diagnostic interview.
    a) Patient's behavior with parents and siblings.
    b) Parental interventions and results.
6. Physical evaluation.
    a) Medical history and examination within past 12 months or more recently if the clinical condition has changed.
    b) Documentation of health history, immunizations, screening for lead level, etc.
    c) Measurement of lead level (if not already done) only if history suggests pica or environmental exposure.
    d) Documentation or evaluation of visual acuity.
    e) Documentation or evaluation of hearing acuity.
    f) Further medical or neurological evaluation as indicated.
    g) In preparation for pharmacotherapy.
        (1) Baseline documentation of height, weight, vital signs, and abnormal movements.
        (2) ECG before TCA or clonidine.
        (3) Consider EEG before TCA or bupropion, if indicated.
        (4) Liver function studies before pemoline.
7. Referral for additional evaluations if indicated.
    a) Psycho educational evaluation (administered individually).
        (1) IQ.
        (2) Academic development.
        (3) Learning disorders.
    b) Neuropsychological testing.
    c) Speech and language evaluation.
    d) Occupational therapy evaluation.
    e) Recreational therapy evaluation.

II. Psychiatric differential diagnosis.

8. ODD.
9. CD.
10. Mood disorders-depression or mania.
11. Anxiety disorders.
12. Tic disorder (including Tourette's disorder).
13. Pica.
14. Substance use disorder.
15. Learning disorder.
16. Pervasive developmental disorder.
17. Mental retardation or borderline intellectual functioning.

III. Treatment planning.

18. Establish target symptoms and baseline impairment (rating scales may be useful).
19. Consider treatment for co-morbid conditions.
20. Prioritize modalities to fit target symptoms and available resources.
    a) Education about ADHD.
    b) Classroom placement and resources.
    c) Medication.
    d) Other modalities may assist with remaining target symptoms.
21. Monitor multiple domains of functioning.
    a) Learning in key subjects (achievement tests, classroom tests, homework, class work).
    b) Academic productivity (homework, class work).
    c) Emotional functioning.
    d) Family interactions.
    e) Peer relationships.
    f) If on medication, appropriate monitoring of height, weight, vital signs, and relevant laboratory

parameters.

22. Reevaluate efficacy and need for additional interventions.
23. Maintain long-term supportive contact with patient, family, and school.
    a) Ensure compliance with treatment.
    b) Address problems at new developmental stages or in response to family or environmental changes.

IV. Treatment.

24. Education of parents, child, and significant adults.
25. School interventions.
    a) Ensure appropriate class placement and availability of needed resources (e.g., tutoring).
    b) Consult or collaborate with teachers and other school personnel.
        (1) Information about ADHD.
        (2) Educational techniques.
        (3) Behavior management.
    c) Direct behavior modification program when possible and if problems are severe in school setting.
26. Medication.
    a) Stimulants.
    b) Bupropion.
    c) TCAs.
    d) Other antidepressants.
    e) Clonidine or guanfacine (primarily as an adjunct to a stimulant).
    f) Neuroleptics-risks usually exceed benefits in treatment of ADHD; consider carefully before use.
    g) Anticonvulsants-few data support use in the absence of seizure disorder or brain damage.
27. Psychological interventions.
    a) Parent behavior modification training.
    b) Referral to parent support group, such as CHADD.
    c) Family psychotherapy if family dysfunction is present.
    d) Social skills group therapy for peer problems.
    e) Individual therapy for co-morbid problems, not core ADHD.
    f) Summer day treatment.
28. Ancillary treatments.
    a) Speech and language therapy.
    b) Occupational therapy.
    c) Recreational therapy.
29. Dietary treatment rarely is useful.
30. Other treatments are outside the realm of the usual practice of child and adolescent psychiatry and are not recommended.

CHILDREN AGED 3 TO 5 YEARS

Same protocol as above, except for the following.

II. Evaluation.

1. Higher index of suspicion for neglect, abuse, or other environmental factors.
2. More likely to require evaluation of lead level.
3. More likely to require evaluation of:
    a) Speech and language disorders.
    b) Cognitive development.

III. Treatment.

1. Increased emphasis on parent training.
2. Highly structured preschool.
3. Additive-free diet occasionally may be useful.
4. If medications are used, exercise more caution, use lower doses, and monitor more frequently.

ADOLESCENTS

Same protocol as for children aged 6 to 12 years, except for the following.

I. Higher index of suspicion for co morbidity with:
    5. CD.
    6. Substance-use disorder.
    7. Suicidality.

II. Teacher reports less useful in middle and high school than in grammar school.

III. Patient must participate actively in treatment.

IV. Increased risk of medication abuse by patient or peers.

V. Greater need for vocational evaluation, counseling, or training.

VI. Evaluate patient's safe driving practices.

ADULTS

I. Initial evaluation (a complete psychiatric assessment is indicated; see American Psychiatric Association Work Group on Psychiatric Evaluation of Adults [1995]).
    1. Interview with patient.
        a) Developmental history.
        b) Present and past DSM (most recently-published edition) symptoms of ADHD (may use symptom or criterion checklist or self-report form).
        c) History of development and context of symptoms and resulting past and present impairment.
            (1) School (learning, academic productivity, and behavior).
            (2) Work.
            (3) Family.
            (4) Peers.
        d) History of other psychiatric disorders.
        e) History of psychiatric treatment.
        f) DSM (most recently-published edition) symptoms of possible alternate or comorbid psychiatric diagnosis, especially:
            (1) Personality disorder.
            (2) Mood disorders-depression or mania.
            (3) Anxiety disorders.
            (4) Dissociative disorder.
            (5) Tic disorder (including Tourette's disorder).
            (6) Substance use disorder.
            (7) Learning disorders.
        g) Strengths (e.g., talents and abilities).
        h) Mental status examination.
    2. Standardized rating scales completed by the patient's parent.
    3. Medical history.
        a) Medical or neurological primary diagnosis (e.g., thyroid disease, seizure disorder, migraine, head trauma).
        b) Medications that could be causing symptoms (e.g., phenobarbital, antihistamines, theophylline, sympathomimetics, steroids).
    4. Family history.
        a) ADHD, tic disorders, substance use disorders, CD, personality disorders, mood disorders, anxiety disorders.
        b) Developmental and learning disorders.
        c) Family coping style, level of organization, and resources.
        d) Family stressors.

e) Abuse or neglect (as victim or perpetrator).

5. Interview with significant other or parent, if available.
6. Physical examination.
    a) Examination within 12 months or more recently if clinical condition has changed.
    b) Further medical or neurological evaluation as indicated.
7. School information.
    a) Standardized rating scales if completed during childhood.
    b) Narrative childhood reports regarding learning, academic productivity, and behavior.
    c) Reports of testing (e.g., standardized group achievement tests and individual evaluations).
    d) Grades and attendance records.
8. Referral for additional evaluations if indicated.
    a) Psycho educational evaluation.
        (1) IQ.
        (2) Academic achievement.
        (3) Learning disorders evaluation.
    b) Neuropsychological testing.
    c) Vocational evaluation.

II. Treatment planning.

1. Establish target symptoms of ADHD and baseline levels of impairment.
2. Consider treatment for co-morbid conditions (monitor possible drug-seeking behavior).
3. Prioritize modalities to fit target symptoms and available resources.
4. Monitor multiple domains of functioning.
    a) Academic or vocational.
    b) Daily living skills.
    c) Emotional adjustment.
    d) Family interactions.
    e) Social relationships.
    f) Medication response.
5. Periodically reevaluate the efficacy of and need for additional interventions.
6. Maintain long-term supportive contact with the patient and family to ensure compliance with treatment and to address new problems that arise.

III. Treatment.

1. Education for patient, spouse, or other significant persons.
2. Consideration of vocational evaluation, counseling, or training.
3. Medication.
    a) Stimulants.
    b) Tricyclic antidepressants.
    c) Other antidepressants.
    d) Other drugs (buspirone, propranolol).
4. Psychosocial interventions.
    a) Individual cognitive therapy; “coaching.”
    b) Family psychotherapy if dysfunction is present.
    c) Referral to support group, such as CHADD.
5. Other treatments are outside the realm of the usual practice of psychiatry.

Appendix

Medical Necessity Criteria - 23 - Hour Observation - Mental Illness

The following criteria will be utilized to determine the medical necessity of 23-hour observation treatment for mental illness:

1. Demonstrated failure to respond to treatment at a less intensive level of care, including medication management if indicated.

2. Documentation of signs and symptoms consistent with DSM-5 diagnosis.

3. There is need for specialized care including complex medication management/monitoring, multiple diagnostic procedures and special risk management.

4. Suicide ideation exists and may be associated with a plan, intent to carry out that plan and the means to carry out the plan or history of a suicide attempts.

5. Evidence of significant self-mutilation, serious risk-taking or other self-endangering behavior.

After 23 hours or less of observation it will be determined if the enrollee meets criteria for a full inpatient admission or can be treated at a less intensive level of treatment.

Medical Necessity Criteria - Initial/Continuation - Inpatient Mental Illness

The following criteria will be utilized to determine the medical necessity of an initial inpatient stay for a mental illness.

1. Demonstrated failure to respond to treatment at a less intensive level of care, including medication management if indicated.
2. Documentation of signs and symptoms consistent with DSM-5 diagnosis.
3. Documentation of disordered behavior that endangers the welfare of the patient or others, or interferes with activities of daily living.
4. Demonstrated need for specialized care including complex medication management/monitoring, multiple diagnostic procedures or special risk management.
5. Documentation of serious risk of suicide or self harm
6. Suicide attempts which are considered by their degree of intent, hopelessness, and impulsivity.
7. Suicide ideation exists and may be associated with a plan, intent to carry out that plan and the means to carry out the plan.
8. Evidence of significant self mutilation, serious risk-taking or other self-endangering behavior.

9. Documentation of serious risk of harm to others.
10. Assaultive behavior which is a result of a psychiatric condition has occurred and there is a risk of escalation or repetition of this behavior.
11. Destructive behavior toward property, which is a result of a psychiatric condition, possibly threatening other, such as setting fires.

The following criteria will be utilized to determine the medical necessity of a continued inpatient stay for a mental illness.

1. Documentation of signs and symptoms consistent with DSM-5 diagnosis.
2. Documentation of ongoing disordered behavior in the milieu, which unmonitored would endanger the welfare of the patient or others or interfere with activities of daily living.
3. Documentation of need for ongoing specialized care including complex medication management/monitoring, multiple diagnostic procedures and special risk management.
4. Evidence of the patient's incapacity for reliable attendance within a partial hospital program.
5. Documentation of active and realistic psychiatric evaluation, treatment and discharge planning under way within the shortest possible time frame.

Medical Necessity Criteria — Child & Adolescent Inpatient — Mental Illness

The following criteria will be utilized to determine the medical necessity for initial inpatient treatment for children and adolescents:

1. Treatment at a less intensive level of care would be ineffective or unsafe.
2. The child/adolescent demonstrates psychiatric signs and symptoms consistent with a DSM-5 mental disorder. The primary diagnosis is not a substance abuse disorder.
3. The child/adolescent demonstrates at least one of the following:
   Suicide attempt has been made with serious intent,
   Suicidal ideation exists with intent, a plan and the means to actualize the plan.
4. Documentation shows a recent pattern of self-mutilation or unsafe acts without regard to life threatening potential.
5. Documented assaultive threats or acts toward people or property that endanger others. Escalation or repetition is likely in near future.
6. Psychotic thinking, bizarre behavior, psychomotor retardation, psychomotor agitation or obsessive compulsive rituals create a level of functional impairment that keeps the child/adolescent from functioning at a lower level of care.
7. Memory impairment or disorientation at a lower level of care.

The following criteria will be utilized to determine the medical necessity for continuing inpatient treatment for children and adolescents:

The child/adolescent patient requires at least one of the following:

1. A comprehensive multimodal treatment plan that requires 24-hour medical supervision and coordination.
2. 24-hour medical supervision and observation are needed to monitor and adjust psychopharmacotherapy.
3. 24-hour supervision is needed to observe and manage physically destructive, self-mutilatory or suicidal behavior.
4. Continuous monitoring and treatment of serious medication side effects.
5. Detoxification for demonstrated sign/symptoms of drug withdrawal.

Both of the following are occurring:

1. The multidisciplinary team is preparing an appropriate discharge plan to transition the patient from inpatient care.
2. The family/guardians are involved intensively in the treatment.

Medical Necessity Criteria - Psychiatric-Adult Initial & Continuation Residential Treatment

Service Description

In order to qualify for coverage for psychiatric residential level of care, a facility's program must meet the following criteria:

1 . Residential treatment takes place in a structured, facility-based setting. Wilderness programs, therapeutic boarding schools, group homes and other supportive living arrangements are not considered residential treatment.
2. Documentation shows that a blood or urine drug screen was done on admission and during treatment, if indicated.
3. Evaluation by a qualified physician done within 48 hours and physical exam and lab tests unless done prior to admission, and eight (8) hour on-site nursing (by either an RN or LVN/LPN) with 24-hour medical availability to manage medical problems if medical instability identified as a reason for admission to this level of care.
4. Within 72 hours, a multidisciplinary assessment with an individual problem-focused treatment plan completed, addressing psychiatric, academic, social, medical, family and substance use needs.
5. Coordination of care with other clinicians providing treatment to the member, such as the outpatient psychiatrist, therapist and the member's PCP, and, where indicated, the clinicians providing treatment to other family members, is documented.
6. Treatment would include the following at least once a day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy and activity group therapy.
7. Skilled nursing care (either an RN or LVN/LPN) available on-site at least eight (8) hours daily with 24-hour availability.
8. Individual treatment with a qualified physician at least once a week including medication management, if indicated.
9. Individual treatment with a licensed behavioral health clinician at least once a week.

10. Unless contraindicated, family members participate in development of the treatment plan, participate in family program and groups and receive family therapy at least once a week, including in-person family therapy at least once a month if the provider in not geographically accessible. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated.
11. A discharge plan is completed within one week that includes who the outpatient providers will be and where the member will reside.
12. The treatment is individualized and not determined by a programmatic timeframe. It is expected that the member will be prepared to receive the majority of their treatment in a community setting.
13. Medication evaluation and documented rationale if no medication is prescribed.

The following criteria will be utilized to determine the medical necessity of an initial residential stay for Psychiatric Conditions in an Adult:

1 . Documentation of signs and symptoms of a current DSM or ICD diagnosis with primary focus on psychiatric care. All services must meet the definition of medical necessity in the members plan document.
2. The member is manifesting symptoms and behaviors which represent a deterioration from their usual status and include either self-injurious or risk taking behaviors that risk serious harm and cannot be managed outside of a 24 hour structured setting.
3. The social environment is characterized by temporary stressors or limitations that would undermine treatment that could potentially be improved with treatment while the member is in the residential

4. There should be a reasonable expectation that the illness, condition or level of functioning will be stabilized and improved and that a short term, sub-acute residential treatment service will have a likely benefit on the behaviors/symptoms that required this level of care, and that the member will be able to return to outpatient treatment.

The following criteria will be utilized to determine the medical necessity of a continued residential stay for Psychiatric Conditions in an Adult:

1 . The member continues to meet all basic elements of medical necessity.

2. <u>One or more</u> of the following <u>must</u> be met:
   a. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
   b. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and modification to the treatment plan, when clinically indicated.
   c. The member has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. <u>All</u> of the following <u>must</u> be met:

a. the individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
b. Continued stay is NOT primarily for the purpose of providing a safe and structured environment.
c. Continued stay is NOT primarily due to a lack of external supports.

Medical Necessity Criteria - Psychiatric Child/Adolescent Initial & Continuation Residential

Service Description

In order to qualify for coverage for psychiatric residential level of care, a facility's program must meet the following criteria:

1. Residential treatment takes place in a structured facility-based setting. Wilderness programs, therapeutic boarding schools, group homes and other supportive living arrangements are not considered residential treatment.
2. Documentation shows that a blood or urine drug screen was done on admission and during treatment, if indicated.
3. Evaluation by a qualified physician done within 48 hours and physical exam and lab tests unless done prior to admission, and eight (8) hour on-site nursing (by either an RN or LVN/LPN) with 24 hour medical availability to manage medical problems if medical instability identified as a reason for admission to this level of care. The physician should be a psychiatrist who is board certified in child/adolescent psychiatry or shows equivalent competence in this area.
4. Within 72 hours, a multidisciplinary assessment with an individual problem-focused treatment plan completed, addressing psychiatric, academic, social, medical, family and substance use needs.
5. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist and the member's PCP, providing treatment to the member and where indicated, the clinicians providing treatment to other family members, is documented.
6. There is coordination with community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated. School contact should address the Individualized Educational Plan as appropriate.
7. Treatment would include the following at least once a day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy and activity group therapy.
8. Care includes evidence based treatment as part of the facility's program.

9. The facility has evidence that it can handle special populations, such as autism, reactive attachment disorder, etc or that they specifically screen out for these populations.
10. Skilled nursing care (either an RN or LVN/LPN) available on-site at least eight (8) hours daily with 24 hour availability.
11. Individual treatment with a qualified physician at least once a week including medication management if indicated.
12. Individual treatment with a licensed behavioral health clinician at least once a week.
13. Unless contraindicated, family member s participate in development of the treatment plan, participate in family program and groups and receive family therapy at least once a week, including in-person family therapy at least once a month if the provider in not geographically accessible. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated.
14. A discharge plan is completed within one week that includes who the outpatient providers will be and where the member will reside.
15. The treatment is individualized and not determined by a programmatic timeframe. It is expected that the member will be prepared to receive the majority of their treatment in a community setting.
16. Medication evaluation and documented rationale if no medication is prescribed.

The following criteria will be utilized to determine the medical necessity of an initial residential stay for Psychiatric Conditions in a Child or Adolescent:

1. Documentation of signs and symptoms of a current DSM or !CD diagnosis with primary focus on psychiatric care. All services must meet the definition of medical necessity in the member's plan document.
2. The member is manifesting symptoms and behaviors which represent a deterioration from their usual status and include either self-injurious or risk taking behaviors that risk serious harm and cannot be managed outside of a 24 hour structured setting.
3. The social environment is characterized by temporary stressors or limitations that would undermine treatment that could potentially be improved with treatment while the member is in the residential facility.
4. There should be a reasonable expectation that the illness, condition or level of functioning will be stabilized and improved and that a short term, sub-acute residential treatment service will have a likely benefit

on the behaviors/symptoms that required this level of care, and that the member will be able to return to outpatient treatment.

The following criteria will be utilized to determine the medical necessity of a continued residential stay for Psychiatric Conditions in a Child or Adolescent:

1. The member continues to meet all basic elements of medical necessity.

2. One or more of the following must be met:
   a. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
   b. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and modification to the treatment plan, when clinically indicated.
   c. The member has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:
   a. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication,
   b. Continued stay is NOT primarily for the purpose of providing a safe and structured environment.
   c. Continued stay is NOT primarily due to a lack of external supports.

Medical Necessity Criteria - Initial/Continuation Partial Hospitalization - Mental Illness

The following criteria will be utilized to determine the medical necessity of partial hospitalizations.

1. Evidence of patient capacity for reliable attendance at the partial hospital program.
2. Evidence of compliance with a recommended medication regime.
3. Risk to self, others or property is not so serious as to require 24-hour medical supervision.
4. Documentation of signs and symptoms consistent with DSM-5diagnosis.
5. Evidence of sufficient impulse control to contract not to harm self.
6. Evidence of sufficient impulse control to contract not to engage in self-mutilating, risk taking or other self-endangering behavior.
7. Evidence of sufficient impulse control to contract not to harm others.
8. Demonstrated need for at least routine medical observation and supervision.
9. Evidence of significant risk for decompensation in the absence of Partial Hospitalization, which would require acute inpatient hospitalization.

The following criteria will be utilized to determine the medical necessity of a continued partial hospitalization.

1. Evidence that in the absence of partial hospitalization there is significant risk for decompensation, which would require acute inpatient hospitalization.
2. Demonstration of need for ongoing medical observation and supervision to effect significant regulation of psychotropic medication.
3. Demonstration of attendance, compliance and progress made with partial hospital programming.
4. Documentation of active and realistic psychiatric evaluation, treatment and discharge planning under way within the shortest possible time frame.

Medical Necessity Criteria - Child & Adolescent Partial Hospitalization - MI

The following criteria will be utilized to determine the medical necessity for initial partial hospitalization treatment for children and adolescents:

1. The child/adolescent has a DSM-5 psychiatric disorder and a level of functional impairment that requires treatment in a structured setting.

2. The child/adolescent and parent/guardian show a capacity for attendance at the partial hospitalization program.

3. The child/adolescent also demonstrates at least one of the following:
   a. Suicidal ideation without intent exists and the patient can report suicidal impulses to staff for evaluation and intervention.
   b. Aggressive tendencies toward persons or property do exist but are not serious enough t o require 24-hour supervision.

c. Continued medical supervision is needed to adjust psychotropic medications.

4. Documentation of a mood impairment or thought disorder that interferes with the patient's ability to function at a lesser level of care.

5. Documentation indicates the need for supervision of self-care, nutritional intake or age appropriate functioning in school, family and community.

The following criteria will be utilized to determine the medical necessity for continuing partial hospitalization treatment for children and adolescents:

1. The patient's disorder and functional impairment prevent the patient from functioning at a lower level of care.

2. Continued need for supervision of psychotropic medication therapy.

3. Active discharge planning is occurring.

Medical Necessity Criteria — Intensive Outpatient Program — Mental Illness

The following criteria will be utilized to determine the medical necessity of initial outpatient treatment:

1. Documentation showing evidence of signs and symptoms consistent with DSM-5 diagnosis.
2. Evidence that the patient is experiencing symptoms which have significantly impaired the ability to function in normal activities.
3. Demonstrated failure to respond to treatment at a less intensive level of care, including medication management if indicated.
4. Demonstrated capacity and need to continue regular work schedule.
5. Evidence that in the absence of IOP there is significant risk for decompensation, which would require a higher level of care.

The following criteria will be utilized to determine the medical necessity for continuing 10P treatment:

1. Documentation showing evidence of signs and symptoms consistent with DSM-5 diagnosis.
2. Evidence that the patient is experiencing symptoms which have significantly impaired the ability to function in normal activities.
3. Documentation regarding precipitating factors indicating acute stressors rather than chronic conditions.
4. Demonstration of attendance, compliance and progress made within lOP.
5. Documentation indicating that appropriate psychotherapeutic interventions consistent with the patient's symptoms have been initiated.

6. Documentation indicating that appropriate medical interventions consistent with the patient's symptoms have been initiated.
7. Documentation reflects an appropriate schedule for treatment termination.
8. Evidence that in the absence of IOP there is significant risk for decompensation, which would require a higher level of care.

Medical Necessity Criteria - 23-Hour Observation - Chemical Dependency

The following criteria will be utilized to determine the medical necessity of 23-hour observation for Chemical Dependency:

1. Documentation of a pattern of substance abuse and/or dependence or prior history of withdrawal symptoms necessitating close observation to determine need for medical detoxification.

2. Documentation of at least two signs of substance withdrawal, which can be attributed to a particular substance that is characteristic of its withdrawal:
   - Tachycardia
   - Hypertension
   - Diaphoresis
   - Significant increase or decrease in psychomotor activity.
   - Tremor
   - Significantly disturbed sleep pattern.
   - Nausea/Vomiting
   - Clouding of consciousness with reduced capacity to shift, focus, and sustain attention.

3. Enrollee reports use of chemicals, the amounts and over a period of time, such that sudden cessation could result in imminent withdrawal.

Medical Necessity Criteria — CD Initial & Continuation Inpatient

The following criteria will be utilized to determine the medical necessity of an initial inpatient stay for Chemical Dependency:

1. Documentation of signs and symptoms indicating that failure to use this level of treatment would be life threatening or cause permanent impairment once substance abuse has stopped.

2. Documentation of need for all inpatient detoxification services including:

a. Fluids and medication to modify or prevent withdrawal complications that threaten life or bodily functions.
b. 24-hour nursing care with close and frequent observation and monitoring of vital signs.
c. Medical therapy, which is supervised and re-evaluated daily, by the attending physician in order to stabilize the patient's physical condition.

3. Documentation of at least two signs of substance withdrawal, which can be attributed to a particular substance that is characteristic of its withdrawal:
   a. Tachycardia
   b. Hypertension
   c. Diaphoresis
   d. Significant increase or decrease in psychomotor activity.
   e. Tremor
   f. Significantly disturbed sleep pattern.
   g. Nausea/Vomiting
   h. Clouding of consciousness with reduced capacity to shift, focus, and sustain attention

The following criteria will be utilized to determine the medical necessity of a continued inpatient stay for Chemical Dependency:

1. The patient continues to manifest acute withdrawal symptoms that can be treated only in a 24-hour medical setting with skilled nursing care.

2. The patient experiences medical or neurological complications, which can only be treated in a 24-hour medical setting with skilled nursing care.

3. The patient's condition is expected to improve within a brief time.

4. A standard detox protocol is in use (i.e., the detox of alcohol would not be accomplished with decreasing dosages of alcohol). CBHA currently promulgates use of a symptom-triggered detoxification protocol, such as CIWA, etc.

5. Patient's medical condition prevents the patient from participating in another level of care.

Medical Necessity Criteria — Substance Abuse Initial & Continuation Residential

Service Description

In order to qualify for coverage under substance abuse residential, a facility's program must meet the following criteria:

1. Evaluation by a qualified physician within 48 hours of admission and weekly visits by a qualified physician if dually diagnosed and psychiatric symptoms identified as a reason for admission requiring this level of care.
2. Physical exam and lab tests done within 48 hours if not done prior to admission and eight (8) hours on-site nursing (by either an RN of LVN/LPN) with 24 hour medical availability to manage medical problems if medical instability identifies as a reason for admission requiring this level of care.
3. Programming provided will be consistent with the member's language, cognitive, speech and/or hearing abilities.

4. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans.
5. Coordination of care with other clinicians providing treatment to the member, such as the outpatient psychiatrist, therapist and the member's PCP, and, where indicated, clinicians providing treatment to other family members, is documented.
6. Within 48 hours, an individualized, problem-focused treatment plan is done, based on completion of a detailed personal substance use history, including identification of consequences of use and identifying individual relapse triggers as goals.
7. The treatment would include the following at least once per day, and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy and activity group therapy.
8. Family supports identified and contacted within 48 hours and family/primary support person participation in treatment at least weekly unless contraindicated. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated.
9. Discharge planning completed within one (1) week of admission including identification of community/family resources, sober supports, connection or re-establishment of connection to community based recovery programs and professional aftercare treatment.
10. Drug screens used after all off-grounds activities and whenever otherwise indicated.
11. All therapeutic services provided by licensed or certified professional in accordance with state laws.
12. The treatment is individualized and not determined by a programmatic timeframe.' It is expected that members will be prepared to receive the majority of their rehabilitation in a community setting.
13. Evaluation for medication that may improve the members ability to remain abstinent; document the rationale if no medication is prescribed.

The following criteria will be utilized to determine the medical necessity of an initial residential admission for Substance Abuse:

Documentation of signs and symptoms of a Substance Use Disorder as defined in the most current DSM or ICD system. Must meet criteria 1 or 2, as well as 3 to qualify:

1. Acute psychiatric symptoms that would interfere with:
   a. The member maintaining abstinence and
   b. Recovery outside of a 24 hour structured setting and
   c. Represent a deterioration from their usual status and
   d. Include either self-injurious or risk taking behaviors that poses a risk of serious harm to the member or others and cannot be managed outside of a 24 hour structured setting.
2. Acute medical symptoms that would likely interfere with the member maintaining abstinence and recovery outside of a 24 hour structured setting.
3. Evidence of major functional impairment in at least 2 domains (work/school, ADL, family/interpersonal, physical health).

The following criteria will be utilized to determine the medical necessity of a continued residential stay for Substance Abuse:

1. The member continues to meet all basic elements of medical necessity.

2. One or more of the following must be met:
   a. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.

b. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and modification to the treatment plan, when clinically indicated.
c. The member has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:
   a. the individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
   b. Continued stay is NOT primarily for the purpose of providing a safe and structured environment.
   c. Continued stay is NOT primarily due to a lack of external supports.

Medical Necessity Criteria — CD Initial & Continuation Partial Hospitalization

The following criteria will be utilized to determine the medical necessity of Chemical Dependency partial hospitalization review criteria:

1. The patient experiences acute withdrawal, medical or neurological complications, which requires a medical selling with skilled nursing care, available for the majority of the day.

2. The patient's condition is expected to improve within a brief time.

3. A standard detox protocol is in use (i.e., the detox of alcohol would not be accomplished with decreasing dosages of alcohol).

4. Patient's medical condition prevents the patient from participating in another level of care such as CD rehabilitation, group, etc.

The following criteria will be utilized to determine the medical necessity of continuing chemical dependency partial hospitalization:

1. Demonstration of attendance, active participation and progress made within partial hospital programming.

2. Demonstration of need for ongoing medical observation and supervision to effect significant regulation of psychotropic medication.

3. Demonstration of abstinence from substance abuse.

4. Patient's medical condition prevents the patient from participating in another level of care.

5. Documentation of active and realistic psychiatric evaluation, treatment and discharge planning under way within the shortest possible time frame.

Medical Necessity Criteria CD - Initial & Continuation - Intensive Outpatient Program

The following criteria will be utilized to determine the medical necessity of initial 10P chemical dependency treatment:

1. Documentation of a pattern of substance abuse and/or dependence, necessitating intensive treatment to effect and sustain remission.

2. Demonstrated capacity and need to continue regular work schedule.

3. Evidence that in the absence of 10P there is significant risk for decompensation, which would require a higher level of care.

The following criteria will be utilized to determine the medical necessity of continuing lOP chemical dependency treatment:

1. Demonstration of attendance, compliance and progress made within 10P.

2. Documentation indicating that appropriate psychotherapeutic interventions consistent with the patient's symptoms have been initiated.

3. Documentation indicating that appropriate medical interventions consistent with the patient's symptoms have been initiated.

4. Documentation reflects an appropriate schedule for treatment termination.

5. Evidence that in the absence of 10P there is significant risk for decompensation, which would require a higher level of care.