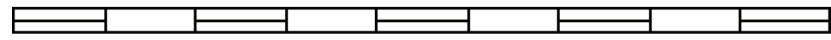




New Avenues



Maximizing Human Productivity and Well-Being

Provider Manual

BEHAVIORAL HEALTH SECTION

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BEHAVIORAL HEALTH SECTION

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ACCESSING ADMINISTRATIVE, CLINICAL, EAP, & UTILIZATION REVIEW SERVICES

PROVIDERS:

Practitioners and facilities may contact New Avenues and MBHN during normal business hours (9:00 am to 5:30 pm Eastern Standard Time, Monday-Thursday, and 9:00 am to 5:00 pm on Friday), for the following:

- a. Enrollee eligibility
- b. Benefits information & explanations
- c. Utilization Review Reports
- d. Case management concerns, clinical updates
- e. Request for authorization for continued treatment
- f. Claims questions
- g. Complaints, appeals
- h. Provider relations including credentialing/contracting issues
- i. Quality management concerns
- j. Forms are available to be down loaded from website www.NewAvenuesOnline.com click: "Provider Desk".
- k. Urgent/Emergent Needs and Inpatient Utilization Review: Call 24 hours a day.

COVERED PERSONS:

Covered persons may contact the MBHN or New Avenues during normal business hours (9:00 am to 5:30 pm Eastern Standard Time, Monday-Thursday, and 9:00 am to 5:00 pm on Friday), for the following:

- a. Accessing all care- EAP & behavioral health
- b. Obtaining referral assistance
- c. Verification of enrollee's eligibility for services
- d. Information regarding behavioral health benefit coverage
- e. Pre-authorization of all behavioral health services
- f. Information about the Provider Network
- g. Case management concerns, inquiries about other services or other providers
- h. Claims questions
- i. Complaints or appeals

The toll-free "Access Line" provides covered persons with Assessment & Referral Services for urgent and emergent needs 24 hours a day, 7 days a week. This number is staffed by clinically-trained, behavioral health professionals. Coverage is accomplished by staff members available during regular business hours and after hours and holidays via an answering service and paging system for urgent/emergent situations. Staff members are on-call for both the Midwest Behavioral Health Network and New Avenues EAP.

CONFIDENTIALITY

New Avenues, in the course of conducting business over 25 years, respects the professional ethics of protecting the privacy of its members and providers. It is committed to procedures and practices that, not only meet regulatory requirements, but also respect the relationship and communication between the member and provider. Therefore, as a provider you will be advised of the following procedures and utilization management activities that support this thinking.

New Avenues adheres to state and federal statutes concerning patient confidentiality and privacy with regard to medical record access, transmittal, disclosure or correspondence about the member and their treatment.

The Health Insurance Portability and Accountability Act (HIPAA) allows for the limited disclosure of patient health information for the specific purpose of treatment, payment or other healthcare operation including utilization management and quality assurance. The following procedures are adopted to ensure appropriate protections in the performance of our duties while maintaining a spirit of cooperation with providers.

A) **NOTIFICATION:** New Avenues will require basic documentation necessary for performing utilization review, claims management and quality assurance. Such information retained in our records may be subject to audit or transmission to the members health plan as contractually required.

B) **DISCLOSURE:** Except for health plan requirements, New Avenues does not disclose to any other party such as social service agencies, attorneys, courts, or non-authorized family members any information without the written consent by the member or member's guardian subject to federal and state law exceptions and regulation.

C) **CONSENT FOR TREATMENT:** Procedurally, New Avenues strongly encourages providers to obtain:

1. **Consent for Treatment:** New Avenues, Inc. strongly encourages providers to obtain a signed consent for treatment as part of their office policy.
2. **Authorization for Disclosure:** Although authorization is obtained by the payor when the member enrolls in the insurance plan, nonetheless, clinicians are wise to obtain a specific release of information in order to contact and share information with New Avenues and their health plan.
3. **Authorization for Release of Information to Primary Care Physician:** Providers are strongly encouraged to coordinate care with the member's primary care physician. It is very important to
 - a. At the beginning of treatment discuss with your patient the importance of coordinating care with their PCP.
 - b. Obtain a signed consent in order to coordinate care with the member's PCP or document in the patient file their refusal to this consent.
4. **Informed Consent:** Within the scope of general evaluation, certain areas might require special emphasis if there is an outstanding legal or administrative issue. Assessment should be undertaken with these issues in mind. Discussions of informed consent, if carried out during the evaluation for the purpose of treatment planning, require documentation. Thus, when a patient's competence to consent to treatment is in question, appropriate questioning to determine mental status should be extended to include items that test the patient's decision-making capacity.

- D) **Transmittal of Information:** MBHN and New Avenues manages the transmittal of documents with providers via hard copy through the U.S. mail and through facsimile transmission as well as telephonic communications. At this time **New Avenues does not allow communication with Providers about patients via e-mail.** Until further protections can be assured for on-line service and e-mail, the current policy is to prohibit any communication of identifying patient information via online methods.
- E) **Re-disclosure:** New Avenues does not re-disclose any information provided to us unless required by contractual relationship with a health plan payor for purposes of operations, quality or payment of claims or if accompanied by a release form.
- F) **Providing Credentialing Information:** New Avenues has established numerous procedures for the protection of Providers' information. Provider credentialing and quality review information is maintained in individual records within secure, locked cabinets. Information beyond the scope of directories and terms listed in Provider contract are not disclosed to anyone unless a health plan (payor) authorized representative is conducting an audit or release of information is on record.
- G) **Medical Record:** New Avenues has established numerous procedures for the protection of private health information and patient identifying information. In the course of conducting utilization review and quality assurance it is necessary to obtain and share relevant clinical and private health information regarding a patient's clinical status and progress. For the purpose of optimizing member privacy, standards and forms have been developed to request only relevant information necessary to perform our duties.

The Provider's Medical Record should contain:

Name, address and contact information, initial assessment with diagnosis, functional status, medical histories, risk evaluation, symptoms, support systems, prior treatment history, history and list of current medications, prescribed changes in dosage, side effects, current labs (related to behavioral health condition) if applicable. Treatment plan goals, objective time frames, modalities and frequency of treatment, prognosis. Progress notes on each encounter, summary of patient's symptoms, functionality, progress, modalities of treatment, frequency, our updating of treatment plan, our results of any psychologicals, and a closing summary.

Psychotherapy Notes Excluded: Recent interpretations of HIPAA concerning the privacy and security of psychotherapy notes: (CFR Section 164.508(a)(3)(iv) (A) define the difference between psychotherapy notes and the medical record with progress notes. New Avenues may need to request information of the medical record but does NOT assume any right to access of psychotherapy notes.

Psychotherapy notes, documentation or analysis, content of conversation during a private counseling session or group, joint or family counseling session are to be used only by the practitioner/therapist. Providers are not required to keep psychotherapy notes, but if they do, such should be maintained separate from the medical record, not co-mingled with the medical record and not in the documentation necessary for healthcare treatment, payment nor operations.

PROVIDER AVAILABILITY AND ACCESS TO CARE STANDARDS

These standards are established to help ensure the delivery of the appropriate level of clinical services within a designated time frame. Members present with behavioral health problems present in differing degrees of severity and intensity, thereby requiring differing levels of immediacy for response. The following description outlines a categorization system for behavioral healthcare problems as well as corresponding expectations with regard to time frames within which services should be provided to an enrollee.

Level of Acuity

Emergent:

- Defined as when an individual is in a crisis such that he/she presents a high probability of actual or potential danger to self or others.
- the person's behavior represents an imminent, real and significant risk to their own life or health, or that of another person (e.g., as demonstrated by a suicide/ homicide attempt or a specific plan with means), and/or
 - the person appears to be a medical risk.

Urgent:

- Defined as when an individual is in acute subjective distress which requires a clinical assessment due to:
- having consistent difficulties with performing routine activities of daily living;
 - significantly reduced levels of social, interpersonal or occupational functioning;
 - moderate to severely dysfunctional behavior which does not appear to be life-threatening; and
 - the absence of indicators which suggest the person is a medical risk.

Routine:

- Defined as when an individual is experiencing a situation or condition that produces a mild to moderate degree of subjective stress and negative life consequences, but is not disabling. In other words, the person has:
- little or no difficulties with performing routine Activities of Daily Living (ADLs);
 - reduced levels of social, interpersonal or occupational functioning;
 - moderately maladaptive behavior with no evidence of life-threatening circumstances; and
 - no indicators which suggest he/she is a medical risk.

Time Period for Delivery of Care

Emergent:

- For life threatening emergencies, assessment and crisis intervention procedures are implemented and authorized immediately in order to provide care as quickly as possible for the enrollee.
- For non-life threatening emergencies crisis intervention procedures are implemented within six (6) hours to include intervention, evaluation and treatment planning.

NOTE: In urgent and emergent situations, the clinician is expected to contact New Avenues/MBHN care manager by phone within (24) hours of meeting with the client in order to discuss the evaluation and treatment recommendations. The clinician will submit a completed Initial Clinical Assessment (ICA) within (2) business days of the evaluation.

Urgent:

New Avenues/MBHN time frame for access to care is based on the urgency of the situation. The provider will conduct clinical session for the purpose of an evaluation and complete an ICA form within forty-eight (48) hours of being contacted by MBHN.

Routine:

Completion of a visit for an Initial Clinical Assessment within ten (10) business days of request for service

New Avenues Response to Emergencies During Non – Business Hours:

New Avenues Inc, has Utilization Review staff available to handle emergencies, pre-certification of inpatient care, triage and referral assistance for members who are in acute distress 24 hours a day, 7 days a week.

Provider’s Responsibility for Response to Emergency Situations During Non-Business Hours:

New Avenues/MBHN recognizes the importance of members’ necessity to access their providers in the event of an emergency during non-business hours or during the absence of the provider from his /her practice. Therefore, New Avenues/ MBHN requires that each professional provide a description of the provider’s plan for responding to behavioral health emergencies during non-business hours. In order to meet this requirement, providers should meet one of the following criteria (Note Standards listed below for psychiatrists):

- Provider has an answering service that will notify the provider and direct calls to the practitioner or designated substitute in event of emergency;
- Provider has a system for sharing “on-call” coverage for his/her practice;
- Provider carries a pager or has some telephonic system that can alert him/her to a member’s needs;
- Provider has an answering machine with a message that directs a patient to an appropriate level of care specifically – such as another provider, an access center of an agency or hospital;
- Provider is part of an agency, hospital or facility that provides 24 hour emergency access; or
- If Provider is in private practice setting, and does not have one of the above services, the Provider will show documentation in the patient record that an Emergency Response Policy has been given to the patient which outlines what procedure to follow in event of an emergency and the patient has indicated by signature that he or she has been informed of what to do. The provider will provide documentation of this policy at the time of credentialing and will furnish a copy of their office policy on Procedures to Follow in Event of Emergency showing a signature line.

Psychiatrists in the Network must provide additional evidence that they have a specific plan that is provided for patients. This plan is to be used for responding to emergencies that informs the patient when in acute distress, how to access either the provider, the person on call; or an Access Center, if employed or with privileges with an agency or hospital. (Merely having a phone message directing a member to a nearby hospital is not adequate for meeting this standard for participating Network psychiatrists.) Availability for prescription refills is not ordinarily considered a medical emergency and thereby is not subject to the same standards for communication during non-business hours.

BEHAVIORAL HEALTH UTILIZATION MANAGEMENT PROGRAM

The following section will outline the behavioral health utilization management policies New Avenues, Inc. has adopted when administering behavioral health benefits. Each payor or employer benefit plan may vary in terms of covered service, eligibility, exclusions and limitations; therefore, the plans are administered according to the terms defined by the specific benefit plan. New Avenues, Inc. affirms that all utilization management decisions are based on the appropriateness of care, clinical guidelines, medical necessity criteria, professional practice standards subject to the member's health plan coverage. New Avenues encourages prohibits any incentives for staff, peer reviewers, and providers that encourages lower utilization or barriers to access to care.

OVERVIEW OF THE UTILIZATION MANAGEMENT PROGRAM

The Care Management System: How It Works

- a. **Utilization Management staff:** Utilization management assessment, judgment, and decisions including pre-authorization of treatment are performed by Care Managers who are either licensed nurses with psychiatric experience and training or licensed clinical social workers or licensed mental health counselors. Intake information, eligibility, information regarding benefits and providers, and facilitation of referral process may be handled by an Intake Specialist who is under the supervision of professional clinical administrative staff. All Care Management policies, procedures, clinical guidelines, and utilization review decisions are subject to review by the Medical Director.

- b. **All behavioral health care requires pre-authorization.** Utilization Review is applied to all cases requiring outpatient, inpatient or alternative facility care. Typically the member is responsible to obtain pre-authorization by calling New Avenues/MBHN. However, the Provider, Primary Care Physician, or an authorized representative acting on behalf of the member may call to obtain initial authorization of treatment. All services are subject to pre-authorization unless the health plan specifies otherwise.

WAIVER: Effective January 1, 2005. In-Network psychiatrists do not have to obtain pre-authorization for up to 8 combined visits of 90801, 90862, or 90805 during a calendar year. Services with other procedure codes or visits that extend beyond 8 visits per calendar year are subject to preauthorization. An ICA or OTR are not required during this period. MBHN reserves the right to request the assessment or progress notes for purposes of utilization review, claims processing, coordination of care, or quality assurance.

- c. **Pre-Service and Concurrent Treatment Plan Subject to Review & Approval:** Case Management and Utilization Review is applied to all concurrent treatment situations through a review of the appropriate providers' documentation of assessment, progress notes, treatment reports, and utilization review communications. This activity is performed by a Care Manager who determines if the treatment meets the terms of the health plan, standards of medical necessity, is being provided at the least restrictive level of care, is accomplishing appropriate outcomes for the level and length of treatment, and is within professional standards of practice. Providers are responsible to obtain pre-authorization for continued care by submitting prior to ending of their initial authorization, an Outpatient

Treatment Report and request for continuation of extended services. (See Forms Section for copy of documents to be used by providers.)

- d. **Post Service Review:** There are occasions in which a service has been delivered, and, because of some specific circumstance, needs to be reviewed retrospectively. In this event the Care Manager, Medical Director, or Clinical Council may request the medical record or discussion with the provider in order to determine if the patient's service met the clinical criteria for medical necessity. This Post Service Review may be a review for quantity, quality, or substance of the service; to obtain additional information about the patient's condition; or to better understand the transactions which occurred in the treatment in question. New Avenues/MBHN, at all times, retains the right to review the provider's treatment record.
- e. **Role of Medical Director/Peer Reviewer:** The Medical Director is a board certified licensed psychiatrist and provides direction and oversight for all behavioral health Utilization Management activities. New Avenues/MBHN uses board certified psychiatrists, addictionologists, or psychologists as behavioral health peer reviewers to assist in making utilization management decisions. The Medical Director supervises behavioral health peer reviewers, evaluates their performance and makes recommendations for their continued participation in the program. In addition, the Medical Director evaluates the consistency between behavioral health peer reviewers and New Avenues/MBHN Medical Necessary Criteria and also performs behavioral health peer review activities as appropriate. Any case situation for which there exists question as to whether treatment meets medical necessity criteria must be reviewed by a psychiatrist or approved peer reviewer for a final determination – this applies to any situation that may result in an adverse determination. A Care Manager cannot deny benefits for treatment on the basis of medical necessity.
- f. **Role of Clinical Criteria Guidelines & Professional Standards:** New Avenues, through a license agreement, has adopted **The Mihalik Group Clinical Criteria For Medical Necessity Guidelines**. Medical necessity criteria are relied upon when conducting utilization review to ensure that services and/or supplies proposed or provided by a Hospital, Physician, or other Provider to identify and treat an illness or injury are:
1. Intended to identify or treat a behavioral health disorder or condition that causes pain or suffering, threatens life, or results in illness as manifested by impairment in social, occupational, scholastic, or role functioning.
 2. Consistent with nationally accepted standards of medical practice, professional code of ethics, and within the scope of practice for the provider's qualification;
 3. Are in consideration of the specific patient's current needs and consistent with symptoms, or diagnosis and treatment of the condition, disease, ailment or injury.
 4. Are reasonably expected to help restore or maintain the individual's health or to improve or prevent deterioration in the individual's behavioral disorder or condition.
 5. Not primarily for the convenience of the patient, the patient's family, the physician, or the provider.
 6. Provided in the least restrictive setting that balances safety, effectiveness and efficiency.

The criteria are written, comprehensive, objective criteria, annually reviewed and based on sound scientific evidence, clinical principles and expert opinion used to determine the appropriateness of treatment interventions.

Medical necessity determinations are clinical decisions whose purpose is to identify which health care services are covered under the terms of a member's health plan. Health care coverage always contains both clinical and non-clinical exclusions, limitations or requirements. Coverage for medically necessary services may be reduced or eliminated because of non-clinical factors such as benefit limits, coverage exclusions, or pre-certification requirements.

The Provider may review the criteria by request by contacting a New Avenues Care Manager. The Care Managers shall fax or e-mail the information within 48 hours of request.

Professional Standards of Care: New Avenues has adopted professional standards of care and reference guidelines for ensuring that members are receiving optimal efficacious treatment. Sources for establishing accepted standards are as follows:

- American Psychiatric Association Diagnostic and Statistical Manual IV-TR
- American Psychiatric Association Clinical Practice Guidelines
- American Society of Addiction Medicine Standards
- Discussion with senior consultants in the field
- Review and input of peer reviewers and committees for utilization management and quality improvement.

Utilization Review Standards: Utilization Review is conducted in compliance with policy and procedure standards established by the National Committee for Quality Assurance (NCQA).

- g. **Role of Care Managers as Provider Liaison and Coordinators of Care:** The New Avenues/MBHN care management staff maintain an ongoing dialogue with Providers in order to ensure the needs of the client are being optimally served by the treatment delivery system. This entails coordinating the various professional services within the New Avenues/MBHN provider network such as therapy, psychiatric services, psychological testing, programmatic care, discharge planning and the use of community resources. The Care Manager may also be in dialogue with the Medical Plan's Utilization Review Department or the Primary Care Physician (PCP) in order to coordinate optimal use of the behavioral health benefit. Providers are encouraged to obtain consent for a release of information from the member in order to communicate and coordinate treatment with the member's primary care physician and other professionals collaborating in the client treatment.
- h. **Preferred Provider Network:** New Avenues/MBHN maintains a network of credentialed, contracted practitioners and facilities that together comprise the treatment resources available to Members seeking behavioral health services which cover the entire spectrum of behavioral health care. This network is comprised of a select number of facilities and clinical professionals throughout the United States. To ensure high quality, easily accessible treatment, all clinical providers complete a credentialing process prior to being eligible to provide clinical services and receive authorization for EAP or insurance benefits. Credentialing Procedures have been established in compliance with the current standards of the National Committee for Quality Assurance and professionals must be credentialed individually in order to be authorized to perform assessments and treatment. In order to promote the delivery of high quality care, the New Avenues/MBHN also evaluates provider effectiveness in (4) four ways: 1) Client and Provider Satisfaction Surveys, 2) Quality Improvement Studies, 3) Outcome Studies, and 4) Provider Utilization Analysis.

DESCRIPTION OF SERVICES AVAILABLE

CRISIS INTERVENTION SERVICES:

Appropriate responses to urgent and emergent requests for services are critical to serving members who are in immediate need of care. Access standards for urgent and emergent treatment are provided in the next section. All New Avenues/MBHN Providers must have provision within their office practice to direct a client to appropriate resources if urgent or emergent services are required. See standards for Provider in responding to request for emergencies in Section on Provider Availability.

- A. **Emergency Triage:** This service consists of an assessment and treatment of an enrollee by a participating clinician who conducts an evaluation on a client who has presented themselves for services with urgent or emergent needs. While the goal of any assessment is to formulate a treatment plan that will stabilize the patient and resolve the presenting problem, in this instance the focus of care is to address the immediate distress and dysfunction of an enrollee who:
1. is demonstrating behavior, as determined by New Avenues/ MBHN staff member or an in-network clinician, as appropriately fitting one or more components of the Axis I clinical categorization system delineated in the Diagnostic & Statistic Manual (DSM IV) of the American Psychiatric Association; and
 2. whose behavior represents an imminent, real and significant risk to the life or health of the enrollee, or the life or health of another person (as demonstrated by a suicide/homicide attempt or a specific plan with means); and
 3. who needs immediate care.

Immediate referral of such cases to in-network providers and/or community resources will take place. MBHN covers emergency assessment without prior authorization for situations that meet “prudent lay person” standards of an emergency; however, we request notification of the service delivered within 48 hours of the service.

- B. **Twenty-three Hour Period for Observation:** This level of care is designed to provide services for both emergent and crisis situations for up to 23 hours. The program is delivered in an inpatient facility setting and provides extended evaluation to include a psychiatric assessment as well as crisis stabilization for enrollees needing an level of care. Treatment focuses on assessment of the patient’s symptoms, their risk of self harm, threat to others, psychological status, need for medications, and on mobilizing support and resources so that the enrollee can be managed in the least restrictive setting. A requirement of this type of service is that the patient receive a psychiatric assessment within the 23-hour period.

OUTPATIENT EVALUATION & REFERRAL SERVICES:

This program component provides for the face-to-face diagnostic evaluation ICA (Initial Clinical Assessment) of an enrollee making non-emergent, routine requests for service. In this instance, a member will request services of a non-urgent nature in order to access treatment for behavioral health by contacting New Avenues/MBHN. Upon requesting service, the member is referred to an appropriate provider based on the specialty of care needed, geographic convenience, availability of appointment time, and member preference. The assessment is conducted by a participating network provider in their office or Access Center after a referral by the Care Management staff of

MBHN or New Avenues, and is pre-authorized. Referrals to appropriate community resources also may occur as part of the initial evaluation process.

INPATIENT ACUTE DETOXIFICATION IN BEHAVIORAL HEALTH SETTING:

A medical regime designed to:

- Systematically detoxify the individual from the substances requiring a medical detoxification;
- Provide reasonable control of active withdrawal symptoms;
- Avert a life threatening medical crisis.
- This service is based on a behavioral health history and mental status evaluation completed by a psychiatrist or physician qualified in addiction medicine or by a behavioral health professional licensed, certified, or registered to practice independently and reviewed by a psychiatrist or physician qualified in addiction medicine prior to admission, the individual is diagnosed as having; or there is a strong presumptive evidence that the individual has a diagnosis of a substance dependence disorder according to the most recent version of the DSM that requires and is likely to respond to professional therapeutic intervention.
- A concurrent medical assessment does not indicate that a non behavioral medical condition is primarily responsible for the symptoms or behaviors necessitating treatment in this setting.
- The individual is dependent on a class or classes and quantity or quantities of substances requiring a medical detoxification.
- The individual has a history of medically complicated detoxification episodes or the individual has unstable vital signs not treatable on an outpatient basis.
- The individual has a medical co-morbidity that significantly increases the probability that the individual will become acutely, seriously, medically compromised during the detoxification.

INPATIENT ACUTE CARE:

- Treatment of a psychiatric, chemical dependency or dual diagnosis condition requiring admission to a hospital with the expectation that the enrollee will be admitted to and remain in the facility a minimum of 24 hours.
- Acute care also indicates the member's condition represents such a severe deterioration of functioning or the patient represents a danger to themselves or another than any less restrictive level of care would not protect and adequately treat the patient's disorder.
- Treatment is subject to assessment, intervention, stabilization, and restoration of functioning within timeframes established by the current Milliman Care Guidelines and the current American Psychiatric Association guidelines for the acute treatment of behavioral health or substance abuse disorders.
- Chronic conditions are typically not covered by plans administered by New Avenues/MBHN, except when there is a need for the acute stabilization of the patient. (Residential treatment, custodial care, group home, 28-60 day specialized treatment programs are not typically covered by the benefit plans administered by New Avenues/MBHN.)
- Treatment of children and adolescents requires active involvement of the parent as demonstrated with at least one family therapy visit per week unless there is medical rationale for not arranging the contact.

PARTIAL HOSPITALIZATION PROGRAMS:

This type of behavioral health service can be a stand alone program or part of a larger continuum of services offered in an inpatient or outpatient setting. Partial hospitalization is appropriate for the patient with serious psychiatric or substance abuse disorder who requires medical supervision of care, intensive, and comprehensive treatment not provided in a less intensive level of outpatient treatment. Although listed here as outpatient services in that the patient typically returns home during the night, these benefits are typically covered through the member's inpatient benefit and are subject to those limits. These programs must consist of services:

- which are comprehensive and integrated in purpose;
- delivered by a multi-disciplinary team but having active involvement of the attending psychiatrist and nursing staff for the purpose of monitoring medications, symptom reduction, and requiring treatment in a medical setting;
- which are primarily medical and therapeutic in programming focus, with educational components to treatment activity;
- which are provided a minimum of fifteen (15) hours a week of structured programming; and
- scheduled in sequential full-day, half-day, and weekend formats.

INTENSIVE OUTPATIENT PROGRAMS (IOP):

A type of intensive programming not requiring physician or nursing supervision, but involving intensive treatment for optimizing the recovery of the individual. These programs are most typically used for the treatment of substance abuse and dual diagnosed disorders; however, specialized IOP's also are contracted for the treatment of psychiatric conditions, eating disorders, and child/adolescent disorders.

IOP's deliver services which:

- have multiple services and modalities;
- are comprehensive and coordinated in nature;
- presented in an outpatient setting; and
- require participation of at least two and a half (2 ½) hours/day for a minimum of three (3) days/week.

AMBULATORY DETOXIFICATION:

A medical regime to systematically reduce the amount of a toxic substance in an enrollee's body and provide reasonable control of active withdrawal symptoms on an outpatient basis. This service is conducted under the supervision of a psychiatrist or addictionologist.

OUTPATIENT CHEMICAL DEPENDENCY REHABILITATION:

Group therapy services delivered in an outpatient setting for a maximum of two hours a week. Treatment plans must have patient – specific treatment goals and allow patients to participate with addressing specific concerns, symptoms, behaviors of the patient. Educational programs do not meet a criteria of medical necessity even though they may be therapeutic in nature. Family involvement is strongly urged in the treatment program.

OUTPATIENT BEHAVIORAL HEALTH TREATMENT:

Treatment must meet criteria of being medically necessary for the alleviation of symptoms and the improvement in functionality as diagnosed under the 5 axes of the DSM-IV.

Network services include:

- Psychiatric evaluation and medication management
- Psychological testing when appropriate; and
- Individual, conjoint and/or family, or group psychotherapy.

Outpatient services are usually delivered one to four hours a month with the intensity related to the severity of symptoms and within a treatment plan that provides for effective and timely restoration of functionality. The Network emphasizes treatment which is system and family oriented, focused on behavioral outcome changes as demonstrated by improvements in the GAF scores, symptom reduction, and improved functionality in as efficient a use of behavioral health benefits as is possible. Treatment should be directed by joint planning with the patient that utilizes clearly delineated, time-limited, behaviorally-oriented goals, objectives and outcomes which are solution-focused and promote crisis resolution (when applicable), symptom alleviation, increased functionality, stabilization, and discharge from treatment.

PSYCHOEDUCATIONAL PROGRAMS:

These programs are a continuation of therapy, lectures and didactic programs designed to support recovery, and to prevent relapse. Such programs must meet criteria of level of care requirements for medical necessity for benefit coverage. New Avenues encourages members to participate in educational steps including community, 12-step and support programs to facilitate recovery, stabilization and continued improvement toward remission.

CARE MANAGER - PROVIDER COLLABORATION

REQUIREMENT: ALL SERVICES MUST BE PRE-AUTHORIZED WITH THE EXCEPTION OF EMERGENCY CARE AND ANY WAIVED INITIAL PSYCHIATRIC VISITS. FAILURE TO OBTAIN PROPER AUTHORIZATION BEFORE PROVIDING NON-EMERGENCY CARE COULD RESULT IN A DENIAL OF CLAIMS PAYMENT.

MANAGING THE INITIAL SCREENING & REFERRAL – NEW AVENUES/MBHN ROLE:

SINGLE POINT OF ENTRY:

The New Avenues/MBHN programs provide clinical services through a single point-of-entry model. The New Avenues/MBHN provide a toll free telephone number which allows access for routine, urgent, and emergent services to covered employees/members. EAP/MBHN employees or covered members have this toll free line available (24) hours a day, seven days a week for emergencies staffed by mental health professionals. This coverage is provided by clinically trained staff during regular business hours and during non-business hours for urgent and emergent situations through an answering service with access by page to New Avenues/MBHN clinical staff who are on call. Clinical staff are on call and available for both New Avenues EAP and MBHN Care Management services.

THE INITIAL TELEPHONIC TRIAGE and SCREENING:

A New Avenues/ MBHN staff member will gather data from employees/enrollees seeking services by conducting an "Initial Intake," also called telephone triage. During an Initial Intake, the Intake Specialist may gather demographic and eligibility information; a Care Manager will always handle the clinical inquiry portion of the call for those seeking utilization of their insurance benefit.

The staff persons will:

- a. Complete the initial Intake triage form by gathering the benefits, demographic, clinical and referral data necessary to make an appropriate referral for the member;
- b. Collect information determining why the employee/enrollee is seeking professional help at this time.
- c. Verify the specific benefits available to the enrollee; and
- d. Make a determination of the level of urgency, level of care, and provide a referral to an appropriate provider.
- e. Inform enrollee of need to call Provider to set up an appointment that is mutually agreeable to both (within the 10 day period); and
- f. Inform employee/members that the authorization will be faxed to the provider. Unless contraindicated, initial authorizations will be mailed to the home of members who utilize their behavioral health benefit through insurance managed by MBHN.
- g. Members utilizing their insurance benefit are typically given authorization for an ICA (Initial Clinical Assessment 90801) plus 8 sessions (90806/90847) in order to allow the therapist to finish routine cases with mild symptoms, and/or make an informed judgment of the number of additional sessions that are needed to complete treatment.
- h. If additional sessions are deemed medically necessary, providers submit an OTR (Outpatient Treatment Report) to New Avenues/MBHN in order to request additional sessions before the last session authorized is used. Care Manager responds to OTR reports.

NEW AVENUES/MBHN COMPLETION OF AN “URGENT” OR “EMERGENT” INITIAL INTAKE:

If the Care Manager determines level of urgency. Then the following actions take place:

- **For Life-Threatening Emergencies:** the Care Manager will direct the employee/member to the nearest hospital or psychiatric emergency service; in the event that the member does not have transportation or is unwilling or unable to arrange safe transportation; then the staff will contact family; if unavailable, a call to 911 or an ambulance service, may be necessary to effect an immediate transfer.
- **For Non Life-Threatening Emergencies:** the Care Manager will direct the employee/member to either the office of a Practitioner skilled in crisis intervention or to the nearest hospital or psychiatric emergency service. An appropriate referral to an office based Practitioner requires that a crisis intervention specialist is available to see the employee/member within six (6) hours. If the caller requests that a specific in-network Practitioner or Facility handle the emergency, a referral will be made to the requested Practitioner or Facility, if appropriate. If the Care Manager makes a referral to a crisis intervention specialist and not to a hospital or psychiatric emergency service, the Care Manager will call the practitioner to ensure that an appointment can be made in six (6) hours. Care Manager will request the Practitioner to call immediately if the Member does not keep the appointment. With a hospital or psychiatric emergency service, the Care Manager will ask the Practitioner or Facility to notify them of the referral. In all instances, the Care Manager will ask the Practitioner or Facility to call at the conclusion of the evaluation and before the Member leaves the treatment setting. The Care Manager will call the Practitioner or Facility if a call is not received within six (6) hours to verify that the Member was seen and an appropriate disposition arranged.
- **For an Urgent Situation:** the Care Manager will direct the Member to a Practitioner skilled in crisis intervention. An appropriate referral to a Practitioner requires that a crisis intervention specialist is available to see the Member within 48 hours. The Care Manager will, in an urgent situation, complete the Initial Intake triage by telephone and arrange an appointment for the employee/member with a provider able to perform an immediate or urgent full assessment within the timeframes established, or make a referral to either an Access Center, Emergency Assessment Team or Network Psychiatric Facility. The Provider should call the Care Manager within 24 hours to verify if the member was seen and provide a treatment plan.

OUTPATIENT CARE

POLICY ON DOCUMENTATION STANDARDS FOR OUTPATIENT CARE:

- It is the responsibility of the member to notify New Avenues/MBHN in a timely manner of any proposed behavioral health treatment for which the member will be seeking benefit coverage. New Avenues/MBHN requests the member or member's family representative to initiate the request for services. However, New Avenues/MBHN will allow any licensed treatment Facility, Practitioner or designated member representative, including a family member, to assist in fulfilling that responsibility.
- New Avenues/MBHN makes behavioral health utilization management decisions and notifies appropriate parties (practitioner, and/or facility and/or member) as described in the Timeliness for Utilization Management Decision and Notification table within time frames appropriate to the urgency of the situation.
- New Avenues/MBHN makes all reasonable efforts to obtain the information necessary to make utilization management decision but the responsibility for supplying such information rests with the member or Facility.
- If the member, Practitioner, Facility, or designated member representative will not provide the information required for review, New Avenues/MBHN makes its decision on the information available.

ROLE OF CARE MANAGER:

Provide behavioral health case management consisting of activities that address a member's longitudinal course of care including continuity and coordination among providers or programmatic treatment.

1. Will review the Provider report of the ICA (Initial Clinical Assessment) and Treatment Plan, OTR (Outpatient Treatment Report), and any other treatment reports pertinent: i.e. inpatient records, psychological reports, etc.
2. Will refer to the Benefit Coverage so that services may be coordinated within the terms and conditions of the benefit plan.
3. Will be responsible to utilize the Clinical Council in any situation where review is needed regarding treatment plans, progress reports, projected outcomes. Clinical Council will review documentation of progress, change in Global Assessment of Functioning, projected outcomes, recommendations for treatment, and make recommendations to include if additional resources should be considered.
4. Will review ICA and treatment plans for consistency with appropriate professional standards and clinical guidelines.
5. Is designated as a resource to be available to members and Providers to assist with questions or concerns.
6. Will coordinate care.

ROLE OF TREATING PROVIDER:

The treatment provider is responsible for the delivery of care and documenting assessment and progress utilizing New Avenues/MBHN forms. The provider is responsible for maintaining internal treatment records detailing treatment plan, progress notes, dates, times, etc. recognizing that the quality of treatment really is in the hands of the provider. Both New Avenues and MBHN conduct satisfaction surveys to obtain both provider and client feedback regarding services, availability in obtaining services and overall perception of quality. The most prominent means to conduct monitoring is through documentation. There are (4) basic very brief forms to use in communicating provider synopsis of the assessment and treatment: (View forms in Forms Section and on website).

- • Initial Clinical Assessment (ICA)
- • Outpatient Treatment Report (OTR)
- • Closing Summary
- • Request for Psychological Testing Form

ROLE OF PSYCHIATRY IN NEW AVENUES/MBHN PATIENT CARE:

In outpatient behavioral healthcare, New Avenues/MBHN considers the most cost effective use of a psychiatrist's time to be spent in providing medically related services. In this setting, those services consist of the following:

- Comprehensive psychiatric examinations: including recommendation for other services,
- Medication management: (CPT 90862 or 90805)
- When medically necessary, medication management accompanied by brief therapy or family consultation will be approved depending on the specific rationale.

New Avenues/MBHN strongly encourages a model in which members are offered therapy services through in network psychologists and licensed clinical social workers and mental health counselors.

NOTE: Effective January 1, 2005 MBHN waived pre-certification and documentation requirements for in-network Psychiatrists for up to 8 combined visits (90801, 90862, 90805) during a calendar year. Other procedures or services extending beyond 8 visits /year are subject to pre-certification.

PROVIDER DOCUMENTATION FOR OUTPATIENT TREATMENT:

The ICA FORM - The Initial Clinical Assessment (ICA) should be submitted to New Avenues/MBHN fully completed in all areas and be:

- Written in clear layman's language;
- action and solution focused;
- Indicate anticipated timeframes for completion;
- Indicate specific behaviors that will signal treatment is completed;
- Goals of treatment are clearly outlined in objective, measurable terms;
- Responsibilities and actions required in treatment are clearly indicated.

Timeframe for sending reports to New Avenues/MBHN:

1. **Routine assessment** – ICA submit after the initial or second visit
2. **Urgent assessment** – ICA submit within two (2) business days
3. **Emergent assessment** – ICA submit within one (1) business day

All referrals for care (treatment) are made by the NEW AVENUES MBHN staff. If the Initial Clinical Assessment has been completed and the assessing clinician believes a different provider, or

additional services are needed, the assessing clinician should contact a NEW AVENUES/ MBHN Care Manager to facilitate a proper in-network referral. The assessing clinician should not automatically refer the enrollee to another provider or colleague. If the requested treatment service is not covered by the enrollee's benefits, the assessing clinician will work with a New Avenues/MBHN Care Manager regarding the most appropriate referral.

OUTPATIENT TREATMENT REPORTS (OTR'S) & UTILIZATION REVIEW OF CONTINUED OUTPATIENT CARE:

1. In order to request additional care for a client, a completed Outpatient Treatment Report (OTR) must be submitted either by mail, or facsimile transmission, in order for a subsequent authorization to be granted. The OTR forms are the documentation of progress and request for continued provision of care and course of treatment. They are the primary source of data for the New Avenues/ MBHN Care Manager when conducting concurrent reviews of outpatient cases. Submitting OTR's in a timely manner is crucial in the reimbursement process.
2. Timeframe: Network clinicians who deliver outpatient care services are expected to contact a New Avenues/MBHN Care Manager by submitting an OTR prior to the use of the last authorized outpatient visit. After receipt and a review of the OTR, the Care Manager may contact the network clinician by telephone for additional clarification regarding the request before authorizing additional services.
3. It is crucial for the Provider to manage the treatment of the Member within the number of sessions authorized and within the dates of the authorization period.
4. For concurrent review of routine outpatient behavioral health care, decisions to approve or deny are made within two (2) working days of obtaining all reasonably necessary information to make the determination.
5. If the Care Manager is unable to make a decision due to lack of necessary information, it will notify and request the specific additional information in writing from the Practitioner within 15 calendar days so as to provide the specified information.
6. The Practitioner and member are notified by telephone, letter, or facsimile within two (2) working days of receipt of the request and upon receipt of all necessary information needed to make the decision. If the notification is by telephone, New Avenues/MBHN sends the member and Practitioner a written authorization (or denial) as confirmation of the decision by mail or facsimile within one (1) additional working day.
7. If there exists a question as to the proposed treatment meeting criteria of medical necessity, then the request for services and OTR reports are sent to the Medical Director for a review. If the Medical Director makes a decision to deny coverage for continued care: The Practitioner and member are notified of the decision and sent a confirmation of the decision within one (1) working day of date of the original notification which includes a description of the reasons for the denial, the specific Medical Necessity Criteria, utilization management criteria or benefit provisions used in the determination and how the member or authorized representative of the member may initiate the next level standard or expedited Appeal of the Adverse Determination.
8. The Provider is reminded not to bill the patient for any amount beyond the co-payment or deductible listed on the authorization form. The provider contract prohibits direct billing of members for any amount beyond the co-pay and deductible amount listed on the authorization form. The Provider should submit their charges on the claim form for services rendered within 90 days. (Refer to Claims Section)
9. Claims submitted for non-authorized services may be subject to denial.

IMPORTANT: If a provider fails to submit the proper documentation and provides

unauthorized services, the provider will not be paid for the services rendered and the member must be held harmless our contract stipulates that New Avenues/MBHN Covered members may not be billed for services that are unauthorized due to the provider's failure to meet the terms of the provider contract with New Avenues/MBHN.

For post service review of behavioral health care, decisions are made within 30 calendar days of obtaining all reasonably necessary information. New Avenues/MBHN may issue a decision based on the information available, if, after determining that additional information is necessary and requesting such additional information in writing from the member and Practitioner, the necessary information is not received within 30 calendar days of the written request. The Practitioner and member are notified of the decision in writing within 30 calendar days of the date of the request.

NOTE: If the decision is to deny coverage, there is written notification to the Practitioner and member, Health Plan, and PHO (if involved). The written notification of the decision to deny coverage will include an explanation of the decision including the medical necessity or contractual rationale for the decision, description of how to initiate the next level standard and expedited appeal of the adverse determination, list of the title(s) and qualifications of the person participating in the decision, provide a statement of the reviewer's understanding of the pertinent facts of the case, and reference the evidence or documentation used as the basis for the decision and, in the case involving a Medical Necessity denial, instructions for requesting a written statement of the clinical rationale including the Medical Necessity criteria used.

MANAGING PATIENTS WHO ARE NOT COMPLIANT

Treatment Plans should be specifically designed to outline the steps which are needed to facilitate the recovery process for the member/covered person. On occasion, the covered person, his/her significant other, or both are not committed to creating positive change or follow through with treatment recommendations. In such instances when the client, or his/her family, do not fulfill the minimum requirements outlined in the treatment plan, the New Avenues/MBHN should be informed of the non-compliance in the event future request for authorization of benefits is initiated as this could affect their coverage as outlined by their benefit plan.

CASE CLOSING DOCUMENTATION FORM

In addition to a detailed review of the course of treatment, the discharge summary should clearly indicate the reason for the case being closed, i.e., by mutual agreement or because of the patient's unwillingness to follow the established treatment plan. The practitioner is expected to forward a copy of the Case Closing Summary form to New Avenues/ MBHN within ten (10) business days of the case being closed.

BILLING FOR NON COVERED SERVICES

In the event the member requests services that are non-covered by their health plan, or the provider recommends non-covered services, the member must be fully informed that such services are not covered and consent in writing to the services and to accepting financial responsibility for such services.

INPATIENT and PARTIAL HOSPITALIZATION CARE

WHEN TO HOSPITALIZE:

NEW AVENUES/ MBHN considers care provided at the inpatient level of hospitalization to be for the purpose of the facilitation of necessary medically supervised treatment, alleviation of a crisis, and for medical stabilization. This medical supervision is required until the patient is not in acute risk of harm to self or another and can function in a less restrictive environment. New Avenues will fax or send the Medical Necessity Guidelines for hospitalization upon request. MBHN also relies upon the professional standards of care developed by the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders.

EMERGENCY DIRECT ADMISSIONS:

1. Facilities must pre-certify emergency inpatient care by calling the MBHN within 48 hours of admission. Such admissions will be authorized only if the patient's situation meets the MBHN's criteria for emergency hospitalization. The hospital utilization review department is required to call New Avenues/MBHN for review in order to determine if the patient's condition meets criteria of medical necessity.
2. Requests for authorization of emergency direct admissions will typically be approved for either 23 hour-observation up to 3 days depending on the initial reported condition. Additional requests for authorization will be addressed through frequent concurrent telephonic utilization review reports between the New Avenues Care Manager and hospital UR staff subject to the guidelines for the inpatient treatment.

Most Inpatient, Partial and programmatic care requires pre-authorization prior to admission. Failure to pre-authorize treatment, and notify MBHN or New Avenues within 48 hours of an admission may result in a denial of claim.

UTILIZATION REVIEW:

MBHN requests at the time of the initial admitting telephonic call, information on the member's current condition including:

- Tentative Diagnosis
- GAF Score (Axis V)
- Description of severity of signs and symptoms of current patient functioning with history of functioning within last seven days
- Assessment of suicidal, homicidal risk, self care factors
- Notice if patient is admitted under detention or restraint, seclusion, or precautions
- Presence (absence) of substance use
- Assessment of any thought disorder; impairment in reality testing, or psychosis
- Current medications patient is on and who prescribed, list of medications given at time of evaluation, and/or recommended for the next 24 hours
- History of prior behavioral health treatment
- Family support issues
- Assessor's recommendation for level of care
- Psychiatrist's written assessment within 72 hours of admission.

DISCHARGE NOTIFICATION CONSISTS OF THE FOLLOWING:

New Avenues/MBHN requires the Provider submit notification of discharge telephonically or by facsimile on the day of discharge from levels of care other than traditional outpatient services.

- A. Date of Discharge
- B. Discharge diagnosis on five axis
- C. Recommendations for follow-up and referrals including the use of community resources and natural supports as appropriate
 - Date, time and place of follow-up appointment with a behavioral health practitioner within seven (7) days of discharge.
 - Discharge instructions including instructions on any medications, with description of side effects, procedures to use if any complications do arise, a plan for who will continue prescribing medication
 - Notification to the member primary care physician of the discharge plan, this should be accomplished by obtaining a consent to release information form to the PCP and sending a copy of the discharge plan to the physician at the same time as sending New Avenues/MBHN a copy.

CONCURRENT UTILIZATION REVIEW TELEPHONIC REPORTS are expected to include information on the patient's progress including:

- Diagnosis
- GAF score
- Participation, motivation and patient response to treatment interventions
- Lab and vital sign reports
- Discharge plans
- Ongoing family counseling updates

NOTE: New Avenues strongly encourages involvement of family members in the treatment process and discharge planning from the initial stage of admission. Medical Necessity Criteria requires active and substantive involvement of parents in the treatment of children and adolescents at a minimum of one family conference per week unless there exist clinical reasons to restrict contact. Benefit coverage will be subject to active involvement of family. Facilities are expected to arrange family conferences on a regular basis.

- Recommendations for additional psychological tests or consultants
- Notification that medical procedures such as MRI, CT scan, Neurology consultation, or x-rays are being ordered.

NOTE: These services may be subject to pre-certification by the medical UR agent. MBHN coverage does **NOT** include such medical procedures.

(The reports listed above will typically be conducted during regular business hours, however, weekend reports may be requested).

WRITTEN REPORTS REQUESTED OF A FACILITY IN ALL INPATIENT AND PARTIAL HOSPITALIZATION CASES include, but are not limited to:

- Receipt of the Psychiatrist's Assessment conducted within 24 hours of admission and sent to New Avenues/MBHN within 72 hours
- Intake Assessment conducted by the Assessment and/or nursing staff
- Discharge summary by the nursing staff which includes details on discharge, plan for medications, follow-up appointments within seven (7) days of discharge, and functional status
- Psychiatrist's discharge summary
- Psychological reports within 2 weeks of discharge
- Documentation: release of information form to send discharge plan to PCP (or verification of the patient refusal to sign the release)

NOTE: It is the New Avenues/MBHN's belief that a patient's time during hospitalization should be targeted towards the primary goal of discharge -- to an appropriate, less intensive level of care -- at the earliest date possible. When it comes to identifying a discharge date for a hospitalized member, a discharge plan should begin preparation within 24 hours of admission; it should be part of the inpatient assessment and treatment plan.

MANAGING SPECIAL PROBLEMS OF HOSPITALIZATION:

- A. **Non-involvement:** Occasionally, family members will be reticent or unwilling to participate in the overall treatment process. The New Avenues/ MBHN Care Manager will work with the attending clinicians to facilitate the involvement of family members whenever therapeutically indicated. Refusal to participate may result in a denial of coverage.
- B. **Timely departure:** Sometimes a member will not leave the facility at the appropriate time. New Avenues/MBHN will inform the Member of the benefits coverage.
- C. **Collusion against case management:** On occasion, a treatment facility's clinical staff will align with a covered person when it comes to length-of-stay. The New Avenues/MBHN role in such cases is to remind such staff of the contractual language agreed to when joining the new Avenues/ MBHN. Specifically, the contractual language states a Provider agrees to abide with the case management process and refrain from making disparaging remarks about the New Avenues/MBHN to members. The Provider has access to the Medical Director or peer review throughout the course of treatment for consultation and formal appeal process. Inpatient and partial hospitalizations are considered emergent and thereby subject to expedited appeal procedures. The MBHN also considers appropriate getting second opinion and consults; these should be explored as constructive steps to obtaining consensus in treatment planning.
- D. **Medical evaluation:** If needed in the course of initial or extended monitoring of a patient, the treating provider or peer reviewer must contact the Care Manager. (such testing as; neurology consult, MRI, CT scans, internal medical consult) Such services may be subject to pre-certification by the medical UR agent and are **NOT** typically covered under the behavioral health coverage.
- E. **Need to transfer to medical facility:** If a need to transfer to medical facility arises; contact the Care Manager within 24 hours of intention to or action has occurred.

Sentinel Events/Adverse Incidents: Provider Responsibility to Inform New Avenues
New Avenues Inc. is committed to ensuring that Members are provided safe and

appropriate treatment. As part of its Utilization and Quality Management Program, New Avenues shall monitor Sentinel Events including adverse incidences and situations that represent higher risk to the patient or others. New Avenues shall monitor the frequency, type of occurrences, providers, and type of cases to determine if there exist any delivery issues or member care issues that can be improved through root cause analysis. Such sentinel events may indicate a need for additional case management, need for authorization for higher levels of service, more intense level of services, or administrative involvement. These events also may sentinel potential network or health plan liability. New Avenues also shall monitor individual case situations through the utilization management program, and through the quality improvement program that may include provider inquiry, investigation, and peer review.

All Providers are responsible to notify a New Avenues Care Manager or administrative personnel regarding a sentinel event, adverse incident that is related to injury, death, property damage that involves a patient under the active care of a provider during an episode of treatment for which the patient was enrolled under a New Avenues plan.

Reporting responsibilities also include situations in which a patient has made an allegation of misconduct or threat of legal action against the provider related to treatment received while a covered person under a New Avenues plan.

Provider should contact New Avenues under the following circumstances:

1. Any incident involving slips, falls, injuries occurring to a client/patient while on the property or in vehicle of a provider, or
2. Any injuries or death occurring to the provider, its employees, or agents, or another party as a result of a patient/client's actions at the provider's facility.
3. Provider Property damage caused by a patient /client 's actions.
4. Suicide attempts resulting in medical or behavioral health treatment while an active patient under the care or supervision of the provider. Suicide attempt shall mean any self-inflicted action with intent to cause death, and has resulted in bodily harm, illness, or injury, or has seriously jeopardized the health of the covered person.
5. Deaths from suicide or homicide while under the care or supervision of the provider. This includes persons who are under active treatment within 90 days of an event and their actions contribute or cause death to self or another or the case comes under formal investigation for suicide or for charge of homicide.
6. Any mistaken procedures, executed incorrectly or misdiagnosis rendered.
7. Any severe drug reactions by a client or patient.
8. Elopement or patient leaving facility against medical advice (AMA).
9. Any patient who has had seclusion or restraint while in inpatient treatment.
10. Any covered person transferred to a medical facility or unit from behavioral health facility or provider office.
11. Any patient allegations or claims of professional misconduct, professional impropriety, abuse, or threatened legal action against the provider.
12. Accusation of or legal proceedings initiated by a patient of claim of malpractice related to an episode of care for a patient under treatment as a covered person with a New Avenues plan.

PROCEDURES (As excerpted from New Avenues Policy & Procedure Manual)

1. **All active cases in which such a sentinel event has occurred shall be reported. A Member shall be considered “active” if meeting one of the following conditions:**
 - 1.1 **The Member has an open authorization for treatment at the time of the event,**
or
 - 1.2 **The Member has a patient-provider relationship that was not terminated prior to the event, or**
 - 1.3 **There is evidence that the member obtained treatment with the Provider within a 90 day period prior to the event.**
2. Upon receiving information of an adverse incident or high-risk situation event, the Care Manager or other staff shall document the information on an Adverse Incident Report Form (see attached) that describes the event, Provider, and type of occurrence. Staff members may become aware of an event through a Member’s self-report, family member report, Provider report, or news media. In the event that the situation involves a member for whom our records indicate is “active”, then the situation shall trigger filing an incident report.
3. A copy of the incident report shall be entered into the Member file and forwarded to the Executive Director within five (5) days; The Executive Director will review, sign and submit to the Director of Administrative Operations and Quality Improvement for tracking. Any cases involving serious injury, death, or harm shall be subject to individual case review and inquiry through the utilization management and/or quality improvement programs.
4. **Tracking:** The Director of Administrative Operations shall keep a log of all events in the computer Adverse Incident Log noting the Date of Incident, Date of Report, Type, Member’s Name, Case Number, Provider, and Health Plan and shall monitor these and report to the QI Committee on a regular basis.
5. **Review:** All cases involving sentinel events shall be referred to the Medical Director for review at the next Clinical Council meeting, or if warranted, may be directed to the Medical Director within ten (10) business days of receipt of the report. The case should be sent for review to determine if the level of care is appropriate given the event, assessment of need for more intense case management or Provider treatment resources. The Medical Director and Clinical Council shall determine further course of action from the following alternatives:
 - a. Follow the case through the routine utilization review process based on Utilization Review information that the treatment appears appropriate.
 - b. In the event of a serious, life-threatening suicide attempt, suicide, homicide, or other incident that has resulted in serious injury or death, then the case shall include an inquiry with the Provider. The Executive Director shall send a letter of inquiry asking the Provider to submit response to standard questions within a time period not to exceed 30 days. The responses shall be reviewed in peer review at the next Quality Improvement Committee Meeting. The inquiry is meant to be an investigation only for fact finding; there is no implication of blame or fault on the part of the Provider.
 - c. The New Avenues investigation may include a request for the Member’s record, review of the Provider’s file for any other quality issues or patterns of such occurrences; response to specific standardized questions, review of the Provider’s policies as they relate to Member safety, access, or other actions.
 - d. It should be noted that legal counsel has advised us that Indiana statute (IC34-

30-15-8a) allows the Provider, if employed by an agency, may elect to submit findings of an internal peer review process of an agency, to New Avenues. And we may accept those findings as part of our investigation. Any final conclusions regarding Providers shall be kept in the Provider file as part of a quality of care review, and handled through the Provider Credentialing/ Sanctioning channels.

6. In the event that a specific case is referred to the Quality Improvement Committee, the Quality Improvement Committee may review the documentation related to the case, or appoint an independent Peer Review Committee, and/or may recommend that an investigation be initiated to determine if appropriate clinical actions have been taken by the Provider in the treatment of the Member. The Committee shall attempt to determine a) if the Provider had acted responsibly and within proper professional and MBHN standards of care, b) if access to care was within the New Avenues standards, c) if proper medical management had occurred, d) if the New Avenues has acted appropriately with regard to referral and utilization management procedures, e) if the Provider had exercised appropriate precautions if she/he had evidence of imminent danger, f) if there existed presence of alcohol, drugs, treatment non-compliance, cognitive impairment or psychosis which could have seriously affected the individual's judgment at the time of the incident.
7. The Committee should conclude its inquiry with a finding that is reported back to the Provider within 30 days from the Committee conclusion; and noted in the Provider's file, and shall include any recommendations as to whether any corrective actions should be taken.
8. The New Avenues shall track and monitor the volume, types, and frequency of the occurrences on a monthly basis and report its findings to the Quality Improvement Committee on a bi-monthly basis. The New Avenues also shall cooperate with the Payers who may request statistical information on occurrences.
9. The Quality Improvement Committee will evaluate aggregate data and root cause analysis of events on an annual basis to determine if the network needs to address any systemic or Provider issues affecting Member access or quality of care. The Quality Improvement Committee shall make recommendations for actions to improve quality of care for its Members that reduce possibility of any adverse incidences occurring related to systemic or procedural issues.

Provider Questions About Confidentiality:

Providers are expected to inform the New Avenues if such event occurs. In the event that questions emerge related to protection of Member privacy or Provider's uncertainty or reluctance to disclose such events, the following explanations clarify HIPAA compliance and protection of the Member's privacy concerns.

The New Avenues as a business associate of a health plan may give statistical information or disclosure of the events pertaining to the respective health plan's Members specifically for the purpose of monitoring quality without the requirement of obtaining Member's authorization for Consent to Disclose.

The New Avenues uses such material at its level of review to improve delivery of a care on behalf of the Member and for quality improvement activities. The Adverse Incident Monitoring Program is considered a formal quality improvement initiative.

A Provider, as a "Covered Entity", may inform the New Avenues Network as a "Business

Associate” of such an incident without receiving Authorization for Disclosure by the Member, as it is part of the exceptions to requirements for obtaining Consent for Disclosure. HIPAA regulations indicate that a Provider is not required to obtain Authorization for Disclosure when using and disclosing the health information for purposes of treatment, payment, or healthcare operations. “Treatment” definitions applies to situations in which the Provider may share health information with one or more healthcare providers for the purpose of providing treatment, coordinating treatment, or management of the Member’s healthcare and related services. “Healthcare Operations” includes activities such as conducting quality assessments and improvement activities, evaluating Provider performance, measuring the performance of the business ... and general administrative activities. The standard of asking Providers to inform the New Avenues of an adverse incident meets the HIPAA standard of use for the purpose of coordinating treatment and for monitoring for quality improvement activity. Therefore, the Provider who does inform the Care Manager is within their legal bounds to do so. In the event that the Provider elects to inform the Member and prefers to obtain the Member’s authorization to disclose an event, then the Member has the right to restrict such disclosure. The Provider should document in the Member file any times that the Provider has disclosed an event as the Provider is expected to be able to produce for a Member an accounting of all disclosures whether authorization has been obtained or not.

New Avenues has an **Incident Report Form** and template **Provider Inquiry letters** on record and available for review.

ROLE OF CLINICAL COUNCIL IN MEDICAL MANAGEMENT (Utilization Management Committee)

PURPOSE OF CLINICAL COUNCIL:

The primary purpose of the Clinical Council is to monitor the appropriateness of care provided by MBHN when it comes to access, consistency of care with Professional and clinical practice standards and authorization of clinical services. This will be implemented through both concurrent and retrospective review of patient charts. In addition, the Clinical Council will help direct the MBHN efforts to:

- Maintain high quality patient care in its utilization management
- Efficiently manage resources
- Meet the requirements of regulatory bodies and managed care contracts for medical oversight
- Monitor provider treatment approaches, modalities, and programmatic outcomes
- Enhance clinical provider satisfaction
- Increase member satisfaction and assurance of quality outcomes by providing oversight of patient treatment for high risk case situations or in cases demonstrating minimal response to treatment
- Assess patient needs for more intensive case management

The Clinical Council meets at least three (3) times per month to review the status of current cases, as well as examine critical factors related to program utilization such as:

- Ensure patient's are treated at the appropriate level of care
- Review treatment plans for consistency with clinical guidelines and standards of care
- Determine authorization of benefits subject to benefit plan for ongoing professional clinical practice guidelines
- Review "critical incidents," complaints/grievances/appeals, complaints regarding network providers, and make recommendations for corrective actions necessary to ensure the delivery of high quality, cost effective behavioral health care in the appropriate setting.

Membership in the Clinical Council includes but is not limited to:

- New Avenues/ MBHN's Medical Director (committee chairperson)
- Executive Director
- Behavioral Health Care Manager(s)
- Peer Reviewers, by telephonic consultation as needed.

PSYCHOLOGICAL TESTING

The New Avenues/MBHN views psychological testing as one means to efficiently gather clinical data and to clarify the diagnosis and/or redefine the treatment plan for the treatment of mental health/substance abuse conditions. At the same time, the New Avenues/MBHN considers psychological testing to be an adjunct to treatment, not a customary procedure in the treatment process. This type of intervention should be requested and authorized only when a thorough clinical assessment and psychosocial history have failed to provide information essential to the formulation of a diagnosis or a treatment plan. It is the belief of the New Avenues/MBHN that the purpose of psychological testing is to answer specific questions about the member that will:

- Enhance and clarify the diagnosis of the members problems; and
- Support the treatment planning process.

Based on this orientation, specific and focused psychological testing requests should be selected for cases directed toward a specific goal. Psychological testing directed to address the issues listed below are often not considered specific enough to relate to the medical necessity of treatment or diagnostic issues, and therefore may be excluded or not covered under the benefit plans administered. Each plan is different and will need to be addressed on a case specific basis.

EXCLUSIONS:

Types of testing that may not be covered by behavioral health benefits:

- Vocational or occupational /career interest testing;
- Educational testing, i.e.: related to academic performance, learning disabilities court-ordered testing for custody/visitation, criminal, civil, or other judicial proceedings; and
- Testing to determine level of impairment, treatment plan related to medical or organic conditions, or the need to rule out medical conditions – these are typically considered a benefit of the medical plan if the preponderance of evidence is suspect of a medical/organic etiology such as Alzheimer’s, dementias, head injuries, post trauma or surgery, or impairment as a result of stroke or one of the other mentioned neurological disorders.

PRE-SERVICE PROCEDURE (RE: PRE-AUTHORIZATION):

The Provider upon conducting, at a minimum, a thorough assessment, may recommend psychological testing. The Provider should complete the “**Request for Psychological Testing**” form and fax to New Avenues/MBHN prior to the testing: (Refer to Forms Section).

- The Care Manager is to review and make a decision within two (2) days unless this is expedited for emergency purposes and will issue an authorization to the provider by facsimile.
- New Avenues/MBHN recognizes the expertise of psychologists reviewing other psychologists regarding the specialized area of testing. New Avenues/MBHN has contracted with a licensed psychologist to review requests for testing if needed when requests are for more than (4) units, for consultation to New Avenues/MBHN, and for utilization review on appeals.
- Psychological Testing List – see Exhibit of Psychological Tests /and respective units.
- New Avenues has clinical protocols for the following testing situations – please contact New Avenues for a copy of the protocol.
 - ADHD Protocol
 - Neuropsychiatry Protocol
 - Bariatric Assessments (protocol is under development)
 - Pervasive Development Disorders Autism/Aspergers

MBHN LIST OF COMMON PSYCHOLOGICAL TESTS

Listed below are common types of psychological testing as well as the amount of service units to be reimbursed for the services:

1. Test administration and scoring
2. Interpretation of test results
3. Production of report.

The actual amount of reimbursement for psychological testing will depend upon the current fee schedule. Services will be authorized by units with one unit equivalent to 60 min.; or .25 or .50 fractions. One unit is equivalent to one (1) session for insurance benefit utilization.

Psychological Testing	Service Units
Personality/Psychopathology -Objective	
MMPI-11 Adult- Minnesota Multiphasic Personality Inventory -II	1.5
MMPI-A Adolescent	1.5
MCMI-11 Millon Clinical Multiaxial Inventory - II	1.25
MAPI Millon Adolescent Personality Inventory	1.25
MACI Million Adolescent Clinical Inventory	1.25
PIC Personality Inventory for Children	1.25
Beck Depression Inventory	.75
Beck Anxiety Inventory	.75
Reynolds Depression Scales, Child, Adolescent, Adult	.75
BASC Behavioral Assessment System for Children	.75 per admin.
CBCL Child Behavior Checklist	.75 per admin.
Connors Rating Scales	.75 per admin.
Personality/Psychopathology- Projective	
Rorschach Inkblots Procedure	1.5
Apperception Technique: <ul style="list-style-type: none"> • Thematic Apperception Test • Children's Apperception Test • Robert's Apperception Test 	1.25
Projective Drawings: <ul style="list-style-type: none"> • DAP • House-Tree-Person • Kinetic Family Drawing • Sentence Completion/Incomplete Sentence Pro. • Bender Visual-Motor Gestalt Test 	.50
Cognitive-Intellectual Testing	
WPPSI-R (PRE-SCHOOL)	1.5
Wechsler Pre-School & Primary Scale	1.5
WISC-III Wechsler Intelligence Scale for	1.5

Children	
WAIS-R Wechsler Adult Intelligence Scale-Revised	1.5
Kaufman Brief Intelligence Test	.75
Attention Deficit Disorder Type (See the Protocol for more details)	
TOVA Test of Variables of Attention	1.0
Other	
Reitan Aphasia Screening	} subject
Dementia Rating Scale	} to
Wechsler Memory Scale	} review

It is noted this is not a comprehensive complete list of psychological assessment instruments available. Additional tests may be reviewed with the psychologist conducting Utilization Review and time allocation. Please contact New Avenues for information regarding tests not included.

Comprehensive neuro-psychological batteries are not generally covered under the behavioral health plan, but would need to be referred to the Medical Plan for pre-certification.

APPEAL/GRIEVANCE PROCESS

The New Avenues/MBHN has an established policy for members, clinicians or facilities to appeal an adverse determination/denial. Throughout this process, it is important to remember that:

1. In all dealings with the insured persons whose benefits New Avenues/MBHN manages, New Avenues/MBHN, its staff and any outside committee members will respect the right of the member by adherence to the following principles:
 - a. All individuals have the right to question the utilization management decisions that are made on their behalf.
 - b. Members shall be informed about their benefits and decisions made related to those benefits, with respect and understanding.
 - c. All responses to a member or provider will be completed by New Avenues/MBHN in a timely manner, as defined by the standards described below, so as to minimize the stress and uncertainty experienced by the member or provider.
 - d. New Avenues/MBHN Quality Assurance Program shall document the nature, frequency, and type of complaints and appeals in order to evaluate any trends and continue to examine means of improving its services.
2. Utilization review decisions and management of Grievances and Appeals will be using criteria in addressing requests for authorization of benefits that meets medical necessity and is within the benefit plan.
3. Determination that the services requested is medically necessary is made by a Care Manager based on information at the time of the request that the treatment is within professional standards and the treatment for the member's condition meets criteria of medical necessity at the time treatment is initiated by the patient, or when there is a request for authorization for on going care. The process includes clinical judgment based on the level of severity of the symptoms, the level of urgency for response, and a determination of the level of services required to positively alleviate symptoms and improve function.
4. If there is a question regarding the request for authorization meeting criteria of medical necessity, the Care Manager will review this request with the New Avenues/MBHM Medical Director or a Peer Reviewer. The determination of whether the request meets medical necessity is the decision of the Medical Director or his designated reviewer, and if not medically necessary will be communicated to the member through a denial.
5. The determination of whether a service will be paid for by the insurance benefit is determined by the scope and the limitations of the member's Health Plan.
6. All decisions regarding coverage of benefit as they relate to the scope and limitations contained in the member's health plan, other than decisions of medical necessity are considered administrative decision, some of which constitute Administrative Denials.

CRITERIA OF MEDICAL NECESSITY:

New Avenues/MBHN has the responsibility to administer the behavioral health benefit plans of its various contracts within the terms of each respective plan. It is also committed to administer the plans in an ethical manner, within the highest professional standards of managed behavioral healthcare. When a dispute over coverage occurs and members, Providers, or Facilities request a change in a decision of New Avenues/MBHN, there is the need to have a structured and fair process to review and adjudicate the issues through a careful evaluation of information from all pertinent sides. All Grievances and Appeal proceedings conducted by New Avenues/MBHN will conform to the standards of the National Committee on Quality Assurance (NCQA), ERISA, HIPAA, and the laws of the State of Indiana for Utilization Review and Appeals as established in the legislation 760 IAC 1-59-10.

Acting as a Utilization Review agent, New Avenues authorizes treatment that meets criteria of “medical necessity.” For treatment to meet criteria of “Medical Necessary”: services must meet the criteria as published by The Mihalik Group called the Medical Necessity Manual for Behavioral Health and the American Psychiatric Association Clinical Practice Guidelines, or other generally accepted professional standards of care. “Medically necessary” treatment of behavioral health symptoms implies goal-focused treatment of an acute phase of the “illness” or symptoms that is consistent with evidence-based professional guidelines for treatment of the diagnosis. Goals for treatment must be focused on recovery, alleviation of symptoms, improved functionality, and/or stabilization. The review of provider documentation in utilization management and approval of treatment as meeting “medical necessity” criteria is typically made by a Care Manager under oversight of the Medical Director. In the event that there is a question of whether a treatment plan or services delivered have not met medical necessity, then the request and related documentation are reviewed by the Medical Director or a designated Peer Reviewer for a determination. A Care Manager is not authorized to issue a denial on the basis of medical necessity; this requires the decision of a board certified psychiatrist or psychologist (in the case of psychological testing). In such cases, the treating Provider is notified of opportunity for a physician-to-physician consultation to allow discussion between the attending provider and the Peer Reviewer in achieving an optimal treatment plan.

An appeal shall be defined as a request to change a previous decision made by New Avenues/MBHN and/or the process of adjudicating the request to change a decision. A member or authorized representative of a member may appeal any adverse decision. An appeal that has as its basis an initial request for authorization or the request for authorization for continuation of treatment will again be reviewed on the criterion of “medical necessity” subject to the terms of the covered person’s health plan. The New Avenues/MBHN uses at times, Peer Reviewers, to review treatment plans and determine appropriate use of benefits.

STANDARDS FOR MANAGING GRIEVANCES AND APPEALS:

ALL DENIAL AND APPEAL NOTIFICATION TO MEMBERS MUST BE IN WRITING AND INCLUDE THE FOLLOWING:

1. Specific Reasons for any denials, citing the specific benefit plan exclusion, terms of coverage or clinical criteria as they relate to administrative inquiry, claims, or medical appropriateness.
2. Offer of alternatives that the plan will consider appropriate.
3. An offer to discuss the decision and proposed treatment with a Peer Reviewer, in the case of medical necessity denials.

4. Title, credentials, and qualifications of the Reviewer.
5. Procedures to follow, if the member wishes to obtain more information or wishes to complain, or desires to file a formal grievance or appeal within 180 days of the notification of the denial for pre service and post service appeals (or a period specified in a Health Plan administered by New Avenues/MBHN.).
6. Addresses and phone numbers for New Avenues/MBHN, the insurance plan Appeals Department, and or any other body that adjudicates the Appeals for their respective group health plan.
7. Their right to submit written comments, documents or other information relating to the appeal.
8. Their right for allowing an authorized representative to act on behalf of the Member.
9. The procedure for registering and responding to expedited pre-service appeals, including the procedure for:
 - a. Oral or written initiation of an expedited appeal by the member or by a practitioner acting on behalf of the member or
 - b. Decision and notification to the member and practitioner as expeditiously as the medical condition requires, but no later than 24 hours after the request is made. The New Avenues/MBHN or the Plan will make a decision as expeditiously as the medical condition requires.
7. Their opportunity to request to participate directly in a hearing when that option is available as it may be in second level appeals.
8. The opportunity to be provided upon reasonable request, access to and copies of all documents relevant to the members appeal.
 - All communication will be sent in writing; this includes authorizations, denials, and appeal procedures.
 - A member or provider may submit a complaint or grievance to the MBHN and/or the Payor. MBHN will cooperate using our own procedures, however, the HMO plan and/or Payor plan takes precedence.
 - Information that a request for an appeal may be made by the member by telephone or letter. The MBHN, as a managed care company, must acknowledge either form, in writing, within three (3) days of receipt.

NEW AVENUES' RESPONSIBILITIES:

1. Administers benefits, adjudicate claims, and reviews appeals according to the terms of the various insurance plans with which the organization contracts.
2. Cooperates with the Grievance and Appeals Departments of the various insurance plans for whom behavioral health benefits are administered.
3. Maintains a log documenting by date the receipt of complaints and appeals, the actions taken, the date of any resolution reached, and when correspondence was sent or received.
4. Coordinates its policies with those of the regulatory agencies in the State of Indiana to assure compliance with their regulations and procedures.
5. Obtains the Medical Director's or a qualified peer reviewer to conduct review for any clinical care decision regarding issues of medical necessity and appropriateness of care. This review shall occur at all levels of service as per established MBHN procedures.
6. Provides a process for the adjudication of expedited appeals in administrative and clinical matters.
7. Has established a procedure to conduct an independent external review as the second or third level of the appeals. This group would be composed of an independent group of professionals in psychiatry, psychology, and social work who will be available for participating in appeals and independent medical review of cases. These individuals will

have sufficient knowledge, training, and experience to appropriately resolve an appeal. If the grievance involves the proposal, refusal, or delivery of a health care service or procedure, *at least one member of the panel* will have knowledge in the behavioral health condition, procedure or treatment at issue and will be licensed in the same profession as the health care provider in the case being grieved. All members of the panel will be independent and uninvolved in the matter being grieved.

The following individuals may **not** be involved in an appeal or final review panel:

- Any individual who was involved in the matter that is basis for the underlying grievance;
- Any individual who was involved in the investigation or resolution of the matter under grievance;
- Any individual who has a direct business relationship with the enrollee or member, or health care provider who proposed, refused, or delivered the behavioral health treatment which is the basis of the grievance.

DEFINITION:

“Grievance” means any dissatisfaction expressed by or on behalf of an enrollee of an organization for whom the MBHN manages behavioral health benefits. Such dissatisfaction may relate to:

1. The availability, delivery, appropriateness, or quality of health care services;
2. The handling or payment of claims for health care services; or
3. Matters pertaining to the contractual relationship between the enrollee and the HMO or a Payor group or individual contract holder and an HMO or Payor group.

As Defined In The Indiana Register, November 1, 1998

NOTE: A grievance shall be considered synonymous with a complaint. These “expressions of dissatisfaction” shall be held to be different than an “appeal,” which shall be defined as a “request to change a previous decision made by the MBHO.”

See table for guideline for managing complaints.

TYPES OF APPEALS AND PROCEDURES FOR EACH TYPE:

There are three (3) types of situations that may be adjudicated. The MBHN defines these situations as immediately follows, and manages the three kinds of situations according to the following procedures.

1. **Medical Necessity/Clinical management issues:** are all decisions regarding clinical treatment. These decisions are evaluated by the application of the criteria of medical necessity. This includes access to care, level of care, and questions of whether care meets the criteria of medical necessity and is at the least restrictive level. The grievance may include proposal, refusal, or delivery issues of a health care procedure, treatment or service. Requests and disputes may emerge from the member or provider. All requests for care involve clinical issues, and are therefore handled by care managers who are licensed clinicians. Any question about care which may lead to an adverse determination must be reviewed by the Medical Director, or designated peer reviewer, for a determination of authorization or adverse determination (denial of coverage).
2. **Claim Issues:** These decisions relate to the payment of claims. The claims department adjudicates that a claim should be paid when: the claim is for a covered service as specified by the Payor plan, paid at a contracted rate, to in-network providers, for authorized service, and billed within the MBHN policy guidelines. The determination of accurate co-payments and the coordination of benefits are also handled within this department. The Claims Manager may deny

a claim if it fails to meet the aforementioned criteria. Provider claim issues that are in dispute and based on New Avenues provider contractual relationship must be appealed and settled within the New Avenues Network. The Provider cannot take these appeals to the health plans. Only a covered member or their authorized representative can appeal at the Health Plan level.

3. **Administrative Issues:** are decisions about service that are based on the terms of coverage of the covered members' group health plan. These matters include but are not limited to the determination of a member's eligibility for service, whether or not benefit coverage includes the service, and if the services have been pre-authorized or not. These judgments also determine if the client followed the procedures specified in the benefit plan, the provider followed the terms of the provider contract, and the MBHN administered the plan in compliance with the benefit plan. Initial decisions are typically made at the care management level. The Executive Director, with consultation of the Medical Director, shall review any requests for appeal based on administrative issues for plans that are non-HMO and for which New Avenues has been designated to handle internal level appeals.

The tables on the following pages outline the procedures the MBHN follows in responding to grievances and appeals for each of the above types of decisions that result in an Adverse Determination – Administrative Denials, Claim Denials, or Medical Necessity Adverse Determinations.

TABLE FOR GUIDELINES FOR MANAGING COMPLAINTS

<u>Administrative</u>	<u>Claims</u>	<u>Clinical- Medical Necessity</u>
<p>1. The member, provider, or facility makes a request that is adjudicated. If the request does not fall within the scope of services covered under plan, or contract; or the member is not eligible, the care manager shall attempt to explain the plan's terms and refer the member into care that is a covered service. If the member does not accept the options presented that would be covered under the terms of the plan or the contract, a denial will be made.</p> <ul style="list-style-type: none"> • Who: the care manager makes this initial judgment, and issues the denial • Timing: a decision to certify care or not is made within two days of receiving all the necessary information. The member and provider are notified of a denial decision via electronic or written confirmation within two working days of making the decision. • Notification: The denial is issued to the member, with a copy going to the provider and Payor. All denials will contain written information of how to appeal the decision with the Payor and/or the MBHN. 	<p>1. <u>When a claim is received which does not meet the criteria for payment a denial is issued.</u></p> <ul style="list-style-type: none"> • Who: The Claims Department Manager makes this decision, and issues the denial. • Timing: "Clean" claims are adjudicated within thirty (30) days of receipt of the claim. • Notification: Denial of the claim is issued to the member on the Explanation of Benefits with a copy going to the relevant provider and Payor. In addition a letter goes to each giving notification of the review/ grievance process. 	<p>1. <i>If a member or provider requests clinical services that in the care manager's opinion do not meet the criterion of "medically necessary," or the services requested are for a more restrictive level of care than necessary, the request for services will be reviewed with the Medical Director.</i></p> <ul style="list-style-type: none"> • Who: The MBHN Medical Director makes all final determinations regarding care being medical necessary and at the appropriate level of care. The denial is issued by the care manager. • Timing: Decisions about care will be made within two (2) working days of obtaining all information. Providers will be notified of authorization within one day of the decision being made. When care is denied, providers and members will be notified electronically or in writing within two working days of the decision being made. • Notification: Authorization of care is issued to the member and the provider. A denial is issued to the member, with a copy going to the provider and Payor. All denials will contain written information of how to appeal the decision with the Payor and/or the MBHN.
<u>Administrative-Level 1 Appeal</u>	Claims –Level 1 Appeal	Medical Necessity – Level 1 Appeal
<p>2. If the MBHN or the Payor receives a request from the provider or the member requesting that an administrative decision be reviewed, then:</p> <ul style="list-style-type: none"> • The receiving staff member must log in the request in the grievance log. • <i>The staff member must acknowledge receipt of the grievance, in writing to the provider or member within three (3) days.</i> • Who: The Executive Director or Director of Quality Management shall a.) conduct a full investigation of the substance of the complaint, b.) make a decision to uphold or change the original decision, and c.) document the complaint and the actions taken. • Timing: the decision and written notification shall take place within 30 days of receipt of the grievance. • <i>Notification: written response shall go to the member, with copies to the Payor and provider. All denials will contain written information of how to appeal the decision with the Payor and/or the MBHN.</i> <p style="text-align: center;">*****</p>	<p>2. If the MBHN or the Payor receives a request from the provider or the member requesting that a claims decision be reviewed, then:</p> <ul style="list-style-type: none"> • The receiving staff member must log in the request in the grievance log. • The staff member must acknowledge receipt of the grievance, in writing to the provider or member within three (3) days. • Who: The Executive Director or Director of Quality Management shall a.) conduct a full investigation of the substance of the complaint, b.) make a decision to uphold or change the original decision, and c.) document the complaint and the actions taken • <i>Notification and Timing: the reviewing staff member shall notify the member or provider of decision within twenty (20) days. If the denial is upheld, the provider or member shall be given written notification of how to appeal the decision with the Payor and/or the MBHN.</i> <p style="text-align: center;">*****</p>	<p>2. If the MBHN or the Payor receives a request from the provider or the member requesting that a care decision be reviewed, then:</p> <ul style="list-style-type: none"> • The receiving staff member must log in the request in the grievance log. • <i>The staff member must acknowledge receipt of the grievance, in writing to the provider or member within three (3) days. This acknowledgement will also describe the appeals process.</i> • Who: The Clinical Council shall a.) conduct a full investigation of the substance of the complaint, b.) make a decision to uphold or change the original decision, and c.) document the complaint and the actions taken. • Timing: the decision and written notification shall take place within 30 days of receipt of the appeal. • <i>Notification: written response shall go to the member, with copies to the Payor and provider. All denials will contain written information of how to appeal the decision with the Payor and/or the MBHN.</i> <p style="text-align: center;">*****</p>
<u>Administrative-Level 2 Appeal</u>	Claims – Level 2 Appeal	Care – Level 2 Appeal
<p>3. If the member or provider appeals the decision: (Many HMO's reserve the right to adjudicate grievances and appeals</p>	<p>3. If the member or provider appeals the decision: (Many HMO's reserve the right to adjudicate grievances and appeals</p>	<p>3. If the member or provider appeals the previous decision , the HMO may reserve the right to review any appeal</p>

<p>3. If the member or provider appeals the decision: (Many HMO's reserve the right to adjudicate grievances and appeals from this point on according to their policies. MBHN shall cooperate in providing any necessary information, when this is the process the HMO chooses to use.)</p> <ul style="list-style-type: none"> ▪ The Executive Director or Director of Quality Management must acknowledge receipt of the grievance, in writing to the member or provider, within 3 days. • If the review occurs at the Payor or HMO level the MBHN will co-operate and abide by the appeals rules of the HMO or Payor. • If the HMO or the Payor request that the MBHN conduct the appeal, then the request may be reviewed by Clinical Council, or at the discretion of the Executive Director, the appeal may go to review by an independent external reviewer. • Who: When a review by the Clinical Council is the method of review, the staff member (either the Executive Director or the Director of Quality Management) that conducted the previous investigation shall present the information gathered to the Clinical Council. This (same) staff member shall not be a participant in the decision making process. • Timing: The appeal hearing must occur within 30 days of receipt of the appeal. • Notification: of the decision of the Clinical Council will be sent to the member or provider within five (5) working days after the day the decision is made. This notification shall describe the appeal process for independent external review. 	<p>from this point on according to their policies. MBHN shall cooperate in providing any necessary information, when this is the process the HMO chooses to use.)</p> <ul style="list-style-type: none"> ▪ The Executive Director or Director of Quality Management must acknowledge receipt of the grievance, in writing to the member or provider, within 3 days. • If the review occurs at the Payor or HMO level the MBHN will co-operate and abide by the appeals rules of the HMO or Payor. • If the HMO or the Payor request that the MBHN conduct the appeal, then the request may be reviewed by Clinical Council, or at the discretion of the Executive Director, the appeal may go to review by an independent external reviewer. • Who: When a review by the Clinical Council is the method of review, the staff member (either the Executive Director or the Director of Quality Management) that conducted the previous investigation shall present the information gathered to the Clinical Council. This (same) staff member shall not be a participant in the decision making process. • Timing: The appeal hearing must occur within 30 days of receipt of the appeal. • Notification: of the decision of the Clinical Council will be sent to the member or provider within five (5) working days after the day the decision is made. This notification shall describe the appeal process for independent external review. 	<p>from this point on. If there is no HMO or the HMO requests further review at the MBHO level, the MBHN is then responsible to set up an independent external review to adjudicate the case dispute. The independent external review will be conducted by an independent review organization as defined by the Indiana Department of Insurance, or an other group of three behavioral health and insurance professionals who are not connected to the case. They will review the information collected by the MBHN, the clinical record, and they have the option of making direct contact with the patient's therapist. The member may participate in a hearing in person or by phone, and the member may appear with or without representation.</p> <ul style="list-style-type: none"> ▪ Who: the independent external reviewer(s) will review all information and make a determination as to resolution of the appeal. ▪ Timing: the decision will be made within 30 days after all information needed to adjudicate the appeal is submitted. ▪ Notification must be made to the member and provider and written notification sent out within 5 days of final decision of the appeal. ▪ That decision is binding.
<p>Level 3 Independent External Review</p>	<p>Level 3 Independent External Review</p>	<p>Level 3 Independent External Review</p>
<p>4. If the member or provider appeals the previous decision, the HMO may reserve the right to review any appeal from this point on. If there is no HMO or the HMO requests further review at the MBHO level, the MBHN is then responsible to set up an independent external review to adjudicate the case dispute. The independent external review will be conducted by an independent review organization as defined by the Indiana Department of Insurance, or at least one independent behavioral health or insurance professional who is not connected to the case. They will review the information collected by the MBHN, the</p>	<p>4. If the member or provider appeals the previous decision, the HMO may reserve the right to review any appeal from this point on. If there is no HMO or the HMO requests further review at the MBHO level, the MBHN is then responsible to set up an independent external review to adjudicate the case dispute. The independent external review will be conducted by an independent review organization as defined by the Indiana Department of Insurance, or at least one independent behavioral health or insurance professional who is not connected to the case. They will review the information collected by the MBHN, the clinical record, and they have the option of making direct contact with the patient's therapist. The member may participate in a hearing in person or by phone, and the member may appear with or without representation.</p> <ul style="list-style-type: none"> ▪ Who: the independent external reviewer(s) will review all information and make a determination as to resolution of the appeal within 45 days after the appeal is submitted. That 	<p>(For care appeals this happens at the previous level)</p>

<p>clinical record, and they have the option of making direct contact with the patient's therapist. The member may participate in a hearing in person or by phone, and may appear with or without representation.</p> <ul style="list-style-type: none"> ▪ Who: the independent external reviewer(s) will review all information and make a determination as to resolution of the appeal within 45 days after the appeal is submitted. That decision is binding. ▪ Notification to the member and provider must be made and written notification sent out within 5 days of final decision of the appeal. 	<ul style="list-style-type: none"> ▪ decision is binding. ▪ Notification to the member and provider must be made and written notification sent out within 5 days of final decision of the appeal. 	
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**SPECIAL CIRCUMSTANCES:
Management for HMO Plan Medical Necessity Appeals,**



MEDICAL NECESSITY APPEAL MANAGEMENT FOR HMO PLANS:

Current HMO Insurance plans for which MBHN administers behavioral health benefits, do not delegate the adjudication of appeals to the network. Consequently, when receiving an appeal from a member (or on behalf of a member) enrolled in a health maintenance plan, MBHN shall direct the member to file an appeal directly with the health plan. "Notification letters of an adverse determination" shall provide information about the Appeal/Grievance Department of the respective HMO. The notification letter, however, may offer the member or the provider opportunity to clarify the denial decision and provide additional information to MBHN that could bear on the case and prompt a reconsideration at the MBHN level.

Reconsideration: In the event the member or provider desires a reconsideration of an adverse decision, New Avenues/MBHN will:

1. Record that a request has been made
2. Provide opportunity for telephonic consultation, reconsideration and expedited reconsideration if the situation warrants.
3. Reconsideration shall include: notifying the member, the provider, and the Health Plan of acknowledgement of receipt of the request for reconsideration.
4. Pre-service reconsideration-electronic or written response to request for reconsideration of a denial of services in advance of the member obtaining care or services within two (2) business days of obtaining the request.
5. Post-service Reconsideration -electronic or written response to request for reconsideration of a denial of services for care or services that have already been received by the member within 30 business days of the request.
6. In an emergent situation, inpatient hospitalization or continued stay for inpatient care, the provider shall be offered opportunity and procedures to contact the Medical Director for a peer review/ telephonic direct consultation of the matter in order to resolve an issue within 24 hours as well as opportunity to arrange an expedited appeal at the HMO level. The verbal disposition of the expedited reconsideration shall be made with 24 hours and the written notification of the reconsideration shall be sent to the member and provider within the next two (2) business days. The Health Plan is responsible to handle an expedited appeal.
7. New Avenues/MBHN reserves the right to consult with an independent reviewer during the utilization management process in order to obtain expertise and opinion during the course of performing utilization management and may submit that opinion to the health plan as additional reference documentation to what expertise and guidelines were used in the performance of its utilization review actions.

MEDICAL NECESSITY APPEAL MANAGEMENT FOR CARVE-OUT/SELF-INSURED PLANS:

New Avenues/MBHN performs administration of benefits for self-insured plans as a carve-out

relationship and in that role may be responsible for managing appeals through one level of appeal. In such situations, NA/MBHN shall provide appeal management to the point of obtaining a decision from a panel of independent reviewers. Any appeal beyond this level such as referral to an external independent board or to the Health Plan's Independent Review Board is at the designation of the Health Plan Sponsor's subject to the specific plan's procedure.

When a Grievance for medical necessity leads to an Appeal, the following procedures based on the type of contractual relationship NA/MBHN has with the Payor or Client Company will be used:

A. APPEAL LEVEL (I) FOR MEDICAL NECESSITY DENIALS:

If a member or provider, has formally, in writing, authorized by member, files a grievance/or appeal on the basis of medical necessity for a non urgent pre-service appeal, the New Avenues/MBHN shall initiate an investigation and obtain all necessary information relevant to the treatment under dispute, and shall provide such information as expeditiously as possible to the New Avenues/MBHN Medical Director for review within two (2) business days of the request for reconsideration.

If the reconsideration results in a decision to uphold the denial, all or in part, the appeal shall be forwarded to an independent reviewer or the Health Plan for subsequent determination.

B. RETROSPECTIVE REVIEW (Post Service): Utilization Review decision process for a request of authorization that occurs after a member's treatment at a given level of service has been completed. A review of the medical record may be requested in order to make the decision regarding this request.

For a retrospective (post service) review, the New Avenues/MBHN will make a decision on the request within 30 business days of obtaining all information. When the decision results in a denial, the New Avenues/MBHN shall notify the member and the provider of the adverse decision and the to appeal process.

C. EXPEDITED APPEALS: Expedited Appeals are those appeals that must be adjudicated very rapidly to serve the needs of members that are in intensive and acute treatment programs. The request for the expedited appeal may be initiated by a member or by a provider acting on behalf of the member. The expedited appeal is available to the member as a first level appeal. Second level appeals and appeals to independent external review agents or panels will proceed on the aforementioned timelines.

An expedited appeal will be adjudicated as soon as is possible, however the MBHN will make a decision and communicate that decision to the member and the provider within 48 hours after the receipt of the appeal.

All decisions about procedure that have not been explicitly delineated in this document shall fall upon the Executive Director of the MBHN. The Executive Director shall, in such instances, create procedure that have as their basis, the five core values, and that will treat the member and/or provider fairly.

APPEAL PROCEDURES FOR BENEFIT DENIALS-ADMINISTRATIVE DENIALS INCLUDING CLAIMS APPEALS:

Initial Action-Reconsideration. These procedures apply to any situation that is not within the

scope of a treatment or access to treatment defined as “medical necessity denials”.

A request to reverse a decision regarding a denial of a claim or benefit on the basis of the benefit shall be reviewed by the Executive Director or designated administrative staff for reconsideration of all pertinent information. The reconsideration is considered the first step of the appeal. If an adverse decision is upheld upon reconsideration, then the appeal will be directed to the Health Plan for final adjudication.

FILING AND RESPONDING TO COMPLAINTS

A Member, person authorized to act on behalf of a Member, or Provider may submit a grievance to New Avenues. For purposes of clarity, New Avenues uses the following definitions in managing

these concerns:

Appeals: Grievances that are related to a request for a change of decision;

Complaint: Grievance related to other types of dissatisfaction.

1. Definition: A "Complaint" means any oral or written expression of dissatisfaction that does not involve a previous decision made by New Avenues and is expressed by or on behalf of a Member or an organization for whom New Avenues manages behavioral health benefits as defined in The Indiana Register, November 1,1998. Such dissatisfaction may relate to:
 - 1.1. The availability, delivery, appropriateness, or quality of healthcare services.
 - 1.2. The handling or payment of claims for healthcare services.
 - 1.3. Matters pertaining to the contractual relationship between the Member and the HMO or a Payor group or individual contract holder and an HMO or Payor group.
2. These "expressions of dissatisfaction" shall be held to be different than an "Appeal," which shall be defined as a *request to change a previous decision* made by New Avenues and/or *the process* of adjudicating the request to change a decision.
3. Grievances based on a *request to change* a previous decision made by New Avenues regarding benefit coverage, claims payment, decisions regarding authorization of services based on medical necessity shall be handled according to the Appeals Procedures described in Appeals Subsection of the Behavioral Health Section.

I. POLICY SUMMARY

This policy describes New Avenues philosophy and orientation to Member, Provider, health plans or other parties. This policy also defines the roles, extent, and limits of responsibilities, and timelines for the Care Managers, the Senior Care Manager, the Medical Director, and the Executive Director in managing complaints.

This policy has been prepared with reference to the IN code 27-13-10-13 and IN 27-13-35 as referenced in Title 760 Department of Insurance rules for HMO Grievance Procedures and the National Committee for Quality Assurance Standards for Managing Grievances and Appeals and is intended to meet compliance with all regulations as well as be consistent with the Appeals Grievances Policies of the HMO plans with which we collaborate.

II. PROCEDURES

1. In all dealings with Members and Providers, New Avenues staff shall show respect to all parties, shall seek to obtain fair and timely resolution, provide disclosure of rationale, and inform all parties of procedures for appeal.
2. New Avenues has implemented the following procedures:
 - 2.1. Members, persons acting on behalf of a member, or Providers may submit a complaint by sending description of the concerns and/or complaint to: New Avenues, P.O. Box 360 South Bend, IN 46624. Phone: 800-223-6246.
 - 2.2. Request that Providers either post or provide members written description of the right to file a Complaint or Grievance. This shall be posted in a conspicuous place in each facility that provides service for New Avenues.
 - 2.3. New Avenues maintains a toll free telephone number, 800-223-6246,

staffed by New Avenues Care Managers forty (40) hours a week, through which Complaints or Grievances may be filed.

- 2.4. Filing a Complaint: There are several ways that a complaint may be communicated to the New Avenues staff. It can come from a Member, an authorized person acting on behalf of a member, an individual Provider, a facility, or health plan and it may be communicated directly to a New Avenues staff member, or it may come through a Payor, a Human Resources Department, a TPA, or the Insurance Plan.
- 2.5. The Complaint may be communicated in writing or via the phone.
- 2.6. New Avenues has a policy to provide timely, adequate, and appropriate notice of how to make a Complaint to any member wishing to make a complaint.
- 2.7. New Avenues investigates all complaints, maintains a Complaint Log for tracking, and monitors overall quality review of its programs, practices, and Providers.
- 2.8. If a member is enrolled in an HMO plan, Grievances and Appeals will be referred to their department and handled according to the HMO's procedures.
- 2.9. New Avenues administers benefits, complaints, or grievances/appeals according to terms of the various insurance plans with which New Avenues contracts.

III. PROCEDURES FOR ADDRESSING COMPLAINTS AND GAINING RESOLUTION

- 3.1. Any professional staff person working for New Avenues may receive the initial information regarding a Complaint.
- 3.2. All Complaints will be documented by the person receiving the complaint on a New Avenues Complaint Report form and submitted to the Senior Care Manager for monitoring.
- 3.3. All Complaints will be acknowledged orally or in writing within three (3) business days of receipt.
- 3.4. The Care Management or Claims Department shall attempt to resolve the complaint within the three (3) business days if able to do so without further investigation.
- 3.5. The Senior Care Manager or the Executive Director will initiate an investigation in those circumstances where more information/investigation is required before making a decision.
- 3.6. The result of a Complaint will be communicated to the griever orally or in writing and will include the griever's right to file an appeal if applicable.
- 3.7. Copies of the Complaint, the acknowledgement, and the result will be filed in the respective chart of the Member, the Provider, and in a complaint log.
- 3.8. Complaints that result in a Grievance or Appeal will be managed through the appeal management process.
- 3.9. Any action to resolve a Complaint that goes beyond the scope of authority of a Care Manager, or other staff's job description, needs the approval of the Executive Director.
- 3.10. Any Complaint that is considered to be clinically urgent, New Avenues will treat the Complaint expeditiously and respond within one (1) day for "emergent" and within two (2) days for an "urgent" situation. On quality of care Complaints, New

Avenues review will involve a Care Manager and the New Avenues Medical Director.

- 3.11. Where there is a right to file an appeal regarding the Complaint, the grievor will be advised of this right and the procedure for filing an appeal according to the Appeal Policy.
- 3.12. A Complaint Resolution Notification to the grievor shall contain documentation of:
 1. The decision.
 2. The reasons, policies and procedures that are the basis of the decision.
 3. Information in order to appeal the decision, if applicable.

IV. TIMEFRAME STANDARD FOR INVESTIGATION AND NOTIFICATION

A Complaint will be investigated, concluded, or resolved via a decision within five (5) days if possible, and maximum of 20 business days of its receipt.

- 4.1. A complaint will be acknowledged orally or in writing in three (3) business days of receipt.
- 4.2. A grievor will be notified of the final results of a resolution within five (5) days, and the results of a more extensive investigation within 20 days.
- 4.3. This notification will take place within five (5) business days of the conclusion of the investigation. If New Avenues must take additional time to investigate the complaint, it will notify the grievor within the 20 business days of this need.
- 4.4. In no instance will New Avenues use more than 30 business days to investigate and make a decision as the result of a complaint.

V. COMPLAINTS REGARDING QUALITY OF CARE AND PROVIDERS

In the event a Member, parent, or individual acting on behalf of a Member shall submit a complaint regarding the quality of care, or a complaint about the practice or behavior of a Provider, then such complaint shall be investigated.

- 5.1. The complaint shall be referred to the Senior Care Manager or Executive Director for investigation.
- 5.2. The information shall be obtained and documented on the Complaint Tracking form. If the Member conveys the information verbally, the staff person shall document the concerns on the complaint form.
- 5.3. In the event that a complaint is given verbally, and the staff Member or Senior Care Manager determines that the complaint needs to be obtained in writing by the Member, such Information shall be requested. The Member should be sent the Member Complaint form providing the Member a structured form for submitting a written complaint.
- 5.4. The concern will be thoroughly investigated from both the Member and Provider's perspective. The goal of such Investigation is to resolve as expeditiously as possible the situation to the satisfaction of the Member, subject to the terms of the health plan. Investigation and early resolution may include notification to the Provider of the Member's complaint including giving the Provider opportunity to explain, present their perspective, correct or re-consider the concern of the Member.
- 5.5. Resolution could include:

- 5.5.1. Mediating any misunderstanding between a Member and Provider, or
- 5.5.2. Explaining to the Member or Provider the terms or benefit coverage of the health plan or the policies of New Avenues.
- 5.5.3. Facilitating change of a Provider at a Member's request, or
- 5.5.4. Other action to ensure that the Member is satisfied with treatment and the Provider meets the Member's expectations (if possible) and New Avenues standards of care.

VI. COMPLAINTS OF SERIOUS NATURE

If the nature of the complaint has implications of serious harm to a Member, or harm to the reputation of a Provider, or New Avenues, and/or the complaint includes allegation about unprofessional conduct, practice of a Provider outside the scope of licensure, professional standards or clinical guidelines, misconduct, or negligence, significant quality issues, such situations shall require the Member to submit a written complaint.

- 6.1. The Member should be directed to submit a letter describing their complaint and complete a New Avenues Member Complaint form and an Authorization for Release of Information form.
- 6.2. New Avenues shall send a Member Complaint form and an Authorization for Release of Information form within three (3) days of receiving such a complaint verbally, and request a return of the form, or a descriptive letter, within ten (10) business days.
- 6.3. Upon receipt of such Member Complaint form and an Authorization for Release of Information, the Senior Care Manager, or Executive Director shall initiate an investigation with the Provider and Member.
- 6.4. Allegations about a Provider shall be treated as part of the Credentialing and Provider Quality Review procedures, subject to the Medical Director's review, and may be subject to formal peer review.
- 6.5. Such investigation may take longer than 20 days to complete, but shall be handled as expeditiously as possible to give all parties opportunity to present full information.
- 6.6. The Member making the allegation shall be informed within five (5) days of actions of New Avenues after conclusion of the investigation.
- 6.7. New Avenues reserves the right to use discretion on release of its findings, and will not release to the Member confidential peer review proceedings.

VII. STANDARDS FOR NOTIFICATION

- 7.1. Members must be informed of:
 - 7.1.1. A statement of New Avenues understanding of the member's complaint.
 - 7.1.2. A description of the resolution reached by New Avenues stated in clear terms and the contract basis or medical rationale for the resolution stated in sufficient detail for the Member to respond further to the New Avenues position. Specific reasons for any decision, whether it is related to an administrative inquiry, a claim, or a determination of Medical Necessity.
 - 7.1.3. A reference to the evidence or documentation used as the basis for

the resolution.

- 7.1.4. A statement of the procedures governing an appeal, including how to file an appeal - i.e., Procedures to follow, if the Member wishes to obtain more information, or desires to file an appeal.
 - 7.1.5. Addresses and phone numbers for New Avenues, the covered member's insurance plan's grievance and appeals department, their PHO (if appropriate), and/or another body that adjudicates the appeals for their plan.
- 7.2. All communication with the Member, Provider, and/or Facility must be sent in writing.
 - 7.3. A member or Provider may submit a complaint or grievance to New Avenues and/or the Payor, member company, or TPA. New Avenues will accommodate the structures and procedures of these entities to the extent possible without violating the spirit or intent of this policy.

VIII. THE NEW AVENUES SHALL MONITOR THE VOLUME, FREQUENCY AND TYPE OF COMPLAINTS, AND TIMELINESS for response on a monthly and annual basis and report its findings to the New Avenues Quality Improvement Committee. It shall also report its findings if requested to Payors as part of quality improvement activities. The ongoing monitoring program shall be developed in a project study as part of the Quality Improvement plan for the New Avenues that shall include root cause analysis, action plans for improving any areas of deficiencies problems, and monitoring improvement.

QUALITY MANAGEMENT

The staff and board of MBHN and New Avenues are deeply committed to quality management, as evidenced by establishing and maintaining a Quality Management Committee. This standing committee assists with the administration of the quality improvement process for New Avenues

d/b/a MBHN. The Quality Management (QM) Committee is responsible for overseeing activities such as reviewing criteria for standards of care, review of clinical outcomes, data analysis, etc. The QM Committee has a subcommittee called the "Clinical Council" established to review utilization management policy and perform clinical case management oversight. This committee under direct involvement with the Medical Director provides oversight of concurrent review process for all inpatient and complex outpatient cases as has been described earlier in this manual. All remaining Utilization Review activities are the responsibility of the Care Management staff under supervision of the Medical Director. The MBHN Director is a member of the Clinical Council and reports on Utilization Review activities at every QM Committee meeting. Listed below are the various components of the MBHN's Quality Management and Improvement Program:

QUALITY MANAGEMENT COMMITTEE:

1. **Description and Duties:** The Quality Management Committee is responsible for directing the quality improvement process for the MBHN. The QM Committee meets on a bi-monthly basis.
 - a. Continuous monitoring of key indicators;
 - b. Problem-focused QM studies;
 - c. Reviews problem provider issues and Credentialing Committee recommendations for compliance of providers with credentialing and practice standards.

2. **Composition of the Quality Management Committee:** Membership in the QA Committee includes participants from the network clinical providers. The QA Committee is comprised of the following personnel:
 - a. MBHN Medical Director;
 - b. Executive Director;
 - c. MBHN Care Manager;
 - d. Director of Administrative Operations & Quality Improvement
 - e. Psychiatrist credentialed as a provider in the network;
 - f. Psychologist credentialed as a provider in the network;
 - g. Physician credentialed as a Primary Care Physician in one of the Physician-Hospital Organization which delegates to the MBHN;
 - h. Social worker or licensed therapist credentialed as a provider in the network.

QUALITY IMPROVEMENT PLAN:

Each year, the Director of Administrative Operations prepares a plan which outlines the planned, systematic, organization-wide approach used for designing, measuring, assessing and improving the performance of its services. This plan is reviewed and approved by the executive staff and the QM Committee. The responsibility for completion of this plan lies with the MBHN Director of QM and the Executive Director. Key components of that plan are:

- Continuous monitoring of key indicators against industry benchmarks;
- Quality improvement studies;
- Review of, and improvement action planning to Client Satisfaction Surveys; and
- Review and response to improvement action planning to Provider Satisfaction Surveys.

QUALITY IMPROVEMENT ACTIVITIES:

The MBHN has an ongoing Quality Assurance & Improvement process which grows out of its commitment to Continuous Quality Improvement. The MBHN has a Quality Improvement Plan, revised annually, which directs the staff's activities. The QIP outlines a variety of data gathering efforts to which help drive the Quality Management process. Listed below are examples of data

gathering:

1. Client Company Satisfaction Surveys
2. Client Satisfaction Surveys
3. Provider Satisfaction Surveys
4. Appeals/Grievances/Complaints
5. Outcome Studies
6. Utilization Analysis Issues
7. Post Hospitalization follow-up compliance with seven (7) and 30 day standards
8. Telephone Access study to determine length of response
9. Coordination of care by providers with members' primary care physician
10. Inter-rater reliability studies of care managers and peer reviewers decisions
11. Timeliness of achieving appointments within 10 days of member's initial call
12. Monitoring of sentinel events