

# MAC Binder Section 3A – Corrective Action Plans

## Table of Contents with Document Summary

Located online at <http://chfs.ky.gov/dms/mac.htm>

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### **1 – Humana IPRO Response\_dte112114:**

Pursuant to DMS letter dated September 22, 2014 (which can be found in section 3 of the Sept. MAC binder), Humana’s response to the 2013 Medicaid Compliance Review conducted by IPRO. Items 2 through 11 that follow are topic specific and correspond to this response letter.

### **2 – HCS CAP Response IPRO HCS2014IPRO-AC-1:**

Humana response to corrective action plan – access to tuberculosis screening, evaluation and treatment not being addressed in the Member Handbook.

### **3 – HCS CAP Response IPRO HCS2014IPRO-BH1:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of behavioral health; appropriate training for hotline staff regarding all contractor programs, service areas and the behavioral health provider network in each service area.

### **4 – HCS CAP Response IPRO HCS2014IPRO-CM1:**

Humana response to corrective action plan – Development of policy & procedures addressing DCBS population reporting, and analysis; and corrective actions plans for indicators measuring utilization, access, complaints, grievances and satisfaction.

### **5 – HCS CAP Response IPRO HCS2014IPRO-ER2:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of enrollee rights; Member Handbook should include information for members regarding contacting DCBS in the event of birth, death or address change.

### **6 – HCS CAP Response IPRO HCS2014IPRO-GS-2:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of Grievance System; establish a KY-specific policy & procedure for this and other MCO procedures and processes. The policy should include the 14-days after mailing requirement.

### **7 – HCS CAP Response IPRO HCS2014IPRO-HR1:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of health risk assessments (HRA); use additional methods to encourage completion of the HRA, outreach attempts documented and tracked.

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#### **8 – HCS CAP Response IPRO HCS2014IPRO-MI-1:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of integration of behavioral health with medical health; address BH integration, performance metrics, analysis and actions taken to address quality of BH services.

#### **9 – HCS CAP Response IPRO HCS2014IPRO-PB1:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of pharmacy rebate administration; develop policy for addressing that HCS shall assist Department with drug rebate manufacturer disputes and for rebate administration for pharmacy services provided through other settings.

#### **10 – HCS CAP Response IPRO HCS2014IPRO-PC-1:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of provider credentialing and re-credentialing; update the 2013 credentialing policy to specifically address the requirement of a professional board certification, eligibility for certification, or graduation from a training program to serve children under age 21 with special healthcare needs.

#### **11 – HCS CAP Response IPRO HCS2014IPRO-UM1:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of utilization management; initial adverse determination notice should include reference to the member's right to a State hearing if the member requests an appeal and the appeal upholds the decision.

#### **12 – PHP Response PHP2014HTL-BH-1 Accepted\_dte112114:**

DMS acceptance of PHP response dated November 10, 2014 (which can be found in section 3 of the Nov. 2014 MAC binder), to behavioral health services.

#### **13 – PHP IPRO Response\_dte121514:**

PHP response to the Medicaid 2014 IPRO Compliance Review corrective action plans dated October 14, 2014 (which can be found in section 3 of the Sept. 2014 MAC binder).

#### **14 – PHP CAP Response IPRO PHP2014IPRO-AC-1:**

Passport response to corrective action plan – updated policy CR 21.0 Non-Participating Providers to reflect payment to not exceed the Medicaid fee-for-service rates.

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#### **15 – PHP CAP Response IPRO PHP2014IPRO-BH-1:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of behavior health services; behavioral health hotline may serve multiple contractor programs and service areas if hotline staff is knowledgeable about all of the contractor programs and service areas.

#### **16 – PHP CAP Response IPRO PHP2014IPRO-CM:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of case management/care coordination. PHP will ensure quality checks are performed on the required reports and update applicable policy for care management and documentation for DCBS members.

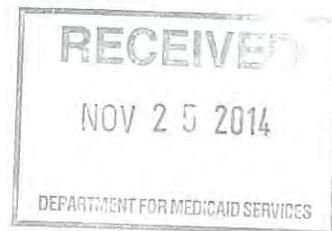
#### **17 – PHP CAP Response IPRO PHP2014IPRO-CR:**

Humana response to corrective action plan – Non-compliance and/or minimal compliance in the area of credentialing structure & operations; developed policy for electronic health record incentive funds and adding contractual language to CR 1.01 and CR 4.01 as well as adding language to the provider manual.

# Humana

November 21, 2014

Patricia Biggs  
Director of Program Quality and Outcomes  
Department for Medicaid Services  
275 East Main Street 6W-A  
Frankfort, KY 40621



Dear Ms. Biggs,

Pursuant to your letters dated September 22, 2014, and in response to the 2013 Medicaid Compliance Review conducted by IPRO on behalf of the Department, enclosed herewith are Humana-CareSource's Corrective Action Plans.

If you have any questions or need anything further, please feel free to contact me at (502) 476-3082 or [apendleton1@humana.com](mailto:apendleton1@humana.com).

Sincerely,

A handwritten signature in blue ink, appearing to read "A. Chad Pendleton". The signature is fluid and cursive, with a large initial "A" and "P".

A. Chad Pendleton  
Executive Director, Kentucky Medicaid/Duals



### Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Access – Tuberculosis Screening

**Unique Identifier:** HCS2014IPRO-AC-1

**Product:** KY Medicaid

**Compliance/Business Requirement:** The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member for the following services within the Contractor’s network: Tuberculosis screening, evaluation and treatment.

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO’s findings of non-compliance and/or minimal compliance in the area of **30.2 Direct Access Services:** Tuberculosis screening, evaluation and treatment was not addressed in the Member Handbook.

IPRO made a recommendation that direct access for tuberculosis screening, evaluation and treatment should be addressed in the Member Handbook.

#### Summary of actions taken/to be undertaken and completion dates:

Corrective Action	Due Date
An insert to the Member Handbook will be developed setting forth that Humana will ensure direct access and will not restrict the choice of a qualified provider by a Member for tuberculosis screening, evaluation and treatment. The insert will require KDMS approval and will accompany all distributed handbooks and also will be posted online	1/5/15
The language regarding Humana ensuring direct access and not restricting the choice of a qualified provider for tuberculosis screening, evaluation and treatment will be integrated into the 2015 Member Handbook. .	3/14/15

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



### Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Behavioral Health Services Hotline

**Unique Identifier:** HCS2014IPRO-BH1

**Product:** KY Medicaid

**Compliance/Business Requirement:** The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area.

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area of Behavioral Health.

IPRO made a recommendation that Humana CareSource through Beacon Health Strategies should include in its SOP and/or P/Ps and its hotline staff training documentation that the Behavioral Health Services Hotline may serve multiple Contractor Programs and service areas and that the Hotline staff is trained regarding all of the Contractor Programs, service areas and the Behavioral Health Provider Network in each Service Area.

#### Summary of actions taken/to be undertaken and completion dates:

Corrective Action	Due Date
Beacon Health Strategies will incorporate this requirement of plan specific training to hotline staff members working with the Humana CareSource line of business. This specific training will be in the form of: 1) Humana CareSource Behavioral Health/Substance Abuse Cheat Sheet which covers processes for standard customer service issues and regional crisis line information and 2) Kentucky: Humana CareSource CHEAT SHEET which covers plan specific services and code information.	January 1, 2015

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



## Corrective Action Plan

**Date:** November 20, 2014

**Topic:** DCBS Population Reporting, Analysis and Follow-ups

**Unique Identifier:** HCS2014IPRO-CM1

**Product:** KY Medicaid

**Compliance/Business Requirement:** DCBS Population Reporting, Analysis and Follow-ups

The MCO should establish policies/procedures for tracking, analyzing, reporting and developing corrective action plans for indicators measuring utilization, access, complaints and grievances, and satisfaction with care and services for the DCBS population. Evidence of reporting, analysis and follow-up should be included for EQRO review.

### Background:

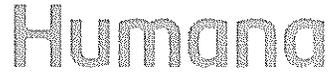
P/P CM 22. 2013 Kentucky Care Management Model discusses program evaluation utilizing tools such as member surveys, SF-12 survey and outcomes based quality and utilization indicators. The program is reviewed annually and as needed. A summary report is posted to the provider's website. A Quality Improvement Work Plan is created annually and submitted in writing for review and approval prior to implementing any changes to the program. These activities are described for the overall care management population, not specifically for the Department of Community Based Services (DCBS) population.

Utilization reports provided include inpatient and outpatient medical management key statistics for the Temporary Aid to Needy Families (TANF) and Aged, Blind and Disabled (ABD) populations. A draft quality measures report includes HEDIS measures with a breakout for children with special health care needs. Reporting for access, complaints and grievances, and satisfaction for this population was not provided.

**Summary of actions taken/to be undertaken and completion dates:**

<b>Corrective Action</b>	<b>Due Date</b>
HCS will develop a policy and procedure addressing tracking, analyzing, reporting and developing corrective action plans for indicators measuring utilization, access, complaints and grievances, and satisfaction with care and services for the DCBS population.	January 1, 2015
HCS will develop corrective action plans as appropriate for indicators measuring utilization, access, complaints and grievances, and satisfaction with care and services for the DCBS population based on reports received.	January 1, 2015
Reports will be revised to provide information specific to the DCBS population for access, complaints and grievances, and satisfaction.	January 1, 2015

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



### Corrective Action Plan

**Date:** November 20, 2014  
**Topic:** Forensic Pediatric Sexual Abuse Examinations  
**Unique Identifier:** HCS2014IPRO-CM2

**Product:** KY Medicaid

**Compliance/Business Requirement:** 32.9 – Forensic Pediatric Sexual Abuse Examination. Contractor shall have providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.

**Background:**

In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO’s findings of non-compliance and/or minimal compliance in the area of 32.9 – Pediatric Sexual Abuse Examinations.

IPRO made a recommendation that Humana CareSource should establish a policy/procedure that addresses this requirement.

**Summary of actions taken/to be undertaken and completion dates:**

Corrective Action	Due Date
<p>Humana-CareSource has a policy in place that provides:</p> <p>“Provider Relations will monitor the contracted network to ensure broad access and availability to quality healthcare services by physicians, hospitals and ancillary providers, while ensuring administrative, service and financial integrity. Specialists shall be commensurate with the subpopulations designated by the Department, and include sufficient pediatric specialists to meet the needs of Members younger than twenty-one (21) years of age.”</p>	<p>Effective January 2013</p>
<p>Humana-CareSource will revise its Provider Recruitment Policy to specifically identify that it will assure that adequate services are contracted to meet the needs of its members in the area of Pediatric Sexual Abuse Examinations. The revised Policy is currently in draft form and will be reviewed and approved by the due date.</p>	<p>February 1, 2015</p>

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



### Corrective Action Plan

**Date:** November 20, 2014

**Topic:** School Based Services Coordination

**Unique Identifier:** HCS2014IPRO-CM3

**Product:** KY Medicaid

**Compliance/Business Requirement:** School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage. However, in situations where a child’s course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. Coordination between the schools and the Contractor shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child.

**Background:** IPRO recommendation: Humana CareSource should establish a policy/procedure addressing this requirement and document coordination with schools and agencies that provide EI services and school-based services.

**Summary of actions taken/to be undertaken and completion dates:**

Corrective Action	Due Date
Humana CareSource will incorporate this requirement into the Care Management Policy to include coordination with schools and agencies that provide EIP services and school-based services.	January 1, 2015

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



### Corrective Action Plan

**Date:** November 20, 2014

**Topic:** First Steps Program

**Unique Identifier:** HCS2014IPRO-CM4

**Product:** KY Medicaid

**Compliance/Business Requirement:** The Contractor shall coordinate services between the First Steps program and Contractor coverage. The First Steps program is an entitlement program established by the Federal Individuals with Disabilities Education Act (IDEA) and is funded by federal, state and local funds. The goal of the program is to provide early intervention services to children from birth up to age three who have developmental disabilities or delays. The intended outcome of the program is to ensure maximum amelioration of the impact of developmental disabilities or delays on infants and toddlers by early and ongoing provision of rehabilitation services.

**Background:** IPRO Recommendation: Humana CareSource should establish a policy/procedure addressing this requirement and document coordination with the First Steps program.

**Summary of actions taken/to be undertaken and completion dates:**

Corrective Action	Due Date
Humana CareSource will incorporate this requirement into the Care Management Policy to include addressing coordinate services between the First Steps program and Humana CareSource and document of coordination with the First Steps program.	January 1, 2015

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



### Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Coordination of First Steps and School Based Services

**Unique Identifier:** HCS2014IPRO-CM5

**Product:** KY Medicaid

**Compliance/Business Requirement:** In order for Contractor and its Providers to effectively manage care for Members who qualify for these services, it will be necessary to coordinate the care provided through both programs as children who are receiving these services are identified, to share information with early intervention/school-based service providers with appropriate permission from parents.

**Background:** Humana CareSource should establish a policy/procedure addressing this requirement and document coordination with the First Steps program.

**Summary of actions taken/to be undertaken and completion dates:**

Corrective Action	Due Date
Humana CareSource will incorporate this requirement into the Care Management Policy to include 1) coordination of the care provided through both programs as children who are receiving these services are identified, 2) to share information with early intervention/school-based service providers with appropriate permission from parents.	January 1, 2015

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



### Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Enrollee Rights

**Unique Identifier:** HCS2014IPRO-ER2

**Product:** KY Medicaid

**Compliance/Business Requirement:** The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information: K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area of Enrollee Rights.

IPRO made a recommendation that the Member Handbook should include information for members regarding contacting DCBS in the event of a birth, death or address change.

#### Summary of actions taken/to be undertaken and completion dates:

Corrective Action	Due Date
<b>KY-MMED-532 (Kentucky Medicaid Member Handbook)</b> Pages 4 and 44 of the current KY statewide member handbook includes information for members regarding contacting DCBS in the event of a birth, death or address change. Also, the DCBS contact information is included on the inside back cover as well as KDMS and other important state-related contact information.	KDMS File and Use June 19, 2014

Humana – CareSource welcomes the Department's feedback regarding this issue and our proposed corrective steps.



## Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Grievance System

**Unique Identifier:** HCS2014IPRO-GS-2

**Product:** KY Medicaid

**Compliance/Business Requirement:** The Contractor shall provide benefits until one of the following occurs:  
(2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action;

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area of Grievance System.

IPRO made a recommendation: In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and processes. The policy should include Kentucky-specific requirement of 14 days after mailing

### Summary of actions taken/to be undertaken and completion dates:

Corrective Action	Due Date
A Kentucky specific P&P will be developed for grievance and appeals and will include the specific requirement of 14 days after mailing.	1/1/2015

Humana – CareSource welcomes the Department's feedback regarding this issue and our proposed corrective steps.



**Corrective Action Plan**

**Date:** November 20, 2014

**Topic:** Grievance System

**Unique Identifier:** HCS2014IPRO-GS-3

**Product:** KY Medicaid

**Compliance/Business Requirement:** The Contractor shall provide benefits until one of the following occurs:

(3) The Cabinet issues a state fair hearing decision adverse to the Member;

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area of Grievance System.

IPRO made a recommendation: In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and processes. The policy should include the Kentucky-specific requirement, "the Cabinet issues a state fair hearing decision adverse to the Member;"

**Summary of actions taken/to be undertaken and completion dates:**

Corrective Action	Due Date
A Kentucky specific P&P will be developed and will include the specific requirement, "the Cabinet issues a state fair hearing decision adverse to the member"	1/1/2015

Humana – CareSource welcomes the Department's feedback regarding this issue and our proposed corrective steps.



### Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Grievance System

**Unique Identifier:** HCS2014IPRO-GS-4

**Product:** KY Medicaid

**Compliance/Business Requirement:** If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area of Grievance System.

IPRO made a recommendation: In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and processes. The policy should include the Kentucky-specific requirement, " the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b)."

**Summary of actions taken/to be undertaken and completion dates:**

Corrective Action	Due Date
A Kentucky specific P&P will be developed and will include the Kentucky-specific requirement, " the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b)."	1/1/2015

Humana – CareSource welcomes the Department's feedback regarding this issue and our proposed corrective steps.



## Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Grievance System

**Unique Identifier:** HCS2014IPRO-GS-5

**Product:** KY Medicaid

**Compliance/Business Requirement:** Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area of Grievance System.

IPRO made a recommendation: Requirement should be addressed in a policy/procedure.

### Summary of actions taken/to be undertaken and completion dates:

Corrective Action	Due Date
A Kentucky specific P&P will be developed and shall include all requirements pertaining to the State Fair Hearing requirements.	1/1/2015

Humana – CareSource welcomes the Department's feedback regarding this issue and our proposed corrective steps.



### Corrective Action Plan

**Date:** November 20, 2014  
**Topic:** Health Risk Assessment  
**Unique Identifier:** HCS2014IPRO-HR1

**Product:** KY Medicaid

**Compliance/Business Requirement:** Health Risk Assessment

The Contractor shall conduct initial health screening assessment of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's need for any special health care needs within ninety (90) days of Enrollment. Members whose Contractor has a reasonable belief to be pregnant shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.

**Background:**

In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area of Health Risk Assessments.

IPRO made a recommendation that Humana CareSource should consider using additional methods to encourage completion of the HRA, such as telephone follow-up. Outreach attempts should be documented and tracked.

**Summary of actions taken/to be undertaken and completion dates:**

Corrective Action	Due Date
New Member Kit, which contains a Health Risk Assessment, is sent to the new member within a week of identifying the member on the 834 Eligibility File. Tracking of Welcome Packets containing the HRA is currently available.	Current
Two-week Follow Up Mailing <ol style="list-style-type: none"> <li>1. Follow-up HRAs are sent to Members who live in the same household and all members who have not completed an HRA two weeks after initial HRA is sent.</li> <li>2. HCS will track the follow-up mailings that are sent.</li> </ol>	<ol style="list-style-type: none"> <li>1. Current</li> <li>2. March 1, 2015</li> </ol>

<p>Encouragement of HRA completions will be included in the IVR New Member Welcome calls</p> <ol style="list-style-type: none"> <li>1. IVR Welcome Call Script reminder will be developed.</li> <li>2. IVR Script will be sent to the Humana and DMS for approval.</li> <li>3. Full Implementation of IVR Welcome calls with HRA reminder.</li> <li>4. HCS will track the outbound welcome calls with reminder to complete the HRA</li> </ol>	<ol style="list-style-type: none"> <li>1. Third Quarter 2014 (Completed)</li> <li>2. October 2014</li> <li>3. January 2015</li> <li>4. January 2015</li> </ol>
<p>Eliza, Intelligent Speech Recognition Technology System will be used to assist pregnant members with scheduling prenatal care and encourage completion of the HRA.</p> <ol style="list-style-type: none"> <li>1. Investigate use of Eliza, a service incorporating intelligent speech recognition technology into a system of automated outbound phone calls, to encourage consumers to make and keep their prenatal appointments and to complete their HRA.</li> <li>2. Implement Eliza speech recognition system to encourage HRA completion.</li> <li>3. Develop a monthly Eliza report to identify the volume of pregnant member who were outreached to for a HRA completion.</li> <li>4. HCS will track Eliza prenatal calls completed and members who receive the calls.</li> </ol>	<ol style="list-style-type: none"> <li>1. Third Quarter 2014</li> <li>2. March 1, 2015</li> <li>3. March 1, 2015</li> <li>4. March 1, 2015</li> </ol>
<p>Implementation of the J &amp; J/Health &amp; Wellness interactive web based Member Health Assessment and coaching program.</p>	<ol style="list-style-type: none"> <li>1. February 16, 2015.</li> </ol>
<p>HCS will send outreach letters to all Members who have not completed an HRA informing them that the interactive web-based Member Health Assessment and coaching program is live and encouraging the Member to complete the HRA via that tool, pending approval of the member communication by KDMS. HCS will track the mailing of the outreach letters.</p>	<p>March 1, 2015</p>

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



### Corrective Action Plan

**Date:** November 20, 2014  
**Topic:** Health Risk Assessment  
**Unique Identifier:** HCS2014IPRO-HR2

**Product:** KY Medicaid

**Compliance/Business Requirement:** Health Risk Assessment

The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire.

#### Background:

In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO’s findings of non-compliance and/or minimal compliance in the area of Health Risk Assessments.

IPRO made a recommendation that Humana CareSource should consider using additional methods to encourage completion of the HRA, such as telephone follow-up. Outreach attempts should be documented and tracked. Humana-CareSource should ensure that Welcome packets are mailed within one week of enrollment/eligibility.

#### Summary of actions taken/to be undertaken and completion dates:

Corrective Action	Due Date
New Member Kit, which contains a Health Risk Assessment, is sent to the new member within a week of identifying the member on the 834 Eligibility File. Tracking of Welcome Packets containing the HRA is currently available.	Current
Two-week Follow Up Mailing <ol style="list-style-type: none"> <li>1. Follow-up HRAs are sent to Members who live in the same household and all members who have not completed an HRA two weeks after initial HRA is sent.</li> <li>2. HCS will track the follow-up mailings that are sent.</li> </ol>	<ol style="list-style-type: none"> <li>1. Current</li> <li>2. March 1, 2015</li> </ol>

<p>Encouragement of HRA completions will be included in the IVR New Member Welcome calls</p> <ol style="list-style-type: none"> <li>1. IVR Welcome Call Script reminder will be developed.</li> <li>2. IVR Script will be sent to the Humana and DMS for approval.</li> <li>3. Full Implementation of IVR Welcome calls with HRA reminder.</li> <li>4. HCS will track the outbound welcome calls with reminder to complete the HRA</li> </ol>	<ol style="list-style-type: none"> <li>1. Third Quarter 2014 (Completed)</li> <li>2. October 2014</li> <li>3. January 2015</li> <li>4. January 2015</li> </ol>
<p>Eliza, Intelligent Speech Recognition Technology System will be used to assist pregnant members with scheduling prenatal care and encourage completion of the HRA.</p> <ol style="list-style-type: none"> <li>1. Investigate use of Eliza, a service incorporating intelligent speech recognition technology into a system of automated outbound phone calls, to encourage consumers to make and keep their prenatal appointments and to complete their HRA.</li> <li>2. Implement Eliza speech recognition system to encourage HRA completion.</li> <li>3. Develop a monthly Eliza report to identify the volume of pregnant member who were outreached to for a HRA completion.</li> <li>4. HCS will track Eliza prenatal calls completed and members who receive the calls.</li> </ol>	<ol style="list-style-type: none"> <li>1. Third Quarter 2014</li> <li>2. March 1, 2015</li> <li>3. March 1, 2015</li> <li>4. March 1, 2015</li> </ol>
<p>Implementation of the J &amp; J/Health &amp; Wellness interactive web based Member Health Assessment and coaching program.</p>	<ol style="list-style-type: none"> <li>1. February 16, 2015.</li> </ol>
<p>HCS will send outreach letters to all Members who have not completed an HRA informing them that the interactive web-based Member Health Assessment and coaching program is live and encouraging the Member to complete the HRA via that tool, pending approval of the member communication by KDMS. HCS will track the mailings of the outreach letters.</p>	<p>March 1, 2015</p>

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



## Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Quality Assessment and Performance Improvement: Measurement and Improvement

**Unique Identifier:** HCS2014IPRO-MI-1

**Product:** KY Medicaid

**Compliance/Business Requirement:** 19.1 QAPI Program #1

As the Contractor will provide Behavioral Health services, the Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area of Integration of BH with medical health. The QI program is described briefly in the QI Program Descriptions. The reader is referred to the partner/delegate Beacon program descriptions:

- Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 7)
- 2013 Quality Improvement Program, Humana CareSource (p. 18)

The following Beacon documents address monitoring, evaluation and quality improvement:

- Beacon Health Strategies 2013 Quality Management and Improvement Program Description (p. 17-21)
- 2013 HCS QAPI Work Plan – Delegate Beacon (Behavioral Health) Work Plan

However, BH services evaluation is not further addressed in Humana CareSource documents, such as the Annual Program Evaluation (with the exception of the BH PIP). The 2014 Beacon Program Evaluation is not available for review; it is scheduled for committee review in July 2014.

Evaluation of BH services was discussed during the onsite review. The MCO's subcontractor, Beacon, has a different schedule than the Contractor for completing/approving the annual program evaluation. Since this information would not be available to Humana CareSource when preparing the MCO's annual program evaluation, the MCO intends to use information obtained over the course of the year from Beacon in completing its evaluation. The QAC minutes include review and discussion of Beacon metrics on a regular basis.

**I PRO made a recommendation** that Humana CareSource’s QI Program Description and Program Evaluation should address behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services.

**Summary of actions taken/to be undertaken and completion dates:**

Corrective Action	Due Date
The 2014 Program Evaluation will include a full evaluation of behavioral health integration, performance metrics, and analysis and actions to address the quality behavioral services. This evaluation will integrate quarterly Beacon Health Services performance metrics and the Beacon Health Services annual evaluation information. The 2014 QI Program Evaluation will be completed and submitted to the I PRO and DMS by the 1 <sup>st</sup> week of February 2015.	February 6, 2015.
The 2014 Program Description will be updated to fully include behavioral health integration and metrics to be used to evaluate performance. While this info has been provided in the Beacon Health Services documents, the information will be incorporated into the Humana-CareSource (HCS) QI Program Descriptions. The updated 2014 QI Program Description will go back to the HCS Quality Assessment Committee for review and approval in December 2014. The changes made to the 2014 QI Program Description will be integrated into the 2015 QI Program Description as well. This document will go to the HCS Quality Assessment Committee in the 1 <sup>st</sup> Qtr. 2015.	Review and approval at the 4 <sup>th</sup> Qtr. QAC December 2014.

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



## Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Pharmacy

**Unique Identifier:** HCS2014IPRO-PB1

**Product:** KY Medicaid

**Compliance/Business Requirement:** Pharmacy Rebate Administration – 31.4. The Patient and Affordable Care Act (PPACA) signed into law in March 2010 requires states to collect CMS level rebates on all Medicaid MCO utilization. In order for the Department to comply with this requirement the Contractor shall be required to submit NDC level information including J-code conversions consistent with CMS requirements. The Department will provide this Claims level detail to manufacturers to assist in dispute resolutions. However, since the Department is not the POS Claims processor, resolutions of unit disputes are dependent upon cooperation of the Contractor. The Contractor shall assist the Department in resolving drug rebate disputes with the manufacturer. The Contractor also shall be responsible for rebate administration for pharmacy services provided through other settings such as physician services.

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area of Pharmacy Rebate Administration – 31.4.

IPRO made a recommendation that Humana CareSource should develop a policy/procedure addressing the following:

- assist the Department in resolving drug rebate disputes with the manufacturer
- be responsible for rebate administration for pharmacy services provided through other settings such as physician services.

**Summary of actions taken/to be undertaken and completion dates:**

<b>Corrective Action</b>	<b>Due Date</b>
Develop policy addressing that Humana-CareSource shall assist the Department with drug rebate manufacturer disputes.	8/28/2014
Develop a policy regarding Humana-CareSource's responsibility for rebate administration for pharmacy services provided through other settings such as physician services.	2/1/2015

Humana – CareSource welcomes the Department's feedback regarding this issue and our proposed corrective steps.



## Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Provider Credentialing and Recredentialing

**Unique Identifier:** HCS2014IPRO-PC-1

**Product:** KY Medicaid

**Compliance/Business Requirement:** 27.2 Provider Credentialing and Recredentialing

The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:

E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area that the 2013 Credentialing Policy does not addresses this requirement. IPRO also noted that during its audit, 20/20 credentialing files were compliant with this requirement.

IPRO made a recommendation to update the 2013 Credentialing Policy to specifically address the requirement of a professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age.

**Summary of actions taken/to be undertaken and completion dates:**

<b>Corrective Action</b>	<b>Due Date</b>
The Kentucky Medicaid Credentialing and Recredentialing policy (CR102) has been revised to state the following: "Credentialing Operations will verify a provider's professional board certification, eligibility for certification, or graduation from a training program to service children with special health care needs under twenty-one (21) years of age before making a credentialing or recredentialing decision".	10/20/2014

Humana – CareSource welcomes the Department's feedback regarding this issue and our proposed corrective steps.



## Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Provider Credentialing and Recredentialing

**Unique Identifier:** HCS2014IPRO-PC-2

**Product:** KY Medicaid

**Compliance/Business Requirement:** 27.2 Provider Credentialing and Recredentialing

The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:

- A. A current valid license or certificate to practice in the Commonwealth of Kentucky.

**Background:** In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area that the 2013 Credentialing Policy does not address licensure/certification in the Commonwealth of Kentucky, specifically. The 2013 Credentialing Policy lists requirements for state licensure and verifying state licensure in general. IPRO also noted that during its audit, 20/20 credentialing files were compliant with this requirement.

IPRO made a recommendation to update the 2013 Credentialing Policy to specifically address the requirement that the practitioner have a current valid license or certificate to practice in the Commonwealth of Kentucky.

**Summary of actions taken/to be undertaken and completion dates:**

<b>Corrective Action</b>	<b>Due Date</b>
The Kentucky Medicaid Credentialing and Recredentialing policy (CR102) has been revised to state the following: "When a provider practices in the state of Kentucky, Credentialing Operations will verify the provider has a current valid license or certificate to practice in the Commonwealth of Kentucky before making a credentialing or recredentialing decision. Credentialing Operations will verify out of state providers have a current valid license issued by the state in which they practice".	10/20/2014

Humana – CareSource welcomes the Department's feedback regarding this issue and our proposed corrective steps.



### Corrective Action Plan

**Date:** November 20, 2014

**Topic:** Utilization Management

**Unique Identifier:** HCS2014IPRO-UM1

**Product:** KY Medicaid

#### Compliance/Business Requirement:

20.7 Adverse Actions Related to Medical Necessity or Coverage Denials

The Contractor shall give the Member written notice that meets the language and formatting requirements for Member materials, of any action (not just service authorization actions) within the timeframes for each type of action pursuant to 42 CFR 438.210(c). The notice must explain:

(d) The Member's right to request a State hearing;

#### Background:

In March 2014, IPRO conducted the 2013 EQR Audit on behalf of the Department. As requested by the Department, this CAP is the result of IPRO's findings of non-compliance and/or minimal compliance in the area of Utilization Management. IPRO made a recommendation that Humana-CareSource's initial adverse determination notice should include reference to the member's right to a State hearing if the member requests an appeal and the appeal upholds the decision.

#### Summary of actions taken/to be undertaken and completion dates:

Corrective Action	Due Date
Update the member denial letter with the appropriate language outlining the member's rights to file a state fair hearing.	Complete 10/08/2014
Letter review with legal	Complete

	10/10/2014
Submit letter through internal Communications CRF to be filed with the state	Complete 10/10/2014
KDMS approval (*can take up to 60 days)	12/10/2014
Submit approved letter template to MCNA, Pharmacy and Clinical Operations for implementation	12/10/2014
Letter fully implemented within 20 business days	01/01/2015

Humana – CareSource welcomes the Department’s feedback regarding this issue and our proposed corrective steps.



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

275 East Main Street, 6W-A  
Frankfort, KY 40621  
P: 502-564-4321  
F: 502-564-0509  
[www.chfs.ky.gov](http://www.chfs.ky.gov)

**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

November 21, 2014

Mark Carter  
Passport Health Plan  
5100 Commerce Crossing Drive  
Louisville, KY 40229

Dear Mr. Carter,

The Division of Program Quality & Outcomes is in receipt of the response developed for PHP2014HTL-BH-1 (regarding 33.6 Behavioral Health Services Hotline) dated November 10, 2014. Please be advised that the response is accepted.

If I may be of additional assistance, please contact me at the above-referenced telephone number. Thank you for your attention and cooperation during our review.

Sincerely,

A handwritten signature in cursive script that reads "Patricia Biggs, RN".

Patricia Biggs, R.N., C.P.C.  
Director of Program Quality and Outcomes  
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services  
Christina Heavrin, General Counsel, Cabinet for Health and Family Services  
Elizabeth Justus, Manager, Managed Care Oversight, Department of Medicaid Services

# PASSPORT HEALTH ★ PLAN



5100 COMMERCE CROSSINGS DRIVE  
LOUISVILLE, KY 40229  
502-585-7900 / 800-578-0603  
WWW.PASSPORthealthplan.com

December 15, 2014

Ms. Patricia Biggs  
Director of Program Quality and Outcomes  
Department for Medicaid Services  
275 East Main Street  
Frankfort, KY 40621



RE: 2014 IPRO Compliance Review – Corrective Action Plans  
PHP2014IPRO-MI-1, PHP2014IPRO-MI-2, PHP2014IPRO-GS-1, PHP2014IPRO-GS-2,  
PHP2014IPRO-CR-1, PHP2014IPRO-CR-2, PHP2014IPRO-AC-1, PHP2014IPRO-UM-1,  
PHP2014IPRO-UM-2, PHP2014IPRO-CM-1, PHP2014IPRO-CR-2, PHP2014IPRO-CM-3,  
PHP2014IPRO-CM-4, PHP2014IPRO-CM-5, PHP2014IPRO-MR-1, PHP2014IPRO-BH-1

Dear Ms. Biggs:

Please accept this correspondence as Passport Health Plan's Corrective Action Plan (CAP) proposal to address the requirements in the above-referenced correspondence dated October 14, 2014. The CAP's proposed are a result of IPRO's findings, on behalf of the Department for Medicaid Services (DMS), during the 2013 Medicaid Compliance Review conducted in March, 2014.

Following IPRO's review, their findings reflect eight (8) of the sixteen (16) substantive areas met full compliance. It is our goal to bring all other areas reviewed to full compliance.

In accordance with Section 21.5 (C) of Passport's Contract with DMS, attached are the updated CAP tools that were provided by IPRO including Passport's response, corrective action plan proposals and any additional documentation in reference to the proposals.

All documentation has been loaded to SharePoint and IPRO's secure web portal. The materials submitted are proprietary and confidential and we respectfully request that they be utilized accordingly.

Sincerely,

Kim Myers, CCEP  
Compliance Director

Enclosure

cc: Passport Mark Carter, David Henley  
CHFS/DMS Stephanie Patchen, Lawrence Kissner, Christina Heavrin, Elizabeth Justus,  
Jan Thornton  
IPRO Chuck Merlino



## CR 21.0 Non-Participating Provider Claims Set-Up

		<b>Policy/Procedure</b>	
<b>Policy Name: Non-Participating Provider Claims Set-Up</b>		<b>Policy Number: CR 21.0</b>	
<b>Date of Next Annual Review: December 10, 2015</b>		<b>Original/Issue Date: 2/19/14</b>	
<b>Approved By: XXXXXXXX</b>		<b>Title: Manager, Provider Network Management</b>	
<b>Signature: SIGNATURE ON FILE</b>		<b>Date Approved: 12/10/14</b>	
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>	
New (Date policy was created)	<input type="checkbox"/>		
Reviewed (No changes to policy)	<input type="checkbox"/>		
Revised (Content changes made to policy)	<input checked="" type="checkbox"/>	12/10/14	
Retired (Policy no longer active)	<input type="checkbox"/>		
<b>APPLICABILITY</b>			

This policy is applicable to all Passport Health Plan (PHP) associates, temporary staff and interns.

### PURPOSE

The purpose of this policy is to define the method by which claims are processed for providers who are not contracted with Passport Health Plan, but are providing services to plan members.

### POLICY

Under certain circumstances, it may be necessary to process claims for services delivered by a provider who is not contracted, and does not wish to be contracted, as a participating provider with Passport Health Plan. This occurs when services deemed medically necessary are not available within the contracted network, or if a member must utilize services outside of Passport's service region. This also can occur when medically necessary services are available within the network, but the rendering provider is non-participating, such as hospital-based providers who specialize in anesthesia, radiology, pathology or emergency medicine.

### DEFINITION(S)

**Non-Participating Provider:** A provider who has not been credentialed and/or contracted to become a participant in Passport Health Plan's provider network.

**Participating Provider:** A provider who is credentialed and contracted with Passport Health Plan's provider network.

**Non-Participating Provider Set-Up Form:** The form to be used by Provider Maintenance to obtain the necessary information to establish a provider in Passport Health Plan's claims system prior to the services being rendered.

**Non-Participating Provider Letter of Agreement:** A letter that may be necessary prior to services being rendered that outlines the agreed upon services and reimbursement terms. This letter requires

## CR 21.0 Non-Participating Provider Claims Set-Up

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the provider's signature.

DMS: Department for Medicaid Services

### **PROCEDURE**

1. The provider may contact Provider Network Management, Provider Services, the Provider Claims Services Unit (PSCU), or Utilization Management (UM) to initiate the process to be loaded as a non-participating provider in Facets.
  2. If initiated in Provider Network Management, PCSU, or Provider Services, the process will be as follows:
    - The non-par setup form will be sent to the provider.
    - The provider will fax or email the non-par setup form and W-9 to Amerihealth Provider Maintenance as noted on the form.
    - Once loaded in Facets, Amerihealth Provider Maintenance will fax or email the non-par setup form back to the provider with the newly assigned provider number and effective date noted on the form.
  3. If initiated in UM, the process will be as follows:
    - The UM representative will obtain as much information from the provider to issue the authorization.
    - The non-par setup form will be faxed to the provider with the authorization number listed at the top. The representative will remind the provider that they must complete the form and return it along with their W-9 to Amerihealth Provider Maintenance. The representative will also remind the provider that without the required information their authorization will not be deemed complete.
    - The provider will fax or email the non-par setup form and W-9 to Amerihealth Provider Maintenance as noted on the form.
    - Once loaded in Facets, Amerihealth Provider Maintenance will fax or email the non-par setup form back to the provider with the provider's newly assigned provider number and effective date noted on the form.
  4. If a provider contracting opportunity exists, UM will notify Provider Network Management regarding the non-par authorizations that occur.
  5. Non-par provider utilization reports are available on Passport Health Plan Intranet which may also be utilized by Provider Network Management to determine if a provider contracting opportunity exists.
  6. If appropriate, Provider Network Management will contact the provider and attempt to establish a formal contractual participating relationship.
    - A. If the provider is interested in participation, contracts and enrollment packet will be sent to the provider. The completed enrollment packet will be received by Passport Health Plan's Provider Enrollment Department for processing.
    - B. Non-Participating providers will be paid based on an established Letter of Agreement or the PHP non par fee schedule which is no greater than 90% of the Medicaid fee-for-
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## CR 21.0 Non-Participating Provider Claims Set-Up

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service rate.

### **CROSS REFERENCES/REFERENCE MATERIALS**

Non Par Set Up Form

### **REVIEW AND REVISION DATES (Annually at a minimum)**

April 2006, March 2007, April 2008, April 2009, March 2010, March 2011, March 2012,  
February 2014, December 2014

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End of Policy

**CR 21.0 Non-Participating Provider Claims Set-Up**

		<b>Policy/Procedure</b>
<b>Policy Name: Non-Participating Provider Claims Set-Up</b>		<b>Policy Number: CR 21.0</b>
<b>Date of Next Annual Review: December 10, 2015</b>		<b>Original/Issue Date: 2/19/14</b>
<b>Approved By: Richelle Burress</b>		<b>Title: Manager, Provider Network Management</b>
<b>Signature: SIGNATURE ON FILE</b>		<b>Date Approved: 12/10/14</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
<b>New</b> (Date policy was created)	<input type="checkbox"/>	
<b>Reviewed</b> (No changes to policy)	<input type="checkbox"/>	
<b>Revised</b> (Content changes made to policy)	<input checked="" type="checkbox"/>	12/10/14
<b>Retired</b> (Policy no longer active)	<input type="checkbox"/>	
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## CR 21.0 Non-Participating Provider Claims Set-Up

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  5. Non-par provider utilization reports are available on Passport Health Plan Intranet which may also be utilized by Provider Network Management to determine if a provider contracting opportunity exists.
  6. If appropriate, Provider Network Management will contact the provider and attempt to establish a formal contractual participating relationship.
    - A. If the provider is interested in participation, contracts and enrollment packet will be sent to the provider. The completed enrollment packet will be received by Passport Health Plan's Provider Enrollment Department for processing.
    - B. Non-Participating providers will be paid based on an established Letter of Agreement or the PHP non par fee schedule which is no greater than 90% of the Medicaid fee-for-
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## CR 21.0 Non-Participating Provider Claims Set-Up

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service rate.

### **CROSS REFERENCES/REFERENCE MATERIALS**

Non Par Set Up Form

### **REVIEW AND REVISION DATES (Annually at a minimum)**

April 2006, March 2007, April 2008, April 2009, March 2010, March 2011, March 2012,  
February 2014, December 2014

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End of Policy

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- c. Call Center Phone Scripts
- d. Clinical Functions - Woburn based
- e. Integrated Partnership Model
- f. Member requesting their Medical Record

**III. Clinical Algorithms**

- a. Emergent, Urgent and Routine Call Procedures
- b. Member at Risk Flow
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- d. Request for help finding a therapist - Routine
- e. Request for an Urgent Appointment
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## **Beacon Health Strategies**

### **Procedures for Emergent, Urgent and Routine calls**

From time to time Member Services Representatives (MSRs) and / or Beacon Clinicians will receive calls from members who present with behavioral health situations or conditions that require urgent or emergent responses. MSR's are in a key position to identify those members needing immediate assistance and arranging for the member to get the help the member needs. While MSR's can offer reassurance through their calm and professional handling of all member calls, it is important that **Member Services Representatives never offer medical / clinical advice or attempt to diagnose a member's condition.**

- **Emergent (Emergency)** – a member states that it is an emergency or believes that there is an immediate (high) risk to the member's health or someone else's safety.
- **Urgent** – a member is in distress or expressing a life threatening situation and assessed to be at risk of harming themselves or someone else.
- **Routine** – a member is seeking or is in need of an appointment, but is at low risk of harming themselves or someone else.

#### **EMERGENCY CALL PROCEDURES**

**Emergency** - If a MSR receives a call from a member regarding an **emergency** the following procedures are followed:

- ✓ Instruct the member to call 911 *or*
- ✓ Instruct the member to go to the nearest emergency room or hospital *or*
- ✓ Instruct the member to go to the nearest location where they can seek immediate medical attention

**Life Threatening Situation** - If a MSR receives a call from a member who is presenting a **potentially life threatening situation, such as expressing suicidal thoughts or thoughts of harming someone else**, the following procedures is followed:

- ✓ **Keep the member on the phone. Do not put the member on hold or transfer the member to Beacon's telephone queue.**
  - ✓ As early in the call as possible, **get the telephone number and the location from where the member is calling.** Enter into FlexCare.
  - ✓ **Always remain calm with the caller.**
  - ✓ Engage the caller in conversation, but do not make commitments or promises to the caller. **Ask the caller if there is anyone else with them.**
- ✓ Alert a clinician or another MSR via instant message (IM), or any other nearby employee, that you need assistance from a Beacon Clinician. You can do this by whatever means works, such as standing up to get someone's attention, waving your arms, tapping on the cubicle wall, etc.
- ✓ Advise the caller that you are getting someone (a Clinician) who will be able to assist the member.
- ✓ Be aware that you will need to remain on the phone until a Clinician comes to your desk to take the call and/or until emergency services arrive at the member's location.

Following this type of call you may find it helpful to discuss the call with one of the Clinicians or your supervisor or manager. This will provide you with an opportunity to express any feelings or concerns about the call and to receive support from an individual who is accustomed to handling similar situations.

## Beacon Health Strategies Procedures for Emergent, Urgent and Routine calls

Following is an algorithm script to be used by Member Service Representatives and Beacon Clinicians as appropriate. This script should be used in both Mental Health and Substance Use Disorder inquiries.

Script -“Good morning (afternoon, evening), Member Services, this is (your name) can I help you?”

Member			Provider (PCP or Behavioral Health Provider)	
<i>Type of request</i>	<i>Level of Urgency</i>	<i>Responsible Party/who is able to take the call</i>	<i>Type of request</i>	<i>Responsible Party/who is able to take the call</i>
Member reports a medical emergency or there seems to be an immediate threat to member’s health or safety	Emergent	Member Services follows Beacon Emergency Call Procedures	Provider reporting member is experiencing a medical emergency or that there is an immediate threat to member’s health or safety.	Member Services transfers call to Beacon clinician. Beacon clinician and provider work collaboratively to call 911.
Member presents a potentially life-threatening situation (such as expressing suicidal thoughts or thoughts of hurting someone else)	Emergent	Member Services follows Beacon Emergency Call Procedures	Provider reporting member is experiencing a potentially life-threatening situation (such as expressing suicidal thoughts or thoughts of hurting someone else)	Member Services transfers call to Beacon clinician. Beacon clinician and provider work collaboratively to get member to closest ER or ESP.
Member looking for urgent outpatient services. Member either verbalizes that they need an urgent appointment or member’s voice seems upset or anxious	Urgent	Member Services transfers call to Beacon clinician to assess level of urgency.	Provider asking for an urgent appointment for member	Member Services transfers call to Beacon clinician. Beacon clinician will talk with the provider, gather information, including member’s phone # and then call the member to assess the level of urgency.
Member seems under the influence, looking for detox	Urgent	Member Services transfers call to Beacon clinician to assess level of urgency		
			Call from clinician at ER, ESP, or provider’s office asking to precertify an admission for acute or diversionary services, or requesting clinical discussion regarding a member they are evaluating	Member Services transfers call to Beacon clinician; if none immediately available, takes information on Clinical Response Log and gives to next available Beacon clinician
Member checking eligibility/benefits	Routine	Member Services	Provider checking eligibility/benefits	Member Services
Member checking for PA (prior approval) number, authorization	Routine	Member Services	Provider checking for PA (prior approval) number, authorization number	Member Services

**Beacon Health Strategies**  
**Procedures for Emergent, Urgent and Routine calls**

number				
Member looking for outpatient services (member's voice seems in control, not upset or anxious)	Routine	Member Services	Provider looking for a names of participating providers	Member Services
Member asking for names of detox facilities	Routine	Member Services, with the exception of Fallon Commercial Members, these calls are transferred to Beacon clinician to assess	Provider asking for names of detox facilities	Member Services
Member asking for specific information about admission criteria, levels of care, treatment details, length of stay, etc.	Routine	Member Services transfers call to Beacon clinician	Provider asking for specific information about admission criteria, levels of care, treatment details, length of stay	Member Services transfers call to Beacon clinician
Member requesting out of network services	Routine	<b>Outpatient</b> - Member Services explains OON criteria; if member seems to meet criteria, or if member is insistent, Member Services completes OON form for outpatient team  <b>Inpatient</b> - Member Services transfers call to Beacon clinician	Provider requesting out of network services	<b>Outpatient</b> – Member Services explains OON criteria; if member seems to meet criteria, or if member is insistent, Member Services completes OON form for outpatient team  <b>Inpatient</b> - Member Services transfers call to Beacon clinician
Member calling to complain about billing issues	Routine	Member Services completes billing complaint form and forwards to Manager of Member Services	Provider calling to complain about billing issue	Member Services completes billing complaint form and forwards to Manager of Member Services
Member calling to complain about issue other than billing (quality of care, access to care, Beacon network, etc.)	Routine	Member Services follows Beacon Complaint Procedures	Provider calling to complain about issue other than billing (quality of care, access to care, Beacon network, etc.)	Member Services follows Beacon Complaint Procedures
			Provider asking for assistance with filling out the outpatient forms	Member Services, unless questions are clinical in nature, Member Services transfers call to outpatient coordinator
			Provider calling to report an incident	Member Services transfers call to Beacon clinician that covers facility

Kentucky: Passport Health Plan  
CHEAT SHEET

Beacon Health Strategies: Passport: 855-834-5651

Passport Health Plan: Passport: 1-800-578-0603

In KY Passport Health Plan covers Medicaid members - adults/kids/adolescents; the plan has a small number of dual eligible members where Medicare is primary.

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MH Services (IP & OP) - all services available to Passport

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SA by some (Lincoln Trail, Brook KMI, and CMHC programs as with Seven Cos and Pathways)

KY LOC	KY CODES	COMMENTS
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PROFEE	PROFEE	Some inpatient facilities do not have all inclusive rates for all services provided while the member is in the hospital. In order for professional fees to get paid, clinicians will enter an auth with the procedure code "PROFFEE" with a provider name as "Any Provider" (Provider # 1) along with the inpatient auth. It is 1 unit per day for the same date span as the inpatient auth. No PA letters will print. <b>Careful</b> ~ the pop up will only come up on original auth, if you cancel auth & do another auth then pop up won't prompted you for PROFEE.

INSAN	INSAN	<ul style="list-style-type: none"> <li>• KY Plans cover detox on a Psych Floor or Free Standing Psych Hospital (only under 21 and over 65); also cover with JADAC (Jefferson Alcohol/Drug Center- an affiliate of Seven Counties Services) and Recovery Works (Pinnacle dba Recovery Works)</li> <li>• KY Plans: detox on medical floor covered by Plan</li> </ul>
CSU - Adults	S9485	<ul style="list-style-type: none"> <li>• Available to adults and will be telephonically reviewed.</li> <li>• 2 BD allowed to call in pre-cert</li> </ul>
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Extended Care Unit (EPSDT- under age 21) - Mental Health	<p>Many codes used by Providers: SO: USE UMBRELLA CODE: EPSDT Resi</p> <ul style="list-style-type: none"> <li>• T2048HE (MH): OLOP, Rivendell, River Valley, The Brook Dupont/KMI (MH and Eating d/o), Lincoln Trail (MH, SO, SR0, The Ridge</li> <li>• H2029 (SO): Rivendell,</li> <li>• H0018HE (MR SO): Rivendell)</li> </ul>	<ul style="list-style-type: none"> <li>• Must have been IP at least 3x in past 12-14 months to be eligible (MH/Forensic especially)</li> <li>• ECU might be "target" issue specific: resi rehab for CD, sexual offenders (SO - Rivendell Hospital only male), sexual reactive (SR - Lincoln Trail Hospital only female), most coded T2048HE but few coded different (Rivendell). We will have umbrella code for EPSDT Resi which will cover all EPSDT inpatient services except chemical dependency. This will include ECU, sex offender units etc.</li> <li>• "Target" specific does not have to meet the IP hx for past year</li> <li>• Considered long-term (2-4 months)</li> </ul>
PRTF (under age 21 only)	PRTF	<ul style="list-style-type: none"> <li>• Psychiatric Residential Treatment Facility - typically for aggressive/behavioral kiddos</li> </ul>
SA REHAB - Adults	128/ H0018	<ul style="list-style-type: none"> <li>• Adults and any adolescents over 18 (per provider assessment)</li> </ul>
SA REHAB -Kids (EPSDT SA - under age 21)	<ul style="list-style-type: none"> <li>• T2048 HF (7 counties &amp; Pathways Hillcrest)</li> <li>• H2036 (Rivendell, Ridge Behavioral, The Brook KMI, United Health Care of Hardin &amp; Cumberland Hall, KY River Community Care</li> </ul>	<ul style="list-style-type: none"> <li>• Kiddos under age 21</li> <li>• No longer EPSDT only service, all children can go even with KCHIP III</li> <li>• Considered long-term (2-4 months)</li> </ul>

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PHP	913/H0035	<ul style="list-style-type: none"> <li>Covered for all members - both SA and MH</li> </ul>
Assertive Community Treatment (ACT)- MH only	H0040	<ul style="list-style-type: none"> <li>Covered for all members with SPMI/co-occurring disorders</li> </ul>
Mobile Crisis	S9484	<ul style="list-style-type: none"> <li>Mobile Crisis - no auth required</li> </ul>

**\*CSR Team to cover: step downs, Post reviews (beyond 1BD).**

### COURT ORDERS

Beacon is required to cover Court Ordered treatment under MIW for members 21 and younger and 65 and older, but other court orders are subject to medical necessity.

### Community Support Services

With the approval of expansion services, KY now offers a host of diversionary options for PHP members: IOP, Partial Hospital, Crisis Stabilization Unit SA OP Tx (individual/group)

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**During regular business hours, please review KY potential denials with KY licensed MDs - Dr. Haas and Dr. Testani. If neither are available, review with any BHS MD, but KY MD must concur with denial. Afterhours clinicians can review with the BHS doctor that is on the schedule.**

### OON vs INN common questions

If a provider is In Network and calls in precert late (after 1BD) and it **MEETS LOC** follow **ADMINISTRATIVELY DENIAL PROCESS:** auth day 1 (day of admission), administratively deny day 2 until the day of the precert was called in, then authorized day that the precert was completed going forward.

If case is called in late (after 1BD) and **DOES NOT** meet loc from day 1, the whole Inpatient admission can be denied from day 1 whether in or out of network.

**If out of network, we cannot administratively deny, but we can clinically deny from day 1.**

NOTE: KY IN Network providers have 1 business day to contact BHS for precerts/admission.

Service Description	Service Code	Unit Value	Service Limits
Individual Therapy (For Behavioral Health Professionals)	90832 90834 90837 Umbrella Code: IMPPLUS OP	30 minutes 45 minutes 60 minutes	Max. 4 combined hours per day of Individual and Collateral therapy Max. 16 combined hours per week of Individual and Collateral therapy
Individual OR Collateral Therapy (For Behavioral Health Professionals under Clinical Supervision)	H0004 IP	15 minutes	Max. 16 <b>combined units</b> per day of Individual and Collateral therapy Max. 48 <b>combined units</b> per week of Individual and Collateral therapy
Individual Therapy-with Pharmacologic Management (Psychiatrist Only)	Utilize Individual Therapy Codes plus 99213, 99214, 99215	Level III Level IV Level V	Max 2 hours for initial psychiatric visit Max 1 hour per follow up psychotherapy session with medication management
Behavioral Health Evaluation	T1023 IP	1 Hour	Max 5 units per evaluation
Collateral Service	90887 IP	15 minutes	Max. 4 <b>combined hours</b> per day of Individual and Collateral therapy Max. 16 <b>combined hours</b> per week of Individual and Collateral therapy
Group Therapy	90853 IP	15 minutes	Max 12 units per day Max 36 units per week

Service Description	Service Code	Unit Value	Service Limits
Targeted Case Management	T2023 IP	1 month	Minimum 4 contacts per month which include: <ul style="list-style-type: none"> <li>• 1 face to face with client – minimum of 30 minutes</li> <li>• 1 face to face with parent/guardian – minimum of 30 minutes</li> </ul>

			<ul style="list-style-type: none"> <li>2 additional contacts – minimum of 30 minutes combined</li> </ul>
Day Treatment	T2012 IP	1 Hour	Max 7 hours per day
Partial Hospitalization	H0035 IP	30 minutes	Max 5 hours per day unless otherwise approved by SHPS
Intensive Outpatient	S9480 IP	1 hour	Max 3 units per day Mas 15 units per week
Therapeutic Summer Program	H2019 IP	15 minutes	Max 24 units per day
Therapeutic After School	H2019 IP	15 minutes	Mas 24 units per day
Crisis Stabilization	S9485 IP	1 day	Max 10 consecutive units
Therapeutic Child Support: Parent-to-Parent Para or Professional	H2021 IP Umbrella Code: IMPPLUS TS	15 minutes	Max 16 units per day
Therapeutic Foster Care	S5145 IP	1 day	3-5 days initial/continued stay
Therapeutic Group Resi	S5145HQ	1 day	7 days initial/7-14 continued stay

### Crisis Numbers/After Hours

The state of KY requires that health plans have a 24 hour crisis line with access to clinicians. We are required to assist members in getting face to face services in the community in the event of a crisis. These services can be accessed through the community mental health centers below.

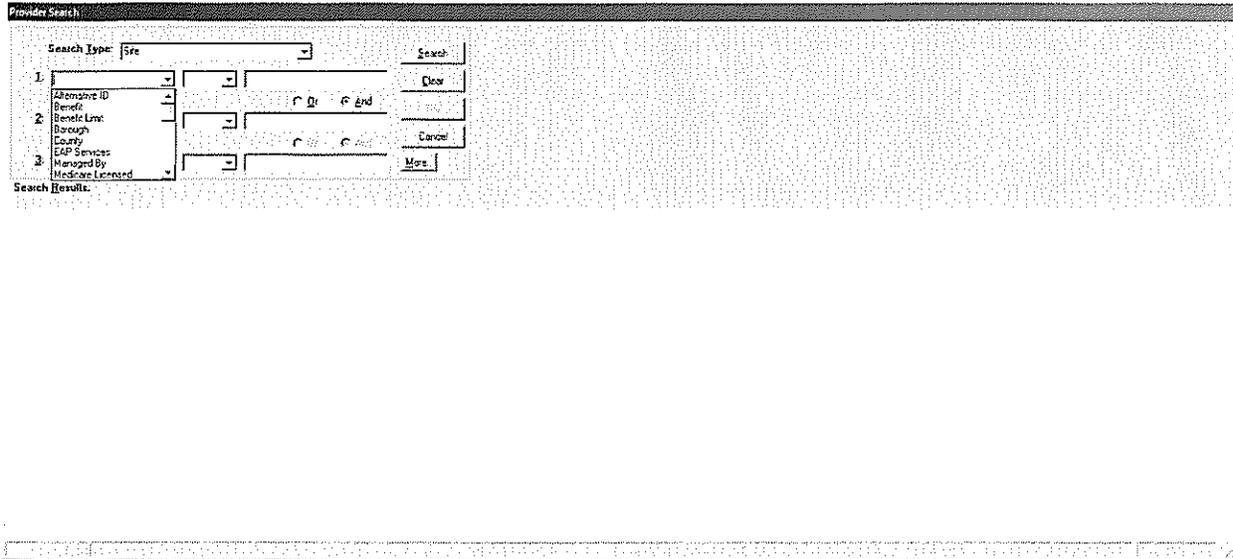
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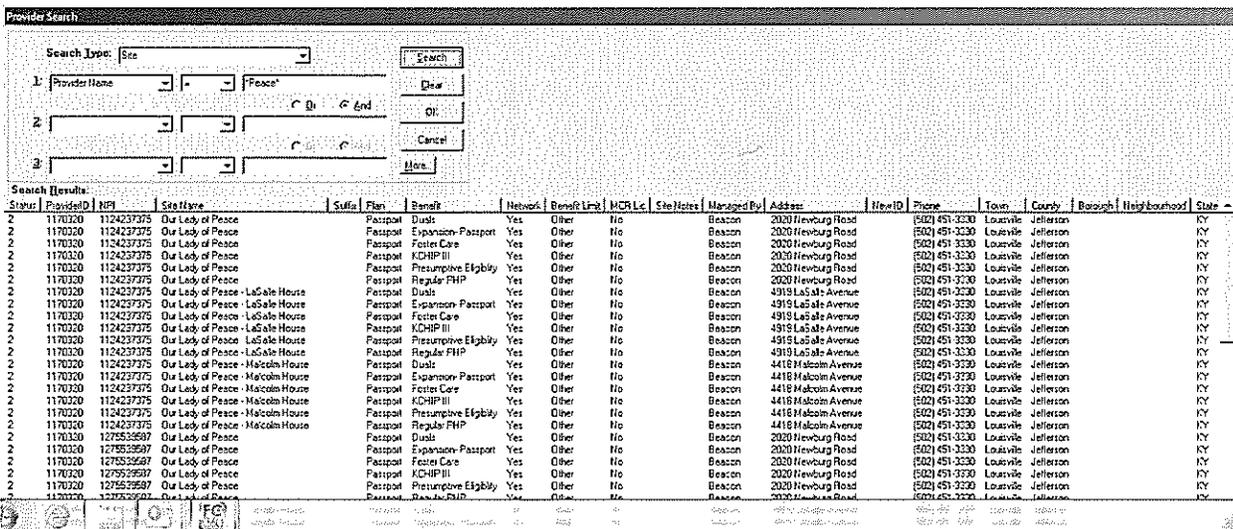
CMHC/Region	Crisis Line
Four Rivers Behavioral Health	Office: 270-442-7121; 1-866-316-8307

	Crisis No.: 800-592-3980
Pennyroyal Regional Center	Office: 270-886-2205 Crisis No.: 877-473-7766 (outside Christian Co.) 270-881-9551 (in Christian Co.)
River Valley Behavioral Health	Office: 270-684-0696 Crisis No.: 800-433-7291 or 270-684-9466
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Communicare, Inc	Office: 270-360-0419 Crisis No.: 270-360-0419 ; 1-800-641-4673
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Kentucky River Community Care	Office: 606-666-9006 Crisis No.: Crisis: 800-262-7491; Rape: 800-375-7273
Cumberland River	Office: 606-528-7010 Crisis No.: Call Collect: 606-864-2104
Adanta	Office: 606-679-4782 Crisis No.: 800-633-5599
Bluegrass	Office: 859-253-1686 Crisis No.: 800-928-8000
<b>MOBILE CRISIS EVALUATIONS</b>	
The Brook KMI	
Lincoln Trail Behavioral Health Hospital	

**Member Service Representative Training in FlexCare to identify providers by name, community, etc.**



Member Service Representatives are trained in how to navigate FlexCare, the Beacon proprietary system for authorizations, claims payment, network, provider network, etc. Staff are able to search for Providers, using limited information with asterisks. The example below is searching for one of the high volume providers.



Staff can also search by address, county or city to find a provider near a Member's home community. If there are no in-network providers, staff will refer to the local market Case Management staff to support an out of network request for services (ex. When a member is seeking a psychiatrist in a rural area).

**Kentucky: Passport Health Plan**  
**CHEAT SHEET**

**Beacon Health Strategies:** Passport: 855-834-5651

**Passport Health Plan:** Passport: 1-800-578-0603

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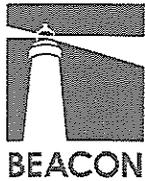
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MOBILE CRISIS EVALUATIONS	
The Brook KMI	
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<b>BEACON HEALTH STRATEGIES</b>		<b>POLICIES AND PROCEDURES</b>	
<b>Policy #:</b> UM 62.28		Page 1 of 8	
<b>Title:</b> Member Services and Clinical Referral and Triage Process			

Date Initiated: September 1998	Initiator: D Zeh
Date Revised: 11/98; 11/99; 5/00; 8/00; 3/01; 11/01; 11/02; 7/03; 1/04; 5/05; 6/06; 6/07; 6/08; 11/08; 11/09; 11/10; 11/11; 1/12; 4/12; 8/12; 12/12; 8/13; 4/14;	Reviewer: H Spikol; B Krueger; D Watson; J Found; D Birt; J Kaufman
CMC Review/Approval Date: 4/25/14	QIC Review/Approval Date: 4/29/14
Annual Review: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Next Annual Review Date: 4/30/15
Approved by: BHS VP for Medical Affairs / Director of Quality / Management and Improvement	Approval Signature on File

▲ This policy and procedure applies when Beacon is delegated network management and triage and referral processes.

**POLICY:**

It is the policy of Beacon Health Strategies, LLC (Beacon) to provide a timely response to Members requesting clinical intervention, referrals to providers, or other services or information from Beacon. This policy and procedure applies when Beacon receives an inquiry from a member, practitioner or provider regarding how and where to obtain a specific type of mental health and/or substance disorder service. See state specific addendum.

This policy also applies to calls received from any distressed Members who may require immediate behavioral health attention. In an emergency, all Members have open access to any behavioral health practitioner without the need for prior authorization. Under certain circumstances, prior authorization is required for selected services as determined by the member-specific Health Plan/Managed Care Organization (HP/MCO) benefit plan. Members have the right to a second opinion from a qualified health care professional. If a second opinion cannot be obtained within the network, members have the right to obtain one outside of the network at no cost to the member.

Access to outpatient behavioral health care by In-network providers is by self-referral; please note there are some specialized plans that require pre-service-authorization for any BH service. The member's designated Primary Care Physician (PCP) may also make a standing in network referral if deemed appropriate. In turn, the BH provider communicates all necessary clinical and administrative information including the treatment plan on a regular basis to the PCP.

**Qualifications and Roles of Staff Responding to Member/Provider Clinical Calls:**

- **Member Services Representative (MSR)**

Qualifications: High School Degree, Bachelor's degree with 1-2 years' experience in behavioral health setting preferred.

Scope of Authority: - Supervised by Member Services Manager. Responsible for checking eligibility, verification of insurance, verification of benefit level, verification of authorizations, review of uncomplicated claims, answering the Primary Care Physician consultation (PCP) line and forwarding the calls to Beacon Physician Advisors (PA), provide referral



BEACON HEALTH STRATEGIES		POLICIES AND PROCEDURES
Policy #: UM 62.28	Page 2 of 8	
Title: Member Services and Clinical Referral and Triage Process		

information, forwarding urgent calls to Utilization Review (UR) Clinician, forwarding clinical calls to UR Clinicians. These positions do not require decisions involving clinical judgment, Member Services staff follow specific protocols to ensure that member calls are handled appropriately and that the caller/member received quality services from Beacon. Whenever the caller meets criteria for a clinical intervention as established by the protocols, or whenever the caller/member requests to speak with a clinician, the call is immediately transferred to a UR Clinician or staff is alerted to have clinician come to the MSR's desk for assistance.

- **Member Services Manager**

Qualifications: Bachelor's degree in Human Services (Social Work, Psychology or Sociology) plus 2-3 years experience in behavioral health environment required. Supervisory experience required.

Scope of Authority: Supervised by Director of Member Services and Claims. S/he acts as back up to the Director of Member Services and Claims, overseeing and monitoring the day-to-day workflow of the Member Service Staff. The Manager functions as the resource person for the Member Service staff, daily answering questions regarding policies and procedures and managing difficult calls.

- **Utilization Review (UR) Clinicians**

Qualifications: licensed master's level behavioral or registered nurse healthcare professionals with a minimum of two (2) years of combined direct behavioral health clinical and managed care experience.

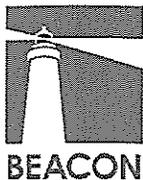
Scope of Authority: Supervised by Clinical Managers or Team Leads and Clinical Director of UM or Senior Clinical Director are available for consultation for cases handled by MSR's. Makes referral decisions requiring clinical judgment according to Beacon's Level of Care Criteria and /or the Referral and Triage Protocols, applies Beacon Referral and Triage Protocols and Level of Care Criteria to emergent, urgent and routine calls, and consults with Physician Advisor/VP of Medical Affairs/CMO on complicated clinical issues.

- **Clinical Case Manager: (ICM)**

Qualifications: Licensed Behavioral Health Clinicians with a bachelors degree or higher. Licensed Independent Clinical Social Worker (LICSW); Licensed Mental Health Counselor (LMHC); Licensed Marriage and Family Therapist (LMFT); Registered Nurse (RN) with at least a bachelor's degree and 3 years behavioral health experience; Licensed Psychologist (Ph.D, Psy.D, Ed.D).

ICM Clinicians are encouraged to sit for certification as case managers. Licensed RN's must have three years clinical practice experience. ICM Clinicians must practice case management within the scope of their licensure (based on the standards of the discipline).

Scope Of Authority: Supervised by Clinical Managers or Team Leads, Clinical Director-Care Management/Senior Clinical Director and has Physician Advisors/VP of Medical Affairs available for consultation as needed. Utilizing Beacon's Intensive Case Management



(ICM) Criteria assist in identification of referrals for the ICM Program and provide Case Management services for members enrolled in the program.

- In District of Columbia, Massachusetts, New York, Texas, and Wisconsin, all ICM Clinicians serve in the roles of both Utilization Reviewer (UR) and ICM clinician.
- In Rhode Island, ICM Clinicians serve only in the role of case manager and do not perform any UR functions.

- **Depression Health Management Clinician (DHM)**

Qualifications: RN degree, minimum of Bachelor's degree in Nursing or related field, strong clinical skills, experience in dealing with patients with depression and working knowledge of depression treatment modalities required.

Scope of Authority: Supervised by Clinical Director-Care Management or Senior Clinical Director and has Physician Advisor/VP of Medical Affairs available for consultation as needed. Outreaches to members who meet criteria for the Depression Health Management program, describes the program, engages members, completes program assessment, encourages participation, develops treatment with, employs interventions that support member self-management, provides members with individualized feedback on their progress. Communicates and collaborates with the member's PCP and behavioral health providers on development of treatment plan and member progress and needs. Collaborates and coordinates treatment planning with plan medical case managers for members with chronic medical illness. The DHM Clinician may serve in the role of Utilization Reviewer (UR).

- **Team Lead (Utilization Management and Case Management)**

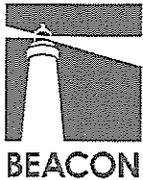
Qualifications:

1. A registered nurse or Master's degree in a health related field with valid and current licensure as a health professional and 3-5 combined years of behavioral health and/or managed care experience; or
2. Certification as a case manager; or
3. Professional certification in a clinical specialty and at least 5 years experience as a case manager

In addition, if s/he has directly supervised the case management process for more than 3 years s/he must hold certification as a case manager.

Scope of Authority: Supervised by the Clinical Manager, Acts as back up to the Clinical Manager and is responsible for the direct supervision of the UR/ICM Clinicians. Continuing Stay Team Leads are responsible for medical necessity review and authorization of all acute and diversionary levels of care, which may include discharge planning, collaboration with Primary Care Physicians, service procurement efforts, triage and referral.

CM Team Leads are responsible for the identification of ICM members and case management services, including a thorough assessment of member situation and functioning utilizing all relevant participants and providers, development of a comprehensive treatment plan based on the assessment and coordination, and monitoring and evaluation of treatment plan effectiveness.



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- **Director of Member Services and Claims**

Qualifications: 15 years experience in customer service and behavioral health call center operations.

Scope of Authority: Supervised by the VP of Operations. Responsible for direct supervision of the Member Service Managers and responsible for overseeing all day-to-day operations, including reporting and analysis of call center data.

- **Managers of Triage and Referral Staff (Team Leads and Clinical Managers)**

Qualifications: Licensed behavioral health care practitioner with a minimum of a Master's degree.

Scope of Authority - Supervises UR Clinicians, ICM Clinicians, DHM Clinician. Consults with Assistant Clinical Director/Clinical Directors-Utilization Management/Clinical Director-Care Management/Senior Clinical Director/Physician Advisor/ VP of Medical Affairs on complicated clinical decisions, oversees all clinical decisions made by departmental staff, including decisions requiring clinical judgment. Resolves complex or serious issues and trains and mentors clinical staff on appropriate decision-making.

- **Chief Medical Officer/VP of Medical Affairs/Physician Advisor/Psychologist**

Qualifications: Licensed, Board certified Psychiatrist with 6 years experience or doctoral level Clinical Psychologist with relevant experience in clinical risk management.

Scope of Authority - Guides staff in their clinical decision-making using Level of Care Criteria and Beacon Referral and Triage Protocols. Consults with staff on clinically complicated cases and makes denial decisions based on accepted Level of Care Criteria. Oversees all clinical decisions made by departmental staff, assists in resolving complex or serious clinical issues. S/he trains and mentors clinical staff on how to apply the Level of Care criteria.

- **Psychotropic Drug Intervention Program (PDIP) Program Specialist and Member Outreach Health Coach**

Qualifications: High School Degree, Associate's degree preferred.

Scope of Authority: - Supervised by PDIP Administrative Team Lead.

- Member Outreach Programs: Responsible for checking eligibility and providing transfer of member to Member Services when a provider referral is requested by the member. Responsible for asking member if assistance is required in scheduling a follow up visit with their medication prescriber, and if assistance is needed, coordinates calls with member and prescriber to schedule appointments. Follow up after appointments to track and verify visits occurred.
- Suboxone Program: Responsible for follow up calls when the member has been sent a letter indicating that they are using Suboxone treatment but not currently receiving any behavioral health counseling. The purpose of the call is to provide referral information to the member.

These procedures do not require decisions involving clinical judgment. Staff follow specific protocols to ensure that member calls are handled appropriately and that the



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caller/member received quality services from Beacon. Whenever the caller meets criteria for a clinical intervention as established by the protocols, or whenever a caller/member requests to speak with a clinician, the call is immediately transferred to a PDIP Clinician or staff is alerted to have clinician come to the PDIP program specialist's desk for assistance.

**DEFINITIONS:**

**Member:**

An eligible person who is enrolled in a Health Plan/Managed Care Organization or a qualifying dependent. The terms "Member", "member" "Enrollee" and "enrollee" are equivalent.

**PURPOSE:**

- To ensure a timely response to the needs of members, practitioners and facilities when they contact Beacon for assistance in locating and receiving care from a network provider.
- To assist the member, practitioner or facility in facilitating his/her request by appropriately categorizing the type of call and providing the appropriate information and service resources as necessary.

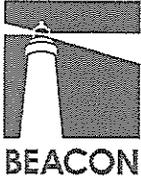
**PROCEDURE:**

1. Calls received via Beacon's dedicated toll free telephone lines are answered live by Member Services Representatives (MSR). The Member Service department uses a capacity model tool that identifies needed MSR resources to meet all Beacon contractual requirements. Beacon telephone answering is measured against contract specific performance requirements and is reported monthly and rolled up quarterly for the following:
  - a. Total call volume received via the dedicated toll-free telephone line
    - Percentage of calls answered within thirty (30) seconds or less
    - Percentage of Calls Abandoned (Abandonment rate)
  - b. 99% of calls received by Beacon will not receive a busy signal
  - c. Average hold time will not exceed two (2) minutesBeacon MSRs receiving any in-coming member call that appears to be a clinical emergency (e.g. suicidal member) will refer the call directly to a Beacon Clinician, as detailed below in #5, and the Beacon Clinician will respond to the member call.
2. Routine calls from members or providers regarding referral information, obtaining a second opinion or other general information not requiring clinical judgment are responded to by Beacon MSRs who have relevant knowledge, skills and follow protocols to answer routine questions verifying insurance, provide information regarding covered benefits, and inform callers about referral procedures for ambulatory care and some diversionary care services. Beacon MSRs make available on requests to members and potential enrollees information that includes but is not limited to:
  - a. The identity, locations, qualifications, and availability of providers;
  - b. Member rights and responsibilities (or where they can access them);
  - c. Procedures available to an member and provider(s) to challenge or appeal the failure of the contractor to provide a covered service and to appeal any adverse actions (denials).



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- d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;
  - e. Information on all covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and
  - f. The procedure for and who to call when the member wants to change Plans or to opt out of the demonstration.
3. From time to time MSR's receive telephone calls from members who are not sure what they are asking for, or who need a specialty referral or second opinion.. In this case the MSR would transfer the call to a Beacon Clinician for further assistance. Clinicians may not perform utilization review at this stage, but rather use their clinical knowledge and training to help members access the services they may need. They would offer input into the provider selection, based on their specialties and geographic location. If a Beacon Clinician is unable to obtain access to second opinion within the network, and an out of network (OON) alternative can be identified, the second opinion can be obtained at no cost to the member. OON providers will be offered the opportunity to negotiate a single case agreement. If an OON provider refuses to negotiate a single case agreement, Beacon does not agree to pay charges unconditionally, nor will Beacon reimburse members directly for payments they have made to providers.
4. If a member call requires a language translator, MSR will first utilize internal resources, which is staff within the company that speaks other languages. If no staff is available, the next step would be to use the designated Translation Service, which is a contracted service that can provide translation for almost any language. When either of these processes is initiated, the call is responded to as a conference call, including the member, the translator and the MSR. Beacon also has a TTY phone for members that are hearing impaired. Interpreter services must be offered at every new contact. Every declination requires new documentation of the offer and decline.
5. From time-to-time MSRs receive telephone calls from members who present with behavioral health situations or conditions that require urgent or emergent responses. MSRs are in key positions to be the first responder to those members needing immediate assistance and arranging for the member to speak with a Beacon Clinician so that the member can get the help they need. While MSRs can offer reassurance through their calm and professional handling of all member calls, MSRs never offer medical advice or attempt to diagnose a member's condition.
- a. If the MSR receives a call in which the member is reporting that they are in distress and, therefore, require a response involving clinical judgment, the call is immediately triaged to a Beacon Clinician. Upon determination that a caller requires clinical intervention, the MSR takes the following steps and whenever possible, obtains the following information, before alerting another MSR or nearby employee that assistance is needed from a Beacon Clinician.
    - Obtains the name of caller/member.
    - Obtains the caller/member phone number
    - Obtains the caller/member location from which the call is being made. (In the event the call is accidentally terminated and onsite crisis intervention is needed.)



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- Asks the caller if they are alone or with another person. Records this answer and incorporates this information into FlexCare
  - Alerts another MSR to immediately notify a Beacon Clinician and advises the caller that assistance is imminent from someone who will be able to assist them
  - Keeps the member on the phone and does not put the member on hold or transfer the member to Beacon's telephone queue
  - Remains calm with the caller
  - Engages the caller in conversations
- b. Once alerted, a Beacon Clinician will immediately take the call from the MSR. The member will not be placed on hold.
- c. Indicators that assistance is needed from a Beacon Clinician:
- Member is reporting suicidal thoughts or a suicide attempt;
  - Member is expressing hostile, angry thoughts and making reference to harming someone; or
  - Member is distraught and reporting an immediate need to talk with "someone"
- d. Once the call has been transferred to a Beacon Clinician, the MSR documents the call in the FlexCare "Member History" section.

#### **EMERGENCY / CRISIS CALL PROCEDURES:**

1. During normal business hours and in the after hours when a Beacon Clinician receives a call and the member or practitioner reports a emergency, and/or the Beacon Clinician believes there is an immediate threat to the member's health or safety, s/he follow the following procedure:
  - a. Review FlexCare to determine if the member has a crisis plan, if so; the Beacon Clinician follows the crisis plan to the extent possible, keeping at the forefront the safety of the member and others
  - b. Assess to the extent possible the nature of the emergency and the risk to the member and others and develop an action plan
  - c. If the risk to the member and / or others is determined **not** imminent, and the member can be engaged the Beacon Clinician will keep the member on the phone and have another clinician arrange for an emergency appointment with the member's therapist or psychiatrist or other healthcare provider
  - d. If risk is determined to be imminent the Beacon Clinician either instructs the caller (may not be the member but someone calling on behalf of the member) to:
    - i. call **911 or call 911 for the caller**
    - ii. Go to local behavioral health emergency service
    - iii. Go to the nearest emergency room or hospital **or**
    - iv. Go to the nearest location where they can seek immediate medical attention
  - e. **Washington DC Addendum:** Phone based assessment must be provided within fifteen (15) minutes of request and, when Medically Necessary, intervention or face-to-face assessment shall be provided within (1) hour of completion of the phone assessment.
2. Once the member is safe, the Beacon Clinician, documents the call and any information discussed in the member's history in the FlexCare Case Management System.



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3. A licensed Psychiatrist and/or a licensed doctoral level Psychologist is available to oversee Beacon's clinical risk management triage and referral decisions.
4. All calls made to 911 in an emergency situation on behalf of a member will be reported to the Clinical Director and Beacon's Privacy Officer.

### **Referral and Triage Decisions**

1. Referral and triage decisions to behavioral health care services are performed by Beacon Clinicians, DHM Clinicians, Team Leaders, Clinical Managers, Assistant Clinical Director, Clinical Director of UM or CM, Senior Clinical Director, Physician Advisors, Psychologist Advisors, and VP of Medical Affairs.
2. All Clinicians who perform referral triage decisions are appropriately licensed within the field of behavioral health care (i.e., RN or Post Master's clinician), with a minimum of three (3) years clinical experience.
3. These clinicians use the following protocols for referral and triage:
  - Beacon's Level of Care Criteria
  - Beacons Referral and Triage Protocols

### **REFERENCED POLICIES:**

NA

### **HOW OFTEN PROCEDURE IS FOLLOWED:**

When a members, practitioners and/or facilities call Beacon

### **WHO IS RESPONSIBLE FOR IMPLEMENTING THE PROCEDURE:**

Beacon staff including the receptionist, telephone operator, MSR, and Beacon Clinicians

### **WHO MONITORS COMPLIANCE WITH THE POLICY:**

Team Leads, Clinical Managers, Member Services Managers, Clinical Directors of UM and CM, Senior Clinical Director, and Director of Member Services and Claims

## Case Management/Care Coordination

Unique Identifier	Requirements	Corrective Action(s)	Business Area	Completion Date
PHP2014IPRO-CM-1	<p>Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance. Members are receiving these services as identified, to share information with early intervention/school-based service providers with appropriate permission from parents.</p>	<p>There are no further action items for Passport Health Plan at this time. Passport Health Plan will ensure that quality checks are performed in the future on the required reports. If Passport has any questions or needs clarification on what documentation is required for the review, IPRO and/or DHS will be contacted in advance.</p>	Behavioral Health Services	
PHP2014IPRO-CR-2	<p>In order for Contractor and its Providers to effectively manage care for Members who qualify for School-Based Services, it will be necessary to coordinate the care provided through both programs as children who are receiving these services are identified, to share information with early intervention/school-based service providers with appropriate permission from parents.</p>	<p>Passport Health Plan has acted upon IPRO's recommendation by updating UIM 31.02 Policy, "Coordination of Care with First Steps for Non-School Aged Children and for Children Receiving School-Based Services and Early Intervention Services" to include the following language: School based services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage.</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 10px auto;">  <p style="font-size: 8px; margin: 0;">UIM 31.02 Coverage of Care</p> </div> <p>In addition, a Department of Health/School Based Services Manager has been hired by Passport Health Plan to assist with the coordination of care provided through all programs as children who are receiving these services are identified and information is shared with the early intervention/school-based service providers with appropriate permission from the parents. Passport Health Plan has developed a policy "Care Coordination for Passport Health Plan Members also receiving First Steps, Early Intervention Services or School-Based Individualized Education Plan Services". This policy is currently being reviewed and is in the final stages of approval. An audit will be conducted of the coordination of care between service providers including sharing of information with parental consent. A minimum of 5 cases will be audited over a 3 month period of time with a performance expectation of 100%.</p>	Care Coordination	<p>Policy Update 8/26/14; Changed the Review Date on Page 2 on 12/9/14 Department of Health/School Based Services Manager Hire Date: August 25, 2014 Care Coordination for Passport Health Plan Members also receiving First Steps, Early Intervention Services or School- Based Individualized Education Plan Services Policy anticipated completion date: January 15, 2015 Audit completion dates anticipated March 30, 2015</p>
PHP2014IPRO-CM-3	<p>Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.</p>	<p>Passport Health Plan has acted upon IPRO's recommendation by updating Policy BH 10.0 to reflect that DCBS files include documentation of ongoing care coordination. Passport Health Plan will continue to work with the State to obtain service plans for all DCBS members.</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 10px auto;">  <p style="font-size: 8px; margin: 0;">UIM 31.02 Coverage of Care</p> </div>	Behavioral Health Services	

Unique Identifier	Requirements	Corrective Action(s)	Business Area	Completion Date
PHP2014IPRO-CM-4	<p>The Contractor shall establish procedures to coordinate care for children receiving school-based services and early intervention services. In a manner that prevents duplication of Contractor provided services. The Contractor shall monitor the continuity and coordination of care for these children as part of its QAPI program. Services provided under these programs are authorized under the Federal Individuals with Disabilities Education Act, but typically excluded from Contractor coverage except in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. IEP services should not be duplicated.</p>	<p>Passport Health Plan has acted upon IPRO's recommendation by updating UM 31.02 Policy, "Coordination of Care with First Steps for Non-School Aged Children and for Children Receiving School-Based Services and Early Intervention Services" to include the following language: School based services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-based services provided by public health departments are included in Contractor coverage.</p> <p>In addition, a Department of Health/School Based Services Manager has been hired by Passport Health Plan to assist with the coordination of care provided through all programs as children who are receiving these services are identified and information is shared with the early intervention/school-based service providers with appropriate permission from the parents.</p> <p>Passport Health Plan has developed a policy "Care Coordination for Passport Health Plan Members also receiving First Steps, Early Intervention Services or School-Based Individualized Education Plan Services". This policy is currently being reviewed and is in the final stages of approval. An audit will be conducted of the coordination of care between service providers including sharing of information with parental consent. A minimum of 5 cases will be audited over a 3 month period of time with a performance expectation of 100%.</p>	<p>Care Coordination</p>	<p>Policy Update 8/26/14;            Changed the Review Date on Page 2 on 12/9/14            Department of Health/School Based Services Manager Hire Date: August 25, 2014            Care Coordination for Passport Health Plan Members also receiving First Steps, Early Intervention Services or School-Based Individualized Education Plan Services Policy anticipated completion date: January 15, 2015            Audit completion dates anticipated March 30, 2015</p>
PHP2014IPRO-CM-5	<p>School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. Coordination between the schools and the Contractor shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child.</p>	<p>Passport Health Plan has acted upon IPRO's recommendation by updating UM 31.02 Policy, "Coordination of Care with First Steps for Non-School Aged Children and for Children Receiving School-Based Services and Early Intervention Services" to include the following language: School based services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-based services provided by public health departments are included in Contractor coverage.</p> <p>In addition, a Department of Health/School Based Services Manager has been hired by Passport Health Plan to assist with the coordination of care provided through all programs as children who are receiving these services are identified and information is shared with the early intervention/school-based service providers with appropriate permission from the parents.</p> <p>Passport Health Plan has developed a policy "Care Coordination for Passport Health Plan Members also receiving First Steps, Early Intervention Services or School-Based Individualized Education Plan Services". This policy is currently being reviewed and is in the final stages of approval. An audit will be conducted of the coordination of care between service providers including sharing of information with parental consent. A minimum of 5 cases will be audited over a 3 month period of time with a performance expectation of 100%.</p>	<p>Care Coordination</p>	<p>Policy Update 8/26/14;            Changed the Review Date on Page 2 on 12/9/14            Department of Health/School Based Services Manager Hire Date: August 25, 2014            Care Coordination for Passport Health Plan Members also receiving First Steps, Early Intervention Services or School-Based Individualized Education Plan Services Policy anticipated completion date: January 15, 2015            Audit completion dates anticipated March 30, 2015</p>



		Policy/Procedure
<b>Policy Name: Coordination of Care with First Steps for Non-School Aged Children &amp; for children receiving school-based services and Early Intervention Services</b>		<b>Policy Number: UM 31.02</b>
<b>Date of Next Annual Review: 08/26/15</b>		<b>Original/Issue Date: 1.5.2006</b>
<b>Approved By: Anna Page, R.N</b>		<b>Title: Director</b>
<b>Signature:</b> <i>Anna Page</i>		<b>Date Approved: 11.12.2013</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
New (Date policy was created)	<input type="checkbox"/>	
Reviewed (No changes to policy)	<input type="checkbox"/>	
Revised (Content changes made to policy)	<input checked="" type="checkbox"/>	08/26/14
Retired (Policy no longer active)	<input type="checkbox"/>	
<b>APPLICABILITY</b>		

All Medical Management Associates

**PURPOSE**

The purpose of this policy is to coordinate services for children with developmental or physical disabilities or delays with the First Steps program or School Based Services.

**POLICY**

To describe the coordination process of physical therapy, speech therapy, and/or occupational therapy with the First Steps program, for non-school aged children (0-3rd birthday) (early intervention services), School Based Services and / or Early Intervention Services to prevent duplication of services.

**DEFINITION(S)**

**Appeal** - Request for review of an action or a decision by the contractor related to covered services or services provided.

**Authorized Representative** – A guardian; a parent of a minor or disabled child; an adult child for a parent; and/or any other individual who has legal authority to act on behalf of another.

**Early Intervention Services** - Services provided to young children designed to help them avoid or overcome physical or emotional development disabilities. Early intervention services provide the help children need to keep pace with other children their age, both socially and academically.

**First Steps Program** – an entitlement program established by the Federal Individuals with Disabilities Act (IDEA) and is funded by federal, state, and local funds. The goal of the program is to provide early intervention services to children from birth up to age three (3rd birthday) who

have developmental disabilities or delays. The intended outcome of the program is to ensure maximum amelioration of the impact of developmental disabilities or delays on infants and toddlers by early and ongoing provision of rehabilitation services.

First Steps is administered by the Kentucky Department for Public Health in the Cabinet for Health and Family Services

**HANDS:** voluntary intensive home visitation program for first-time parents that provides services from the prenatal period to the child's third birthday.

**Home Based Therapy** - Home Based Therapy is made available especially to families or individuals who have a difficult time accessing therapy, or who would benefit from having the therapist come to them.

**Individualized Educational Plan (IEP)** - An document developed to meet the special education needs of the child; specific academic goals are set for the child.

**Long Term Goal** - goal that is the ultimate results desired when a plan is established or revised.

**Medical Necessity (therapy)** - Care is prescribed by a physician in order to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, injury or surgical procedure.

**Physical Therapy** - The treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise; focuses specifically on one injury or set of injuries; work to rebuild muscle groups.

**Plan of Care** - written document that outlines the progression of therapy; Documentation of Presenting Problem - A brief description of the main issue or issues; Goals of Therapy - list of both the overall goal(s) and the interim goal(s) of therapy; Methods - list of the techniques that will be used to achieve the goals; Time Estimate - estimate of the length of time and/or number of sessions needed

**Occupational Therapy** - therapy based on engagement in meaningful activities of daily life, especially to enable or encourage participation in such activities in spite of impairments or limitations in physical or mental functions; focus on a person's functional abilities; helps optimize their independence and ability to accomplish daily activities.

**School Based Services** - are partnerships created by schools and community health organizations to provide on-site medical and mental health services that promote the health and educational success of school-aged children and adolescents.

**Short Term Goal** - goals that can be achieved in a limited period of time and frequently lead to the achievement of a long term goal.

**Speech Therapy** - The treatment of speech and communication disorders

## PROCEDURE

### *Coordination with First Steps*

1. A request is received for therapy services (Physical, Occupational or Speech) for a member between the ages of 0 to 3 (3<sup>rd</sup> birthday). Requests may be received via:
  - a. Phone
  - b. Fax
  - c. Mail
  - d. Secure email
2. The request is referred to the Medical Director for medical necessity determination
  - a. All requests for therapy services for members zero (0) to three (3) years of age are referred to the Medical Director for review determination
3. The Passport Health Plan Medical Director reviews the request for medical appropriateness of the proposed treatment plan and setting.
4. The Medical Director determines if First Steps is an appropriate alternative to traditional therapy services. First Steps eligibility:
  - Serve children from birth to age 3 and their families
  - Eligibility for the program is determined two ways:
    - By developmental delay - A child may be eligible for services if an evaluation shows that a child is not developing typically in at least one of the following skill areas: communication, cognition, physical, social and emotional or self-help.
    - Automatic entry - A child may be eligible if he or she receives a diagnosis of physical or mental condition with high probability of resulting developmental delay, such as Down Syndrome. (see appendix A for established risk conditions that make children automatically eligible for First Steps)
      - Automatic entry does not necessarily mean child is will remain in the First Steps program. These families will have the option to continue with First Steps and be monitored during their 6 month IFSP (individualized family service plan), or they can opt out of the program since it is voluntary
6. If the requested services are those that can be administered **solely** through the First Steps program, the request may be denied by the Medical Director.
7. If a member is eligible for First Steps but requires services beyond what First Steps offers, the Medical Director may approve the request for therapy. If a member is not eligible for First Steps, the Medical Director may approve the request if medically necessary.

A member may receive services through First Steps and services through Passport concurrently.

All requests are evaluated on a case by case basis.

8. If the request is denied, the denial rationale should contain the referral information to First Steps (Anyone can refer a child for First Steps services by calling 877-417-8377 or 877-41 STEPS)

A member or authorized representative may appeal the denial.

9. After the Medical Director has made his/her review determination, the case is routed back to the Nurse Reviewer for completion.

### *Coordination with School Based Services or Early Intervention Services*

1. A request is received for therapy services (Physical, Occupational or Speech) for a school aged member. Requests may be received via:
  - a. Phone
  - b. Fax
  - c. Mail
  - d. Secure email

2. The Nurse Reviewer is to evaluate the request to determine if the member is receiving services through the school system or another Early Intervention program. The nurse Reviewer is to ask the requestor if the member is receiving services through any other organization.

If no, the nurse reviewer may proceed with the request.

3. If the member is receiving services through the school system or through another Early Intervention Program, the request is to be referred to the Medical Director.

The Medical Director will determine if the request is a duplication of services. Duplication of services may result in a denial of the request.

A member or authorized representative may appeal the denial.

4. After the Medical Director has made his/her review determination, the case is routed back to the Nurse Reviewer for completion.
5. In situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, Passport is responsible for providing all Medically Necessary Covered Services.

Std 32.8

School Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage.

Coordination between the schools and Passport shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child.

For any service, the Utilization Management (UM) Nurse obtains the necessary clinical information that includes:

- Diagnosis and co-morbidities
- Duration of illness / injury and prior treatment, if applicable
- Prior function
- Therapy Evaluation: date of evaluation and results
- Signs and symptoms; Functional limitations; Impairments; Deficits
- Plan of care – Should be ongoing, (i.e., updated as the patient's condition changes), and treatment should demonstrate reasonable expectation of improvement
- Long-term and short-term goals that are specific, quantitative and objective and a reasonable estimate of when the goals will be reached;
- The frequency and duration of treatment and modalities
- Short term and long term goals
- Psychosocial history
- Cultural and linguistic barriers
- Information from responsible family members; Home environment

The Nurse Reviewer along with the Department of Health/School Based Services Manager will assist to coordinate the care provided through all programs as children who are receiving these services are identified and to share information with early intervention/school-based service providers with appropriate permission from parents.

Std 32.8

Services provided under HANDS shall be excluded from coverage. HANDS is a home visitation program for first-time parents. It services children under three (3) years of age and it promotes good parenting skills.

**CROSS REFERENCE/REFERENCE MATERIALS**  
(If necessary to cite other policies or documents)

None

**REVIEW AND REVISION DATES (Annually at minimum)**

January 10, 2008  
January 10, 2009  
January 10, 2010  
January 10, 2011  
January 10, 2012  
November 28, 2012  
November 12, 2013  
August 26, 2014

End of Policy  
Appendix A – First Steps Established Risk Conditions

**First Steps: Established Risk Conditions**

Aase-Smith Syndrome (Diamond-Blackfan Anemia)	Aase Syndrome
Acrocallosal Syndrome	Acrodysostosis
Acro-Fronto-Facio-Nasal Dysostosis	Adrenoleukodystrophy
Agenesis of the Corpus Callosum	Agyria
Aicardi Syndrome	Alexander's Disease
Alper's Syndrome	Amelia
Angelman Syndrome	Aniridia
Anophthalmia/Microphthalmia	Antley-Bixler Syndrome
Apert Syndrome	Arachnoid cyst with neuro-developmental delay
Arhinencephaly	Arthrogryposis
Ataxia	Atelosteogenesis
Autism	Baller-Gerold Syndrome
Bannayan-Riley-Ruvalcaba Syndrome	Bardet-Biedl Syndrome
Bartocas-Papas Syndrome	Beals Syndrome (congenital contractual arachnodactyly)
Bixler Syndrome	Blackfan-Diamond Syndrome
Bobble Head Doll Syndrome	Borjeson-Forssman-Lehmann Syndrome
Brachial Plexopathy	Brancio-Oto-Renal (BOR) Syndrome
Campomelic Dysplasia	Canavan Disease
Carbohydrate Deficient Glycoprotein Syndrome	Cardio-Facio-Cutaneous Syndrome
Carpenter Syndrome	Cataracts-Congenital
Caudal Dysplasia	Cerebro-Costo-Mandibular Syndrome
Cerebellar Aplasia/Hypoplasia/Degeneration	Cerebral Atrophy
Cerebral Palsy	Cerebro-oculo-facial-skeletal syndrome
CHARGE Association	Chediak Higashi Syndrome
Chondrodysplasia Punctata	Christian Syndrome
Chromosome Abnormality a. Unbalanced numerical (autosomal) b. Numerical trisomy (chromosomes 1-22) c. Sex chromosomes XXX; XXXX; XXXXX; XXXY; XXXXY	CNS Aneurysm with Neuro-Developmental Delay
CNS Tumor with Neuro-Developmental Delay	Cockayne Syndrome
Coffin Lowry Syndrome	Coffin Siris Syndrome
Cohen Syndrome	Cone Dystrophy
Congenital Cytomegalovirus	Congenital Herpes
Congenital Rubella	Congenital Syphilis
Congenital Toxoplasmosis	Cortical Blindness
Costello Syndrome	Cri Du Chat Syndrome
Cryptophthalmos	Cutis Laxa
Cytochrome-c Oxidase Deficiency	Dandy Walker Syndrome
DeBary Syndrome	DeBoquois Syndrome
Dejerine-Soltas Syndrome	DeLange Syndrome
DeSanctis Cacchione Syndrome	Diastrophic Dysplasia
DiGeorge Syndrome	Distal Arthrogryposis
Donohue Syndrome	Down Syndrome
Dubowitz Syndrome	Dyggve Melchor-Calusen Syndrome
Dyssegmental Dysplasia	Dystonia
EEC (Ectrodactyly-ectodermal dysplasia-clefting) Syndrome	Endephalocele
Encephalo-Cranio-Cutaneous Syndrome	Encephalomalacia
Facio-Auriculo-Radial Dysplasia	Facio-Cardio Renal (Eastman-Bixler) Syndrome
Familial Dysautonomia (Riley-Day Syndrome)	Fanconi Anemia
Farber Syndrome	Femoral Hypoplasia
Fetal Alcohol Syndrome/Effects	Fetal Dyskinesia

Fetal Hydantoin Syndrome	Fetal Valproate Syndrome
Fetal Varicella Syndrome	FG Syndrome
Fibrochondrogenesis	Floating Harbor Syndrome
Fragile X Syndrome	Freeman-Sheldon (Whistling Facies) Syndrome
Fryns Syndrome	Fucosidosis
Galactosemia	Glaucoma-Congenital
Glutaric Aciduria Type I and II	Glycogen Storage Disease
Goldberg-Shprintzen Syndrome	Grebe Syndrome
Hallermann-Streif Syndrome	Hays-Wells Syndrome
Head Trauma with Neurological Sequelae/Developmental Delay	Hearing Loss (25dB or greater in better ear as determined by ABR audiometry or audiometric behavioral measurements)
Hemimegalencephaly	Hemiplegia/Hemiparesis
Hemorrhage-Intraventricular Grade III and IV	Hereditary Sensory & Autonomic Neuropathy
Hereditary Sensory Motor Neuropathy (Charcot Marie Tooth Disease)	Herrmann Syndrome
Heterotopias	Holoprosencephaly (Aprosencephaly)
Holt-Oram Syndrome	Homocystinuria
Hunter Syndrome (MPS II)	Hurler Syndrome (MPS I)
Hyalinosis	Hydranencephaly
Hydrocephalus	Hyperpipecolic Acidema
Hypomelanosis of ITO	Hypophosphotasis-Infantile
Hypoxic Ischemic Encephalopathy	I-Cell (mucopolidosis II) Disease
Incontinentia Pigmenti	Infantile Spasms
Iniencephaly	Isovaleric Acidemia
Jarcho-Levin Syndrome	Jervell Syndrome
Johanson-Blizzard Syndrome	Joubert Syndrome
Kabuki Syndrome	KBG Syndrome
Kenny-Caffey Syndrome	Klee Blattschadel
Klippel-Feil Sequence	Landau-Kleffner Syndrome
Lange-Nielsen Syndrome	Langer Giedion Syndrome
Larsen Syndrome	Laurin-Sandrow Syndrome
Leber's Amaurosis	Legal Blindness (bilateral visual acuity of 20/200 or worse corrected vision in the better eye)
Leigh Disease	Lennox-Gastaut Syndrome
Lenz Majewski Syndrome	Lenz Microphthalmia Syndrome
Levy-Hollister (LADD) Syndrome	Lesch-Nyhan Syndrome
Leukodystrophy	Lissencephaly
Lowe Syndrome	Lowry-Maclean Syndrome
Maffucci Syndrome	Mannosidosis
Maple Syrup Urine Disease	Marden Walker Syndrome
Marshall Syndrome	Marshall-Smith Syndrome
Maroteaux-Lamy Syndrome	Maternal PKU Effects
Megalencephaly	MELAS
Meningocele (cervical)	MERRF
Metachromatic Leukodystrophy	Metatropic Dysplasia
Methylmalonic Acidemia	Microcephaly
Microtia-Bilateral	Midas Syndrome
Miller (postaxial acrofacial-dysostosis) Syndrome	Miller-Dieker Syndrome
Mitochondrial Disorder	Mobius Syndrome
Morquio Syndrome	Moya-Moya Disease
Mucopolidosis II and III	Multiple congenital anomalies (major organ birth defects)
Multiple Pterygium Syndrome	Muscular Dystrophy
Myasthenia Gravis-Congenital	Myelocystocele
Myopathy -Congenital	Myotonic Dystrophy
Nager (Acrofacial Dysostosis) Syndrome	Nance Horan Syndrome

NARP	Neonatal Meningitis/Encephalitis
Neuronal Ceroid Lipofuscinoses	Neuronal Migration Disorder
Nonketotic Hyperglycinemia	Noonan Syndrome
Ocular Albinism	Oculocerebrocutaneous Syndrome
Oculo-Cutaneous Albinism	Optic Atrophy
Optic Nerve Hypoplasia	Oral-Facial digital Syndrome, Types I-VII
Osteogenesis Imperfecta, Types III and IV	Osteopetrosis (Autosomal Recessive)
Oto-Palato-Digital Syndrome, Types I and II	Pachygyria
Pallister Mosaic Syndrome	Pallister-Hall Syndrome
Pelizaeus-Merzbacher Disease	Pendred's Syndrome
Periventricular Leukomalacia	Pervasive Developmental Disorder
Peters Anomaly	Phocomelia
Poland Sequence	Polymicrogyria
Popliteal Pterygium Syndrome	Porencephaly
Prader-Willi Syndrome	Progeria
Propionic Acidemia	Proteus Syndrome
Pyruvate Carboxylase Deficiency	Pyruvate Dehydrogenase Deficiency
Radial Aplasia/Hypoplasia	Refsum Disease
Retinoblastoma	Retinoic Acid Embryopathy
Retinopathy of Prematurity, Stages III and IV	Rett Syndrome
Rickets	Rieger Syndrome
Roberts SC Phocomelia	Robinow Syndrome
Rubinstein-Taybin Syndrome	Sanfilippo Syndrome (MPS III)
Schinz-Giedion Syndrome	Schimmelpenning Syndrome (Epidermal Nevus Syndrome)
Schizencephaly	Schwartz-Jampel Syndrome
Seckel Syndrome	Septo-Optic Dysplasia
Shaken Baby Syndrome	Short Syndrome
Sialidosis	Simpson-Golabi-Behmel Syndrome
Sly Syndrome (MPS IV)	Smith-Fineman-Myers Syndrome
Smith-Limitz-Opitz Syndrome	Smith-Magenis Syndrome
Sotos Syndrome	Spina Bifida (Meningomyelocele)
Spinal Muscular Atrophy	Spondyloepiphyseal Dysplasia Congenita
Spondylometaphyseal Dysplasia	Stroke
Sturge-Weber Syndrome	TAR (Thrombocytopenia-Absent Radii Syndrome)
Thanatophoric Dysplasia	Tibial Aplasia (Hypoplasia)
Toriello-Carey Syndrome	Townes-Brocks Syndrome
Trecher-Collins Syndrome	Trisomy 13
Trisomy 18	Tuberous Sclerosis
Urea Cycle Defect	Valocardiofacial Syndrome
Wildervanck Syndrome	Walker-Warburg Syndrome
Weaver Syndrome	Wiedemann-Rautenstrauch Syndrome
Williams Syndrome	Winchester Syndrome
Wolf Hirschhorn Syndrome	Yunis-Varon Syndrome
Zellweger Syndrome	

Identification of DCBS Clients for Behavioral Health/Care Coordination Services

		<b>Policy/Procedure</b>
<b>Policy Name: Identification of DCBS Clients for Behavioral Health/Care Coordination Services</b>		<b>Policy Number: BH 10.0</b>
<b>Date of Next Annual Review: 11/15/2015</b>		<b>Original/Issue Date: 9/30/10 (CC 5.01)</b>
<b>Approved By: Stephanie Stone</b>		<b>Title: Manager, Out of Home Placements</b>
<b>Signature: SIGNATURE ON FILE</b>		<b>Date Approved: 11/11/14</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
<b>New</b> (Date policy was created)	<input type="checkbox"/>	
<b>Reviewed</b> (No changes to policy)	<input type="checkbox"/>	
<b>Revised</b> (Content changes made to policy)	<input checked="" type="checkbox"/>	11/15/2013; 11/11/14
<b>Retired</b> (Policy no longer active)	<input type="checkbox"/>	
<b>APPLICABILITY</b>		

**PURPOSE**

To define the mechanism for identifying DCBS clients for Behavioral Health Case Management/Care Coordination services.

**POLICY**

Previously CC 5.01 – Identification of DCBS Clients for Care Coordination Services. *Passport Health Plan* (PHP), in collaboration with the Department for Community Based Services (DCBS), review service plans monthly for newly enrolled PHP members to identify DCBS clients for Care Coordination and Behavioral Health Case Management. *Passport Health Plan* utilizes other methods in addition to service plans to identify DCBS clients for Behavioral Health Case Management/Care Coordination services.

**DEFINITION(S)**

**Care Coordination** - is a process that links members with special health care needs and their families and/or caregivers to services and resources in a coordinated effort to maximize the potential of the member, and provide them with optimal health care. Members with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by individuals generally. Care coordination is a collaborative process that promotes quality care and cost effective outcomes which enhance the physical, psychosocial and vocational health of members.

Care Coordination is a central, ongoing component of an effective health care system engaging the member and their families and/or caregivers in the development of a plan of care that links them to health and other services that address the full range of their needs and concerns. The

## Identification of DCBS Clients for Behavioral Health/Care Coordination Services

principles of care coordination reflect the central role of members and their families and/or caregivers in their care, along with the prioritization of member and family/caregiver concerns, strengths, and needs. Activities of care coordination may vary from member to member, but begin with the identification of individual member needs, strengths, and concerns, and aim at meeting those needs.

**Case Management** – a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual’s health needs through communication and available resources, to promote quality cost-effective outcomes.

**Case Alert** – a predictive modeling tool that provides an assessment of members for current and predicted Case Management services.

**DCBS** - Department for Community Based Services

**EXP** – A Windows based inter-company program for communication and reference between departments. Utilized to also scan documentation to incorporate into electronic files.

**Foster Care** – A protective service offered to children and their parents who must live apart from each other for a period of time because of physical abuse, sexual abuse, neglect or special circumstances necessitating the use of foster care.

**Medically Fragile** –

1. Medical condition documented by a physician that may become unstable and change abruptly resulting in a life-threatening situation;
2. Chronic and progressive illness;
3. Severe disability that requires technological assistance;
4. Need for a special service or ongoing medical support;
5. Need for twenty-four (24) hour care by a physician or licensed nurse for the child to survive; or
6. Health condition stable enough to be in a home setting only with frequent monitoring by an attending physician or care of a licensed nurse.

**Streamline** – a database to verify state Medicaid eligibility.

### **PROCEDURE**

1. The DCBS MCO Liaison provides a service plan to *Passport Health Plan* for each *Passport* Foster Care member. Upon enrollment, each member receiving adoption assistance shall have a service plan prepared by DCBS. The process for enrollment of children receiving adoption assistance follows that outlined for Children in Foster Care. Monthly meetings are held to review the service plans.
2. The *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison and DCBS MCO Liaison jointly review the service plans to see if the members are identified as being in need of Behavioral Health or other Case Management (see *Attachment A: Trigger List*

## Identification of DCBS Clients for Behavioral Health/Care Coordination Services

for Care Coordination). When applying the trigger list to a specific request for enrollment into the *Passport Health Plan* Case Management Program, the following factors are considered: age, co-morbid conditions, complications, current treatments and plan of care, psychosocial factors, and home environment. When permission is given by DCBS, the Foster Care/Adoption/Guardianship Liaison attempts to establish contact with the Foster Parent and documents these efforts in the Case Management notes in the dedicated Medical Management system. The DCBS MCO Liaison and Foster Care Liaison will sign each service plan to indicate their agreement with the plan.

3. If identified as a “yes” for Behavioral Health or other Case Management - The *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison either maintains the case him/herself for case management/care coordination or sends the referral to the Behavioral Health Case Management and/or Passport Care Coordination team to be assigned a case manager.
  - a) The *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison or Case Manager contacts the home and completes assessments to determine the member’s Case Management needs. If it is determined there is a need, the Foster Care/Adoption/Guardianship Liaison or Case Manager proceeds with Case Management (see CC 4.05 Identification of Members for Care Coordination). At that time, the service plan becomes part of the child’s permanent Case Management file at PHP. The *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison or Case Manager notifies the DCBS worker by telephone and/or in writing that the child has been enrolled in *Passport Health Plan* Case Management program and documents this information in the dedicated Medical Management system.
  - b) The *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison or Case Manager completes appropriate assessments with the member. (See CM 4.02 Assessment of Care Management Needs.)
  - c) When a member is enrolled in Case Management, the *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison or Case Manager discusses goals with the member and/or the foster parent and then sends a copy of the goals letter to the DCBS Social Service Worker, foster parent, and (when care coordination is for a medical issue) Primary Care Provider..
  - d) The *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison or Case Manager initiates the care plan. If the Social Service Worker, foster parent, or Primary Care Provider has recommendations for changes to the care plan, the Foster Care/Adoption/Guardianship Liaison or Case Manager makes adjustments to the care plan as needed.
4. If identified as “no” – If it is determined there are no Case Management needs, the service plan is kept on file at *Passport Health Plan* in the Behavioral Health Department for a rolling calendar year. An Annual Review is conducted on members who were not

## Identification of DCBS Clients for Behavioral Health/Care Coordination Services

identified to have Case Management needs. This annual review is done with the DCBS MCO Liaison and/or Social Service Worker and the Foster Care/Adoption/Guardianship Liaison. This review includes the service plan and utilization data, to determine the need for further intervention. After one year of storage, the service plan is destroyed by the approved *Passport Health Plan* contracting disposal service. If the need later arises for Case Management/Care Coordination services, the *Passport Health Plan* Foster Care Liaison or Case Manager contacts the DCBS Social Service Worker and collaborates on services to meet the member's needs.

5. The Foster Care/Adoption/Guardianship Liaison serves as the primary contact at *Passport Health Plan* for DCBS representatives and is responsible for ongoing care coordination with DCBS members, including those members not identified to have Case Management needs. The Liaison holds monthly meetings with each DCBS Service Region when *Passport Health Plan* has members from the region. The purpose of the meeting is to discuss DCBS members from the region, addressing ongoing needs of the members and of the DCBS staff in accessing needed resources/services. The Liaison also works to resolve any issues identified for DCBS members between the monthly meetings.
6. If the DCBS and *Passport Health Plan* cannot reach agreement on the service plan for a Member, then information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and *Passport Health Plan* staff will be forwarded to the designated DCBS worker. That DCBS worker shall work with *Passport Health Plan* and a designated Department representative, if needed, to agree on a service plan. If agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.
7. **Notification of Case Status Change** (*Attachment B – Notification of Case Status Change Letter*): This form is completed by the *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison or Case Manager and mailed to the DCBS Social Service Worker upon discharge of a foster care child from the case management/care coordination program. A copy of this completed form is retained in the child's permanent record at PHP.
7. **Pertaining to storage of files**: The service plans, along with the minutes from the meetings between the DCBS MCO Liaison and the *Passport Health Plan* Foster Care Liaison are stored in a secure file cabinet in the Behavioral Health Department for a rolling calendar year. The forms and minutes are kept in folders categorized by "month and year." It is the responsibility of the *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison to maintain these files and keep them current.
8. **Pertaining to "Minutes"**: The minutes consist of a spreadsheet listing the member name, Medicaid ID #, disposition (enrolled or not enrolled in Care Coordination) and the rationale. The minutes are signed by the DCBS MCO Liaison and the *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison. The minutes are recorded

## Identification of DCBS Clients for Behavioral Health/Care Coordination Services

by the *Passport Health Plan* Foster Care/Adoption/Guardianship Liaison. A copy of the minutes is filed in the appropriate folder by month/year with the service plans.

### 9. Other methods for DCBS clients to access Case Management/Care Coordination services include:

- a) Referrals from physicians/practitioners, Children's Review Program, DCBS Social Service Workers, foster parents, Commission for Children with Special Healthcare Needs, Private Child Placing or Child Caring agencies, *Passport Health Plan* Utilization Management, members services, and other agencies.
- b) **Case Alert** – internal *Passport Health Plan* predictive modeling tool that provides an assessment of members for current and predicted Case Management/Care Coordination services.
- c) **Tiny Tot Transition Program** – provides qualified Registered Nurse Care Managers/Care Coordinators to focus solely on the welfare of the detained newborns that cannot be discharged from the hospital with their mothers after delivery due to medical problems.

10. The Manager, Out of Home Placements sends a monthly report of Foster Care Cases to the Manager of Compliance for *Passport Health Plan* within thirty (30) days after the end of each month.

### CROSS REFERENCE/REFERENCE MATERIALS

(If necessary to cite other policies or documents)

CC 4.05 – Identification of Members for Care Coordination  
CC 5.04 – Identification of Members with Special Needs  
CC 25.02 – Tracking and Trending of Member Inquiries and Complaints  
CC 25.01 – Satisfaction Survey  
FC 4.0 – Grievance Process for DCBS Members  
Supersedes FC 2.0 Medically Fragile Foster Children-DCBS  
*Attachment A* – Care Coordination Trigger List  
*Attachment B* – Notification of Case Status Change Letter

### REVIEW AND REVISION DATES (Annually at minimum)

09/30/10  
11/02/10  
11/02/11  
03/08/12  
11/15/13

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End of Policy

## TRIGGER LIST FOR CARE COORDINATION

Initial 9/1/2010

### ***Pediatrics***

Autism	Cancer diagnosis
Cerebral Palsy	Cleft Lip and Palate
Craniofacial anomalies	Cystic Fibrosis
Failure to thrive	Genetic conditions or Congenital abnormalities with Complex treatment regimes
Head Injuries/Brain Trauma	Medically-fragile children or foster children
Hemophilia	Myelomeningocele
HIV+/AIDS	Psychosocial needs (Social Worker)
Mental Retardation with physical disabilities	Seizures
Neurological Impairments	Sickle Cell
Scoliosis	Terminal disease or Palliative Care
Severe renal/heart defects/lung disease	
Technology-dependent	

### ***Adults***

Alzheimer's disease and related disorders	Cancer diagnosis
Cerebral Palsy	Chronic heart/renal/lung disease
CVA with functional disabilities	Developmental disabilities
Diabetes	Hemophilia
High risk pregnancy	HIV+/AIDS
Members who have chronic illnesses and live alone	Members with complicated medications and/or treatment regimes
Mental Retardation	Organ/BMT transplant
Progressive neuromuscular disease (ALS, MS)	Psychosocial needs (Social Worker)
Severe visual impairment or blindness	Sickle Cell Disease
Spinal cord injury with residual damage	TBI with residual damage
Technology-dependent	Terminal disease or Palliative Care
Uncontrolled HTN with complicated medications and/or treatment regime	

*Attachment A*

### ***Individuals with Special Health Care Needs***

Adults over the age of 65

Blind/Disabled children <19 and related populations eligible for SSI

Children in or receiving foster care or adoption assistance

Homeless (upon identification)

Members with Asthma

Members with COPD

Members with Diabetes

Members with Sickle Cell

### ***Others***

Dually diagnosed, including a diagnosis of mental retardation or mental illness

Frequent hospitalizations required

High risk for developing secondary disabilities or comorbidities

Multiple, often multidisciplinary providers

Over-utilization of services

Physician (Medical Director(s), Primary Care Physician, Specialist) request

Date: *(Date)*

To: *(DCBS Supervisor's Name)*  
*(DCBS Supervisor's Email Address)*  
Fax: 595.3068

From: *(Case Manager's Name)*

Re: Notification of open case status change

Member: *(Member's Name)*  
PHP ID#: *(Member's Identification Number)*  
SS#: *(Member's Social Security Number)*  
DOB: *(Member's Date of Birth)*

This member has been discharged from Case Management for the following reasons:

- \_\_\_\_\_ Unable to contact member/caretaker/adoptive parent by telephone or letter
- \_\_\_\_\_ Assessment completed, goals formed with caretaker, letter sent to caretaker/LSW/PCP, all Case management goals achieved
- \_\_\_\_\_ Caretaker/member refused case management services
- \_\_\_\_\_ Member no longer in foster/adoptive care
- \_\_\_\_\_ Disenroll date *(Date Disenrolled)*
- \_\_\_\_\_ Non-par set up for physicians complete
- \_\_\_\_\_ *(Other)*

Please remember that even though a member has been discharged from case management, they can be referred again if needed. My direct number is *(Case Manager's Phone Number)* or if calling long distance 1-800-578-0636 ext. *(Case Manager's Extension)*.

Sincerely,

*(Case Manager's Name)*

*Attachment B*

# QAPI - Structure & Operations - Credentialing

Unique Identifier	Requirements	Corrective Action(s)	Business Area	Completion Date
PHP2014IPRO-CR-1	The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.	Passport Health Plan has acted upon IPRO's recommendation by developing Policy PC 85.0, Electronic Health Record Incentive Funds.  <div style="border: 1px solid black; padding: 2px; display: inline-block;">                       Patricia M. Anderson                      Compliance Manager                 </div>		
PHP2014IPRO-CR-2	The Contractor may enroll providers in their network who are not participating in the Kentucky Medicaid Program. Providers shall meet the credentialing standards described in Provider Credentialing and Re-Credentialing of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted in the network along with the reasons for the non-acceptance. A provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP. If required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.	Passport Health Plan has acted upon IPRO's recommendation by adding contractual language to CR 1.01 and CR 4.01 and is waiting on CMO approval. Passport Health Plan has also added language to the Provider Manual. DWS approval on the 2015 Manual is anticipated to be end of 1st Quarter 2015.		

### 2.7.1.1 Practitioners

New practitioner applicants are required to complete their residency program and be eligible to obtain board certification prior to joining Passport. A practitioner is considered hospital based if they practice exclusively in a facility setting. These practitioners undergo a condensed review as it is the responsibility of the facility to verify their full credentials.

Passport enrolls providers in compliance with the “Any Willing Provider” statute as described in 907 KAR 1:672 and KRS 304.17A-270. Passport enrolls providers in the network who are not participating in the Kentucky Medicaid Program as long as provider is deemed by the Department of Medicaid Services (DMS), eligible to enroll with Kentucky Medicaid Program in accordance with the state’s Provider Credentialing and Re-credentialing standards. A provider cannot enroll in Passport network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process.

Passport enrolls providers in compliance with the “Any Willing Provider” statute as described in 907 KAR 1:672 and KRS 304.17A-270. Passport enrolls providers in the network who are not participating in the Kentucky Medicaid Program as long as provider is deemed by the Department of Medicaid Services (DMS), eligible to enroll with Kentucky Medicaid Program in accordance with the state’s Provider Credentialing and Re-credentialing standards. A provider cannot re-enroll in Passport network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the re-credentialing process.

New practitioners must include the following as applicable:

- A letter adding practitioner to each group.
- Completed Provider Application either a CAQH (Council for Affordable Quality Healthcare) universal credentialing application or the most current version of KAPER1 (Kentucky DMS application), including:
  - Additional copies of pages from the application (as needed);
  - Disclosure questions, as applicable, including but not limited to:
    - Documentation of any malpractice suits or complaints.
    - Documentation of any restrictions placed on practitioner by hospital, medical review board, licensing board, or other medical body or governing agency.
    - Documentation of any conviction of a criminal offense within the last 10 years (excluding traffic violations); and,
    - The attestation page (including the practitioner signature and current date).

- A copy of Medicare Certificate (a letter from the Centers for Medicare & Medicaid Services (CMS) with your unique Medicare provider identification number and practice location), as applicable.
- Copy of current facility accreditation or certification.
- Model Attestation Letter for Psychiatric Residential Treatment Facilities (PRTF).
- DME Accreditation Certificate- exempt organizations need to submit a signed statement attesting to the exemption and documentation from CMS outlining the exemption.
- HME license issued by the KY Board of Pharmacy (per HB 282 and 201 KAR 2:350) (As of September 30, 2012) - exempt providers need to submit a signed statement attesting to the exemption.
- Medicare certification letter less than three years old with effective date of certification and physical location of where DME number is to be used. Medicare requires DME providers to re-enroll every 3 years.
- Independent labs must have a laboratory director, who must satisfy requirements set forth in 907 KAR 1:028 Section 1(8) and KRS 333.090 (1), (2), or (3) and supply documentation thereof.
- If not accredited or certified, a copy of the most recent CMS or state review.
- A copy of the mechanism that the organizational provider uses to monitor and improve patient safety.
- A copy of the transfer policy.
- FOX verification documentation for National Provider Identifier (NPI) and Taxonomy Code(s).

Failure to submit a complete application may result in a delay in Passport's ability to start the initial credentialing process.

Practitioners may contact the Provider Enrollment department at (502) 588-8578 to check the status of their application.

		<b>Policy/Procedure</b>
<b>Policy Name: Practitioner Credentialing</b>		<b>Policy Number: CR 1.01</b>
<b>Date of Next Annual Review: August 18, 2015</b>		<b>Original/Issue Date: November 1, 1997</b>
<b>Approved By: Stephen Houghland, MD</b>		<b>Title: Medical Director</b>
<b>Signature: SIGNATURE ON FILE</b>		<b>Date Approved: 8/18/14</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
New (Date policy was created)	<input type="checkbox"/>	
Reviewed (No changes to policy)	<input type="checkbox"/>	
Revised (Content changes made to policy)	<input checked="" type="checkbox"/>	8/18/14
Retired (Policy no longer active)	<input type="checkbox"/>	
<b>APPLICABILITY</b>		

This policy is applicable to all Passport Health Plan (PHP) associates, temporary staff and interns.

**PURPOSE**

A highly qualified Provider Network is a cornerstone to assuring that the most cost-effective and evidence base care is available to members. This policy provides guidance for validating a practitioner's credentials.

**POLICY**

Passport Health Plan (PHP) has developed a systematic method for assessing practitioner applicants against the health plan's credentialing standards. All prospective practitioners, as defined below, will be credentialed in accordance with the procedures set forth below.

**DEFINITION(S)**

**Practitioner:** Medical Doctor (MD), Doctor of Osteopath Medicine (DO), Doctor of Dental Science (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatry Medicine (DPM), Doctor of Chiropractic (DC), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Advanced Practice Register Nurse (APRN), Certified Register Nurse Anesthetist (CRNA), Family Nurse Practitioner (FNP), and, Physician Assistant (PA), Certified Nurse Midwife (CNM), Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychological Practitioner (LPP), Licensed Psychologist (LP). Practitioners who practice exclusively within the inpatient or freestanding facility setting are not considered practitioners for the purpose of this policy.

**Credentialing:** The process by which the Managed Care Organization (MCO) reviews and evaluates the qualifications of licensed independent practitioners to provide services to its members. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability, and accessibility, as well as, for conformity to the MCO's utilization and quality improvement requirements. A practitioner must complete the entire process to be considered credentialed. PHP does not offer a provisional credentialing status.

**Primary Care Practitioner (PCP):** An individual practitioner who provides primary care services (including family practice, general practice, internal medicine, and pediatrics) and manages routine health care needs. For women, an obstetrician/gynecologist can serve as a PCP if the practitioner so elects and is so contracted.

**Primary Source Verification:** The process by which an organization validates credentialing information from the organization that originally conferred or issued the credentialing element to the practitioner.

**Type I Practitioners:** Practitioners meeting all credentials verification guidelines with no history of malpractice suits and/or adverse professional action.

**Type II Practitioners:** Practitioners not meeting all credentials verification guidelines and/or have a history of malpractice suits and/or adverse professional action.

**Initial Tracking Log:** Excel spreadsheet used to track new practitioners as well as their status throughout the credentialing process.

**PHP Load Spreadsheet:** Excel spreadsheet used to house data from a practitioners application and primary source verification of credentials.

## **PROCEDURE**

### **I. Confidentiality of credentialing information**

- A. Information received through the credentialing process is considered confidential and utilized only for the purpose of reviewing prospective practitioner applicants for participation in the network.
- B. All written documentation received is placed in the practitioner applicant's file and stored in a locked cabinet. The keys to the practitioner file cabinets are maintained by the Provider Enrollment staff.
- C. All electronic files housing the credentialing status of practitioners are accessible only to the Provider Enrollment and Provider Network Management departments.

### **II. Identification/Notification to Credentialing of prospective practitioners**

Upon receipt of a practitioner application packet from contracting or a provider's office, the Provider Enrollment Representative enters the providers name and date received into the initial tracking log and assigns a pending status within one business day.

The Provider Enrollment Representative verifies the packet for completeness within five business days. Once deemed complete the representative enters into initial tracking log the application complete date. Data from the practitioner's application is entered into the PHP load spreadsheet.

A complete credentialing packet includes:

1. Complete Provider Application.
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2. Two signed Participating Provider Agreements, if applicable.
3. Complete and signed MAP Forms, if applicable.
4. A copy of the practitioner's current State License or web verification from the appropriate state licensure board website.
5. A copy of the practitioner's current Federal Drug Enforcement Agency Registration - if applicable.
6. Curriculum vitae or a copy of a summary specifying month and year, explaining any lapse in time exceeding six months. CV available on CAQH application is also acceptable.
7. A copy of a W-9.
8. A copy of the practitioner's current professional liability insurance Certificate of Coverage, including the name and address of the agent, and the practitioner's name (either on the certificate or on an accompanying list). CAQH application is acceptable in lieu of hard copy certificate.
9. A letter adding the practitioner to the existing group contract.
10. A copy of the practitioner's Medicare Certificate (a letter from the Centers for Medicare & Medicaid Services (CMS) with the practitioner's unique Medicare provider identification number), if applicable.
11. ECFMG (Education Council for Medical Graduates) Certificate, if applicable.
12. FOX verification documentation for National Provider Identifier (NPI) and Taxonomy Code(s). National Plan & Provider Enrollment System (NPPES) verification is acceptable.
13. Attestation signature must not be older than 180 days from date the application is submitted.

If the applicant's file is incomplete the Provider Enrollment Representative contacts the practitioner office via phone or e-mail and requests the missing or corrected documentation. After three attempts to obtain the requested additional documentation, the entire packet will be returned to the provider, at which point they must submit a completed packet, thus starting the process all over again.

### III. Credentials Verification and Classification as a Type I or Type II practitioner

- A. Within 10 business days of an application being deemed complete the practitioner's credentials are verified through primary source verifications.
  - B. Items verified and their sources include:
    - **Education** – School, AMA physician master file, ECFMG, AOA, Assoc. of schools of health professions, State licensing agencies or boards, Chiropractic College, Dental school, Residency training, Dental board, Specialty board.
    - **Training** - Confirmation from residency program, AMA physician master file, AOA, confirmation from Association of schools of health professions, confirmation from state licensing agency, Podiatrist specialty board (if certified). **Professional Experience/ Work History/ Hospital Affiliations** - Five years relevant work history obtained through the CAQH or KAPER application or CV. Any gaps exceeding six months must be explained, in writing.
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- **Hospital affiliation** as attested to on the application.
  - **Board Certification** - ABMS or ABMS Display Agents, AOA, AMA Physician Master file, State licensing agency (if they perform Primary Source Verification (PSV) of board certification), ACGME for foreign medical graduates, Specialty boards. If a practitioner is not board certified, the highest level of education and/or training is verified.
  - **Licensure** - Letter or printout from state licensing board.
  - **Sanctions** - Sanctions, restrictions and limitations must cover the most recent five year period for all states where the provider practiced. NPDB, HIPDB, FSMB, State agency, State board, CIN-BAD.
  - **DEA** - Copy of the DEA certificate, AMA physician master file, confirmation with the state pharmaceutical licensing agency.
  - **Malpractice Insurance** - Proof of current malpractice insurance coverage, including dates and amounts of coverage; a copy of the insurance face sheet; five year history of malpractice settlements from the carrier or the NPDB.
  - **Medicare/Medicaid Sanctions** - Practitioners who are excluded from federal health programs will not be considered for participation. Medicare and Medicaid status must be verified to note participation/exclusion status. Sources for Medicare/Medicaid sanctions include state Medicaid agency or intermediary and Medicare intermediary, list of Excluded Individuals and Entities (maintained by OIG), FEHB published by Office of Personnel Management, Office of Inspector General, FSMB, NPDB-HIPDB.
- Attestation** - The provider signs an attestation that addresses:
- Ability to perform the essential functions of the position, with or without accommodation
  - Lack of present illegal drug use
  - History of loss of license and felony convictions
  - Current malpractice coverage
  - History of loss or limitation of privileges or disciplinary activity
  - Correctness and completeness of application
- C. The Provider Enrollment Representative forwards all Type I verification reports to the Chief Medical Officer (CMO), or designated Medical Director (MD) for review. The CMO, or designated MD reviews the Type I practitioners for approval and sign off on all clean files in accordance with the criteria in Attachment A.
- D. The Provider Enrollment Representative forwards all verification reports for Type II practitioners to the CMO, or designated MD, for review prior to inclusion in the next Credentialing Committee agenda. The CMO or MD, reviews the Type II practitioners and identifies any in which additional information would be needed for the committee's review.
- E. The Provider Enrollment Representative develops the Credentialing Committee's packet and includes, at a minimum, an agenda and listing of all Type I practitioners. To ensure a nondiscriminatory review, all Type II practitioner files are de-identified prior to inclusion in the committee packet. The packet is distributed at least five business days prior to the committee meeting.

#### IV. Practitioner Reinstatement

In the event a credentialed practitioner leaves the PHP provider network for greater than 30 days, they must complete the entire credentialing process in order to be reinstated.

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**V. Decision Making Process**

- A. The Credentialing Committee is composed of participating practitioners in the Plan's network and chaired by the Plan's CMO or designated MD. The Committee reviews each applicant in accordance with the criteria for participation Attachment A, and votes for acceptance for participation, denial for participation, request additional information or a modified participation status, i.e. a re-credentialing date of less than three years.
- B. The Credentialing Committee will not vote for acceptance or denial based on a practitioner's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or types of patients.
- C. The committee may request additional information from a practitioner if there are areas in which further clarification is needed prior to making a decision. Practitioners being reviewed and in need of additional information are considered non-participating until a final decision is reached by the committee. The committee may not grant temporary privileges for any reason.
- D. Credentialing actions must be reported to and approved by the Partnership Council. However, the CMO or MD may implement immediate administrative restrictions with regard to any participating provider where the CMO or MD believes such restriction is necessary to protect the health and safety of Plan members pending Partnership Council review. Examples of such circumstances include but are not limited to: Emergency Orders of Restriction and Licensure Board Disciplinary Orders. For approved practitioners the effective date commences with the date the application was deemed complete.

**VI. Following Participating Network Approval**

- A. Once approved for network participation, the provider enrollment representative mails an executed contract, if applicable, along with the welcome letter to the practitioner within 60 days of approval. A list of all newly credentialed practitioners is distributed to designated individuals for the following departments: Chief Medical Officer's Office, Provider Network Management, Medical Management, Member and Provider Services, IT Reporting, Provider Claim Service Unit (PSCU) and Public Affairs.
  - B. A letter from the CMO is sent to all practitioners denied participation with the plan in accordance with Credentialing/Re-credentialing Appeal Process Policy CR 3.01. Notice is also given to the Provider Network Management department of all practitioners denied participation.
  - C. The Provider Enrollment Representative provides notice to the State Medical Licensure Board, Department for Medicaid Services (DMS) and National Practitioner Data Bank (NPDB) of any adverse actions taken by the Plan, in accordance with the NPDB requirements included in CR 11.01 Practitioner Sanctioning and Reporting policy.
  - D. The Provider Enrollment Representative ensures a complete copy of the Credentialing Committee minutes and listing of practitioners reviewed are maintained in the committee binder.
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**CROSS REFERENCES/REFERENCE MATERIALS**

CR 2.01 Credentialing Committee  
CR 3.01 Credentialing/Recredentialing Appeal Process  
CR 5.01 Practitioner's Credentialing Rights  
CR 11.01 Practitioner Sanctioning and Reporting Policy

**REVIEW AND REVISION DATES (Annually at a minimum)**

October 1999, January 2000, March 2000, June 2001, June 2002, June 2003, December 2003,  
January 2004, April 2004, June 2004, June 2005, June 2007, April 2007, May 2007, March 2008,  
March 2009, December 2010, February 2012, March 2013, September 2013, August 2014

End of Policy

### Credentialing Criteria and Decision Making Process for Practitioners

<b>License</b>	Practitioners must hold a valid, current license, in the state in which he/she practices at the time of the credentialing decision. Practitioners without a valid, current license will not be considered for participation. Practitioners with Limited Licenses (LL) or Institutional Licenses (IP) will not be considered for participation per DMS regulations. <i>The verification of the license must not be more than 180 calendar days old at the time of review by the Credentialing Committee.</i>
<b>DEA or CDS Certificate</b>	Practitioner applicants who prescribe medications must hold an active DEA or CDS Certificate at the time of the credentialing decision. DEA- or CDS-eligible practitioners who do not prescribe medications requiring DEA or CDS certificate must provide, in writing, an explanation why he/she does not prescribe medications and describe what arrangements he/she has made for patients who need prescriptions for medications requiring DEA or CDS certification. Practitioner applicants who are considered to be prescribing practitioners not holding a current DEA or CDS Certificate will be considered a Type II practitioner. Type II practitioners for reasons of no DEA or CDS certificate will be considered for participation on an individual basis.
<b>Education</b>	Practitioner applicants must have completed the appropriate level of education for the specialty in which they are applying in accordance with NCQA's requirements for education and training. Practitioners with incomplete education for their specialty will not be considered for participation.
<b>Board Certification</b>	Board certification is not a requirement for participation, but will be presented to the committee as part of the verification report. <i>The verification of board certification must not be more than 180 calendar days old at the time of review by the Credentialing Committee and the expiration date documented.</i> If a practitioner is not board certified, the highest level of education and/or training is verified.
<b>Work History</b>	Practitioner applicants should have no more than six months gap in service during the past five years of practice prior to the credentialing decision. Practitioner applicants with more than a six month gap in service will be considered a Type II practitioner and considered on an individual basis for participation in the Plan. <i>The work history must be submitted by the practitioner within 180 calendar days prior to review by the Credentialing Committee.</i>

<p><b>Malpractice History</b></p>	<p>Practitioner applicants having malpractice history within the past five years from the settlement date either through self-report or as identified through the NPDB, will be considered a Type II practitioner. Practitioners with only pending claims will be presented as a Type I until the claim is settled. Type II practitioners for reasons of malpractice history will be considered for participation on an individual basis. <i>Malpractice history must be verified within 180 calendar days prior to review by the Credentialing Committee.</i></p>
<p><b>Hospital Affiliations</b></p>	<p>Credentialing criteria regarding clinical privileges is as follows:</p> <ul style="list-style-type: none"> <li>• PCPs and specialists whose scope of practice typically requires hospital privileges, must have an unrestricted admitting and/or practice privileges, in good standing, at a network participating hospital, or must submit a written agreement with another network practitioner to admit and treat his/her patients at a network participating hospital. Those without privileges at a network participating hospital will be considered a Type II practitioner.</li> </ul> <p>The committee will consider all Type II practitioner applicants on an individual basis utilizing Geo-Access reports to assess the Plan’s needs for providing coverage of care to the existing or prospective membership. Access needs for Foster Care population will always be considered an exception to the admitting privileges requirements.</p>
<p><b>Malpractice Coverage</b></p>	<p>Practitioner applicants must have active malpractice coverage, up to the minimum amount, in accordance with existing Kentucky or Indiana state laws at the time of the credentialing decision. Practitioners not holding current malpractice coverage will not be considered for participation.</p>
<p><b>Positive responses on the practitioner attestation</b></p>	<p>Practitioners reporting a “yes” answer on the practitioner attestation will be considered Type II practitioners. The committee will consider written statements by the practitioner regarding “yes” responses when rendering a participation decision. Type II practitioner applicants will be considered for participation on an individual basis. <i>The practitioner signature date on the attestation must be within 365 calendar days prior to review by the Credentialing Committee.</i></p>
<p><b>Sanctions</b></p>	<p>Practitioners who are excluded from federal health programs will not be considered for participation. Practitioner applicants having sanctions taken by State Boards, Medicaid/Medicare, Excluded Parties Listing via SAM.gov, DEA/CDS or any hospitals or MCOs which have limited, suspended, or abolished the practitioner’s privileges will be considered a Type II practitioner. All practitioners considered Type II for reasons of sanctions will be considered for participation on an individual basis. <i>Verification of sanctions must have occurred within 180 calendar days</i></p>

CR 1.01 Practitioner Credentialing

	<i>prior to review by the Credentialing Committee.</i>

		<b>Policy/Procedure</b>
<b>Policy Name: Practitioner Re-Credentialing</b>		<b>Policy Number: CR 4.01</b>
<b>Date of Next Annual Review: August 18, 2015</b>		<b>Original/Issue Date: November 1, 1997</b>
<b>Approved By: Stephen Houghland, MD</b>		<b>Title: Chief Medical Officer</b>
<b>Signature: SIGNATURE ON FILE</b>		<b>Date Approved: 8/18/14</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
New (Date policy was created)	<input type="checkbox"/>	
Reviewed (No changes to policy)	<input type="checkbox"/>	
Revised (Content changes made to policy)	<input checked="" type="checkbox"/>	8/14/14
Retired (Policy no longer active)	<input type="checkbox"/>	
<b>APPLICABILITY</b>		

This policy is applicable to all Passport Health Plan (PHP) associates, temporary staff and interns.

#### **PURPOSE**

A highly qualified Provider Network is a cornerstone to assuring that the most cost-effective and evidence base care is available to members. This policy provides guidance for validating a practitioner's credentials and to review quality data regarding the practitioner at least every three years to asset in assuring a high quality Provider Network.

#### **POLICY**

Passport Health Plan (PHP) has a systematic method for assessing practitioners against the health plan's recredentialing standards. All practitioners, as defined below, are re-credentialed in accordance with the procedures set forth below minimally every three years. Practitioners may be re-credentialed earlier than three years if other quality or service data has identified the need for earlier review as noted in CR 10.01, Ongoing Monitoring of Sanctions and Complaints.

#### **DEFINITION(S)**

**Practitioner:** Medical Doctor (MD), Doctor of Osteopath Medicine (DO), Doctor of Dental Science (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatry Medicine (DPM), Doctor of Chiropractic (DC), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Advanced Practice Register Nurse (APRN), Certified Register Nurse Anesthetist (CRNA), Family Nurse Practitioner (FNP), and, Physician Assistant (PA), Certified Nurse Midwife (CNM), Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychological Practitioner (LPP), Licensed Psychologist (LP). Practitioners who practice exclusively within the inpatient or freestanding facility setting are not considered practitioners for the purpose of this policy.

**Credentialing:** The process by which the Managed Care Organization (MCO) reviews and

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evaluates the qualifications of licensed independent practitioners to provide services to its members. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability, and accessibility, as well as, for conformity to the MCO's utilization and quality improvement requirements. A practitioner must complete the entire process to be considered credentialed. PHP does not offer a provisional credentialing status.

**Re-credentialing:** The process by which the MCO evaluates performance monitoring data and re-verifies the credentialing information that is subject to change over time.

**Primary Care Practitioner (PCP):** An individual practitioner who provides primary care services (including family practice, general practice, internal medicine, and pediatrics) and manages routine health care needs. For women, an obstetrician/gynecologist can serve as a PCP if the practitioner so elects and is so contracted.

**Primary Source Verification:** The process by which an organization validates credentialing information from the organization that originally conferred or issued the credentialing element to the practitioner.

**Type I Practitioners:** Practitioners meeting all re-credentials verification guidelines with no history of malpractice suits and/or adverse professional action.

**Type II Practitioners:** Practitioners not meeting all re-credentials verification guidelines and/or have a history of malpractice suits and/or adverse professional action.

**Recredentialing Tracking Log:** Excel spreadsheet used to track practitioners and their status throughout the recredentialing process.

**PHP Load Spreadsheet:** Excel spreadsheet used to house information required for the practitioner recredentialing process.

## **PROCEDURE**

### **I. Confidentiality of recredentialing information**

- A. Information received through the recredentialing process is considered confidential and utilized only for the purpose of reviewing participating practitioners for continued participation in the network.
- B. All written documentation received is placed in the practitioner's file and stored in a locked cabinet. The keys to the practitioner file cabinets are maintained by the Enrollment staff.
- C. All electronic files housing the credentialing status of practitioners are accessible only to the Provider Enrollment and Provider Network Management departments.

### **II. Credentials Re-verification and Classification as a Type I or Type II practitioner**

- A. The re-credentialing process is initiated three months prior to the practitioner's three year anniversary date. The Council for Affordable Quality healthcare (CAQH) database is checked for a complete and current application. If one is available it is downloaded and the
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verification process begins. The CAQH Data Summary and attestation page may be pulled in place of the CAQH application for recredentialing only. If no application is found or it is incomplete or not up to date a letter is sent advising the practitioner to submit a recredentialing application and instructions. (Attachment A). If no application is received a second letter is sent 10 business days later with telephonic follow-up. After three attempts to obtain the requested additional documentation, the entire packet will be returned to the provider at which point they must submit a completed packet thus starting the process all over again.

- B. Practitioners who fail to comply with the Plan's recredentialing program by not completing and submitting the application and/or needed attachments are also referred to the Provider Network Management department for follow up. The Provider Network Management department notifies the practitioner that failure to comply with the recredentialing program violates their contract requirements and that continued non-compliance will result in termination of their contract.
- C. The Provider Enrollment Representative updates the recredentialing tracking log and the PHP load spreadsheet within two business days of verification of a complete application for recredentialing.
- a) Within 10 business of documentation in the recredentialing tracking log and PHP load spreadsheet for complete applications the practitioner's credentials are verified through primary source verifications.
- b) Items verified for recredentialing and their sources include:
- **Professional Experience/ Work History/ Hospital Affiliations** - Five years relevant work history obtained through the CAQH or KAPER application or CV. Any gaps exceeding six months must be explained.
  - Hospital affiliation as attested to on the application.
  - **Board Certification** - ABMS or ABMS Display Agents, AOA, AMA Physician Master File, State licensing agency (if they perform PSV of board certification), ACGME for foreign medical graduates, Specialty boards.
  - **Licensure** - Letter or printout from state licensing board.
  - **Sanctions** - Sanctions, restrictions and limitations must cover the most recent five year period, for all states where the provider practiced. NPDB, HIPDB, FSMB, State agency, State board, CIN-BAD.
  - **DEA** - Copy of the DEA certificate, AMA physician master file, confirmation with the state pharmaceutical licensing agency.
  - **Malpractice Insurance** - Proof of current malpractice insurance coverage, including dates and amounts of coverage; a copy of the insurance face sheet; five year history of malpractice settlements from the carrier or the NPDB.
  - **Medicare/Medicaid Sanctions** - Medicare and Medicaid status must be verified to note participation/exclusion status. NPDB, HIPDB, FSMB, OIG Cumulative Sanctions Report, State Medicaid/Medicare intermediary.
  - **Attestation** - The provider signs an attestation that addresses:
    - Ability to perform the essential functions of the position, with or without accommodation
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- Lack of present illegal drug use
  - History of loss of license and felony convictions
  - Current malpractice coverage
  - History of loss or limitation of privileges or disciplinary activity
  - Correctness and completeness of application
- **Quality of Care Trends and Member Complaints** – Any quality of care reports or documented member complaints received by the Plan during the previous 36 months.
- D. The Provider Enrollment Representative forwards all Type I verification reports to the Chief Medical Officer (CMO), or designated Medical Director (MD) for review. The CMO or MD, reviews the Type I practitioners for approval and sign off on all clean files in accordance with the criteria in Attachment A.
- E. The Provider Enrollment Representative forwards all verification reports for Type II practitioner files to the CMO, or designated MD, for review prior to inclusion in the next Credentialing Committee agenda. The CMO or MD, reviews the Type II practitioners and identifies any in which additional information would be needed for the committee's review.
- F. The Provider Enrollment Representative develops the Credentialing Committee's packet and includes at a minimum, an agenda and listing all Type I practitioners. To ensure a nondiscriminatory review, all Type II practitioner files are de-identified prior to inclusion in the committee packet. The packet is distributed at least five business days prior to the committee meeting.
- G. All Type II practitioners are taken to the Credentialing Committee for review and approval or denial for continued participation.

### **III. Decision Making Process**

- A. The Credentialing Committee is composed of participating practitioners in the Plan's network and chaired by the Plan's CMO or MD. The committee reviews each applicant in accordance with the criteria for participation Attachment A, and votes for continued participation, denial for continued participation, request additional information or a modified participation status, i.e. a recredentialing date of less than three years.
- B. The Credentialing Committee does not vote for acceptance or denial based on a practitioner's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or types of patients.
- C. The committee may request additional information from a practitioner if there are areas in which further clarification is needed prior to making a decision.
- D. Credentialing actions must be reported to and approved by the Partnership Council. However, the CMO or MD may implement immediate administrative restrictions with regard to any participating provider where the CMO or MD believes such restriction is necessary to protect the health and safety of Plan members pending Partnership Council review. Examples of such circumstances include but are not limited to: Emergency Orders of Restriction and Licensure Board Disciplinary Orders. For approved
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practitioners the effective date commences with the date the application was deemed complete.

#### **IV. Following Continued Network Approval**

- A. Once approved for continued network participation, the Provider Enrollment Representative includes a notation in the practitioner's file of the date of the committee's decision to approve or deny continued participation in the Plan.
- B. A letter from the CMO is sent to all practitioners' denied participation with the Plan in accordance with CR 3.01 Credentialing/Recredentialing Appeal Process Policy. Notice is also given to the Provider Network Management and Compliance departments of all practitioners denied participation.
- C. The Provider Enrollment Representative ensures a complete copy of the Credentialing Committee minutes and listing of practitioners reviewed are maintained in the committee binder.

The Provider Enrollment Representative provides notice to the State Medical Licensure Board, Department for Medicaid Services (DMS) and National Practitioner Data Bank (NPDB) of any adverse actions taken by the Plan, in accordance with the NPDB requirements included in CR 11.01 Practitioner Sanctioning and Reporting Policy.

#### **CROSS REFERENCES/REFERENCE MATERIALS**

CR 1.01 Practitioner Credentialing  
CR 2.01 Credentialing Committee  
CR 3.01 Credentialing/Recredentialing Appeal Process  
CR 5.01 Practitioners Credentialing Rights  
CR 10.01 Ongoing Monitoring of Sanctions and Complaints  
CR 11.01 Practitioner Sanctioning and Reporting

#### **REVIEW AND REVISION DATES (Annually at a minimum)**

November 1998, January 2000, March 2---, June 2001, June 2002, June 2003, December 2003, January 2004, April 2004, June 2004, June 2005, June 2006, April 2007, May 2007, March 2008, March 2009, February 2010, December 2010, February 2012, March 2013, September 2013, August 2014

End of Policy

**Recredentialing Criteria and Decision Making Process for Practitioners**

<b>License</b>	Practitioners must hold a valid, current License in the state in which he/she practices, at the time of the recredentialing decision. Practitioners without a valid, current license will not be considered for reappointment. Practitioners with Limited Licenses (LL) or Institutional Licenses (IP) will not be considered for participation in accordance with DMS regulations.
<b>DEA or CDS Certificate</b>	Practitioner applicants who prescribe medications must hold an active DEA or CDS Certificate at the time of the credentialing decision. DEA- or CDS-eligible practitioners who do not prescribe medications requiring DEA or CDS certificate must provide, in writing, an explanation why he/she does not prescribe medications and describe what arrangements he/she has made for patients who need prescriptions for medications requiring DEA or CDS certification. Practitioner applicants who are considered to be prescribing practitioners not holding a current DEA or CDS Certificate will be considered a Type II practitioner. Type II practitioners for reasons of no DEA or CDS certificate will be considered for reappointment on an individual basis.
<b>Board Certification</b>	Board certification is not a requirement for participation, but will be presented to the committee as part of the verification report. The verification of board certification must not be more than 180 calendar days old at the time of review by the Credentialing Committee and the expiration date documented.
<b>Malpractice History</b>	Practitioners having malpractice history within the past five years from the settlement date, which has not been previously reviewed, either through self-report or as identified through the NPDB, will be considered a Type II practitioner. Practitioners with only pending claims will be presented as a Type I until the claim is settled. Type II practitioners for reasons of malpractice history will be considered for reappointment on an individual basis.
<b>Hospital Affiliations</b>	<p>Credentialing criteria regarding clinical privileges are as follows:</p> <ul style="list-style-type: none"> <li>• PCPs and specialists whose scope of practice typically requires hospital privileges, must have an unrestricted admitting and/or practice privileges, be in good standing at a network participating hospital, or must submit a written agreement with another network practitioner to admit and treat his patients at a network participating hospital. Those without privileges at a network participating hospital will be considered a Type II practitioner.</li> </ul> <p>The Committee will consider all Type II practitioner applicants on an individual basis utilizing Geo-Access reports to assess the Plan's needs for providing coverage of care to the existing or prospective membership. Access needs for Foster Care population will always be considered an exception to the admitting privileges requirements.</p>

CR 4.01 Practitioner Re-Credentialing

<p><b>Malpractice Coverage</b></p>	<p>Practitioners must have active malpractice coverage, up to the minimum amount in accordance with existing Kentucky or Indiana state laws at the time of the credentialing decision. Practitioners not holding current malpractice coverage will not be considered for reappointment.</p>
<p><b>Positive responses on the practitioner attestation</b></p>	<p>Practitioners reporting a “yes” answer on the practitioner attestation will be considered Type II practitioners. The Committee will consider written statements given by the practitioner regarding “yes” responses when rendering a participation decision. Type II practitioner applicants for reasons of a “yes” response on the attestation will be considered for reappointment on an individual basis.</p>
<p><b>Sanctions</b></p>	<p>Practitioners having sanctions taken by State Boards, Medicaid/Medicare, or any hospitals or MCOs which have limited, suspended, or abolished the practitioner’s privileges will be considered a Type II practitioner. All practitioners considered Type II for reasons of sanctions will be considered for reappointment on an individual basis.</p>

		<b>Policy/Procedure</b>
<b>Policy Name:</b> Electronic Health Record Incentive Funds		<b>Policy Number:</b> PC 58.0
<b>Date of Next Annual Review:</b> August 28, 2015		<b>Original/Issue Date:</b> 08/28/2014
<b>Approved By:</b> Lisa Dohoney		<b>Title:</b> Director, Provider Network Management
<b>Signature:</b> Signature on File		<b>Date Approved:</b> 8/28/14
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
New (Date policy was created)	<input checked="" type="checkbox"/>	8/28/14
Reviewed (No changes to policy)	<input type="checkbox"/>	
Revised (Content changes made to policy)	<input type="checkbox"/>	
Retired (Policy no longer active)	<input type="checkbox"/>	

**APPLICABILITY**

This policy is applicable to all Passport Health Plan (PHP) associates, temporary staff and interns.

**PURPOSE**

The purpose of this policy is to facilitate the development and maintenance of Passport's provider network by utilizing standard and non-standard contract language as dictated by local market conditions, as well as internal Passport requirements, and to meet DMS network adequacy standards and internal guidelines for access to care to current and future Passport membership.

**POLICY**

At no time will Passport Health Plan withhold offering contracts to Medicaid provider who have received Electronic Health Record Incentive Funds and are willing to meet the terms and conditions for participation established by the Contractor.

The Chief Medical Officer/Vice President (VP) of Operations will have signature authority on all provider contracts, standard and non-standard.

**DEFINITION(S)**

Medicaid Health Record Incentive Funds: The Medicaid EHR Incentive Program provides incentive payments for certain Medicaid health care providers to adopt and use EHR technology in ways that can positively affect patient care.

**REVIEW AND REVISION DATES (Annually at minimum)**

8/28/14

End of Policy

CONTRACT EXCEPTION REQUEST FORM

<b>HPCP ISSUE #:</b> (if applicable)	<b>Date:</b>	<b>Submitted by:</b>
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<b>HOSPITAL OR PROVIDER'S NAME:</b>	<b>HOSPITAL CONTACT:</b>
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**LOI/CONTRACT QUESTIONS:**

1.
2.
3.
4.
5.
6.

If request is to increase reimbursement over 100% Medicaid please fill out the following:

What amount of reimbursement are they requesting?	
How many members are in the area of the provider?	
What services does the provider offer?	
Will there be access issues if we do not contract? Why?	
Does this provider have affiliations to hospitals or	

