Provider Manual

COMMUNITY CARE
Behavioral Health Organization

Welcome!

Dear Network Provider,

Welcome to Community Care Behavioral Health Organization (Community Care). This Provider Manual is designed to introduce you to Community Care and provide you with contact numbers, instructions regarding authorizations, billing, and quality of service, and access to our performance standards.

Information is always changing; please watch for Provider Alerts from us. Provider Alerts amend the content of this manual and your contractual obligations.

As this Provider Manual is utilized for all of Community Care's HealthChoices contracts, we publish a companion guide within the manual for any contract where there are changes related to specific counties (please see Appendix F and Appendix G). The companion guide will identify additions and deletions to specific sections of the manual related to specific counties. Please be sure to review the appropriate document(s) in conjunction with this manual.

We welcome your suggestions about how Community Care can improve our service to you. Together we can present our members with a seamless system of high-quality behavioral health services, and contribute to the communities and regions in which we work.

We hope that you find this manual to be clear and easy to follow. If you have any questions, please call your assigned provider representative. Provider representatives' contact information can be found on our website or call our provider toll-free telephone line, 1.888.251.2224, for assistance. The Provider Line answers 24 hours a day/seven days a week.

We look forward to working with you.

Sincerely,

Kristin Burns
Senior Director, Network Relations

Corporate Office
Community Care Behavioral Health Organization
339 Sixth Avenue, Suite 1300
Pittsburgh, PA 15222

Phone: 412.454.2120 / 1.877.877.3580 (TTY)
Fax: 412.454.2177

Provider Reference Materials

- Appendix T for Mental Health Medical Necessity Guidelines may be obtained on the Community Care website.
- Chemical Dependency Medical Necessity Guidelines, Pennsylvania Client Placement Criteria (PCPC) may be obtained on the Community Care website, or from:

  Department of Health
  Bureau of Drug and Alcohol Programs
  Room 929, Health and Welfare Building
  Harrisburg, PA 17108
- Chemical Dependency Medical Necessity Guidelines, American Society for Addiction Medicine (ASAM) criteria may be obtained from the ASAM Criteria website.

Provider Lines

- Provider Phone Line: 1.888.251.2224
  Answers 24 hours a day, 7 days a week
  - Claims Questions: opt 1, opt 2
- Fraud and Abuse Hotline: 1.866.445.5190

HealthChoices Contact Information

Customer Service Lines for Members (24/7) by County

Adams	1.866.738.9849	Luzerne	1.866.668.4696
Allegheny	1.800.553.7499	Lycoming	1.855.520.9787
Berks	1.866.292.7886	McKean	1.866.878.6046
Blair	1.855.520.9715	Mifflin	1.866.878.6046
Bradford	1.866.878.6046	Monroe	1.866.473.5862
Cameron	1.866.878.6046	Montour	1.866.878.6046
Carbon	1.866.473.5862	Northumberland	1.866.878.6046
Centre	1.866.878.6046	Pike	1.866.473.5862
Chester	1.866.622.4228	Potter	1.866.878.6046
Clarion	1.866.878.6046	Schuylkill	1.866.878.6046
Clearfield	1.866.878.6046	Snyder	1.866.878.6046
Clinton	1.855.520.9787	Sullivan	1.866.878.6046
Columbia	1.866.878.6046	Susquehanna	1.866.668.4696
Elk	1.866.878.6046	Tioga	1.866.878.6046
Erie	1.855.224.1777	Union	1.866.878.6046
Forest	1.866.878.6046	Warren	1.866.878.6046
Huntingdon	1.866.878.6046	Wayne	1.866.878.6046
Jefferson	1.866.878.6046	Wyoming	1.866.668.4696
Juniata	1.866.878.6046	York	1.866.542.0299
Lackawanna	1.866.668.4696		

Clinical Fax by County

Adams	1.866.418.0366	Luzerne	1.866.284.9184
Allegheny	1.888.251.0087	Lycoming	1.855.346.7318
Berks	1.866.418.0366	McKean	1.866.294.1142
Blair	1.855.480.7029	Mifflin	1.866.562.2406
Bradford	1.866.558.2618	Monroe	1.866.562.2405
Cameron	1.866.294.1142	Montour	1.866.558.2618
Carbon	1.866.562.2405	Northumberland	1.866.558.2618
Centre	1.866.562.2406	Pike	1.866.562.2405
Chester	1.888.589.6559	Potter	1.866.294.1142
Clarion	1.866.294.1142	Schuylkill	1.866.558.2618
Clearfield	1.866.294.1142	Snyder	1.866.558.2618
Clinton	1.855.346.7318	Sullivan	1.866.558.2618
Columbia	1.866.558.2618	Susquehanna	1.866.284.9184
Elk	1.866.294.1142	Tioga	1.866.558.2618
Erie	1.855.892.8495	Union	1.866.558.2618
Forest	1.866.294.1142	Warren	1.866.294.1142
Huntingdon	1.866.562.2406	Wayne	1.866.558.2618
Jefferson	1.866.294.1142	Wyoming	1.866.284.9184
Juniata	1.866.562.2406	York	1.866.418.0366
Lackawanna	1.866.284.9184		

TTY for People Who Are Deaf/Hard-of-Hearing:	1.877.877.3580
Spanish Line:	1.866.229.3187
Autism Support Line:	1.866.415.1708
PA Child Abuse Hotline:	1.800.932.0313

About Community Care Behavioral Health Organization

Since 1999, Community Care has worked to serve HealthChoices* members and to create and support a strong network of providers and quality care. Our mission is to improve the health and well-being of the community by delivering effective, high-quality, and accessible behavioral health services in a nonprofit partnership with public agencies, experienced local providers, and involved members and their families.

Community Care is a federally tax-exempt Pennsylvania nonprofit and 501(c)(3) behavioral health managed care organization (BH-MCO). We are a subsidiary of UPMC and part of the UPMC Insurance Services Division.

Licensed as a Pennsylvania risk-assuming PPO by the Pennsylvania Insurance Department, Community Care manages behavioral health services for Medical Assistance beneficiaries who live in the counties served by Community Care. This includes HealthChoices members in each of the regions, Southwest, Southeast, Capital-Lehigh, Northeast, and North Central (state and county options).

To succeed in our partnerships with members, providers, and the communities we serve, and to achieve our goals, Community Care relies on the strong commitment of all parties involved to conduct business lawfully and ethically. Consistent with our code of ethics, Community Care has developed quality management programs, policies, and procedures to ensure compliance with legal, regulatory, and professional requirements.

The following sections describe Community Care's ethical framework and processes in detail. Please call the Provider Line at 1.888.251.2224 with questions about Community Care's ethical framework or other material in this manual.

**Community Care manages behavioral health services for Medicaid recipients (the program is known in Pennsylvania as HealthChoices) in counties throughout the Commonwealth of Pennsylvania.*

Code of Ethics

Community Care's code of ethics includes our Mission Statement, our Values, and our Code of Conduct. Details can be found on Community Care's website.

Cultural Competency Vision

Our vision for an effective and accessible behavioral health system of care leads with high-quality services that improve the health and well-being of our community. Our goal is to offer a system, ultimately free of barriers to obtaining services, comprised of integrated, balanced, and responsive mental health and substance use disorder care.

To help Community Care representatives (including providers) understand and participate in Community Care's vision, we share these definitions:

- **Culture** is the patterns of behavior that include communications, actions, customs, beliefs, values, and institutions of a social group.
- **Cultural Identity** includes but is not limited to race, ethnicity, language, age, region or country of origin, degree of acculturation, socioeconomic class, religious beliefs, and gender.
- **Cultural Awareness** is the understanding that people are shaped by the social, linguistic, ethnic, and behavioral characteristics of the cultures to which they belong, and that there are patterns of expressions, beliefs, values, and practices that can be shown to enable those providing behavioral health care to understand the diversity of people.
- **Cultural Sensitivity** is knowledge about the social, linguistic, ethnic, behavioral, and interactional characteristics of a group or population, how those behaviors and characteristics may influence a group's worldview, and the demonstration of this knowledge through provider and organizational interactions and communications.
- **Cultural Competence** is the ability to systematically translate knowledge and understanding of the social, behavioral, and interactional differences of groups into attitudes and practices of care, such as acknowledgment, inclusion, and helpfulness that promote the behavioral health and well-being of individuals, families, and communities.

Providers will be informed (through mailings, website articles, forums, and other interactions) about Community Care's commitment to a culturally competent system of services provision, and instructed on standards and performance indicators. Providers' commitment is essential to our ongoing development of a responsive system of care.

Overview of Quality Management

Quality management aims to improve and maintain member wellness by measuring and improving care and services within the health care delivery system. Community Care's quality improvement program is designed with input from network providers and follows the guidelines of all regulatory and oversight agencies including the Department of Human Services, the Department of Health, the National Committee for Quality Assurance (NCQA), and URAC.

Community Care focuses on:

- Delivering high-value, culturally competent care that incorporates the special needs and preferences of members.
- Continuously improving the behavioral health care and service provided to members.
- Enhancing the community's health status through behavioral health wellness and preventive programs.
- Pursuing opportunities to improve the health status of members, and targeting efforts to the needs of the population.
- Ensuring that care and services are available and are provided to members in a timely manner appropriate to the member's needs and preferences.
- Ensuring that care and services are coordinated between providers and across all delivery settings through the care management process.
- Establishing collegial relationships with providers to achieve superior clinical and customer service outcomes.
- Providing exceptional customer service.
- Continuously improving quality improvement processes by maintaining comprehensive, current, and effective quality management policies and procedures.
- Analyzing performance data and identifying opportunities to improve performance and outcomes.

Community Care views quality as an integrated company responsibility. Community Care's members, Board of Directors, management, departments, committees, oversight entities, providers, and community representatives all participate in quality improvement activities.

Compliance with Fraud and Abuse Reporting

To fulfill our mission and to act in accordance with our values, code of conduct, policies and regulatory requirements, Community Care maintains a Fraud, Waste and Abuse (FWA) compliance program. The following definitions of FWA are consistent with the Department of Human Services (DHS) Program Standards and Requirements, Appendix F: Fraud and Abuse:

- **Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- **Waste** is the overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.
- **Abuse** is when provider practices are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.

Avoiding Fraud and Abuse

Community Care encourages providers to read this Provider Manual, review the Community Care FWA policies and procedures, and call the Provider Line (1.888.251.2224) with any questions about standards of care, documentation and record keeping, claims/billing procedures, or any other activity that could be associated with a fraud or abuse concern. Providers are required to develop, maintain, and periodically produce a compliance plan for their agency that includes FWA staff training. In addition, Community Care offers provider training on FWA and other topics.

Reporting Suspected Fraud and Abuse to the Department of Human Services

The Department of Human Services has established a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is 1.866.379.8477 and operates between the hours of 8:30 a.m. and 3:30 p.m., Monday through Friday. Voicemail is available at all other times. Callers may remain anonymous and may call after hours and leave a voicemail if they prefer.

Some common examples of fraud and abuse are:

- Billing or charging Medical Assistance recipients for covered services
- Billing more than once for the same service
- Dispensing generic drugs and billing for brand name drugs
- Falsifying records
- Performing inappropriate or unnecessary services

Fraud and Abuse Auditing

Community Care has established an FWA compliance program based on the regulations and requirements of the Office of Inspector General (OIG), Bureau of Program Integrity (BPI), and other regulatory agents in collaboration with our primary contracts.

Community Care continuously monitors for possible FWA within our provider network by conducting compliance audits, investigating reports or referrals related to potential FWA, and analyzing billing and payment data. Community Care also reports the findings of these audits to the appropriate agencies when required (licensing, regulatory, and investigative agencies) and takes appropriate action to prevent future fraud or abuse.

Billing compliance audits of our provider panel are continuously conducted by specially trained staff using recognized standards acceptable to the Medicaid Program.

The outcome of FWA audits may include provider education, repayment of monies paid for the submitted claims, re-audit and/or submission of a corrective action plan that outlines how the audit exceptions will be prevented in the future. Notification of the results of an FWA audit will be sent to the appropriate contract administrators and the contract oversight entities and may be sent to the BPI.

Community Care follows all Medicaid Program regulations and BPI directives when conducting and reporting audit information. No claims or documentation regulations are created by Community Care.

In addition, the DHS' Medicheck list and the OIG's LEIE list are used to verify that no providers sanctioned by the state or federal regulatory authorities are participating in HealthChoices. Suspension or exclusion from the Community Care network of providers may occur as a result of fraudulent activity.

For more information concerning Community Care's Fraud, Waste, and Abuse Policies and Procedures, please visit Community Care's website.

Care Management Team

Should a member require services other than routine outpatient services, he/she will be assigned to a care manager. Care managers effectively assist members in making informed decisions about the services and supports that are available to them and to assist providers in quality service delivery through consultation and collaboration. Care management focuses on:

- Adult mental health services
- Services for children and adolescents
- Substance use disorders services
- Co-occurring disorders
- Dual diagnoses services
- Service precertification
- Members identified as high-risk

Care management operates 24 hours a day/seven days a week, with clinical supervisors on call at all hours. All care management staff have direct access to Community Care's Professional Advisor staff 24 hours a day.

The purpose of the care management team is to:

- Ensure that services are medically necessary and are being delivered at the appropriate intensity for a prescribed length of time.
- Ensure timely access to geographically convenient needed services and equitable access to care for members across the network.
- Ensure that the member and family (if indicated) are involved in treatment planning.
- Ensure coordinated care for all services and supports that the member is receiving and follow-up care when a member is transitioning from one level of care to another.
- Monitor the quality of care in several ways, including review of treatment documents, attendance at team meetings, member and provider feedback, and analysis of utilization information.
- Ensure that care meets standards and quality criteria.
- Ensure quality care at the least restrictive level.
- Assess and correct for overutilization, underutilization, inefficiency, and delays in access to services.
- Ensure that behavioral health services result in positive outcomes for members.
- Ensure that services are culturally competent.
- Provide a responsive complaint and grievance process that ensures members can voice their opinions about the care, services, and information they receive.
- Be available to answer questions from members and providers.

It is common for Community Care's care managers to attend treatment team meetings, to work with groups of providers and other stakeholders in specialty areas to improve the quality of care, and to design trainings in areas where education is requested and/or needed. Care managers work with members, families, providers, and others often in community settings.

For routine outpatient services, Community Care customer service representatives will ensure members' timely access to geographically convenient services.

Adult Mental Health, Substance Use, and Co-Occurring Services

In care management, it is important to ensure coordinated care and follow-up. This is especially important when members are unfamiliar with treatment and community support options.

Care managers are looking for:

- Appropriate clinical information including discussion of treatment options with the member and/or family.
- The consideration of non-traditional services such as Psychiatric Rehabilitation, Diversion and Acute Stabilization, Enhanced Clinical Case Management, Acute Case Management, and Community Treatment Teams (CTT) as well as Recovery and Peer Supports.
- Proactive discussion, planning, and documentation of strategies for members to utilize when dealing with crisis situations.
- Effective provider collaborative efforts focused on diverting members from the most restrictive levels of care and increasing community tenure.
- Identification of a need for workgroup meetings with providers, members, and other stakeholders to establish consistent "best practices" for specific levels of care.

Care managers act as consultants to the treatment team when requested. They also closely monitor:

- Overall access to services within designated time and distance standards and gaps with needed services.
- The demographic make-up of the provider network ensuring a diverse network of options for members.
- The appropriate application of medical necessity guidelines and proper documentation of supporting information for the purpose of utilization management.
- Coordination of care activity between behavioral health and physical health providers.
- Inquiries, complaints, and strategies to assist members with multiple and/or complex needs.
- The extent to which members with a co-occurring disorder receive referrals for services and supports that fully address their needs.

In order to serve special population groups and members with high utilization of the most restrictive levels of care, a "tier" methodology is utilized to identify members who may require special intervention by a care manager. All members have a specific care manager assigned to them.

Team members work collaboratively to serve members who have co-occurring mental health and substance use disorders. Mental Illness/Substance Abuse (MISA) screenings have become part of a formal program for members who are receiving both mental health and drug and alcohol services. Care managers ask questions during regular utilization reviews to determine whether providers are screening for dual disorders and offering appropriate referrals to members when a co-occurring disorder is identified. The program is monitored on an ongoing basis through quality record reviews.

Services for Children and Adolescents

Community Care's child and adolescent team is a specialized group of care managers with a strong background and expertise in the areas of child and adolescent services as well as family systems.

These care managers:

- Provide parents with specific information.
- Monitor the prescription of services and actual service delivery for each child.
- Attend interagency team meetings.
- Monitor Behavioral Health Rehabilitative Services for Children and Adolescents (BHRSCA) through active participation with the treatment team.
- Monitor Residential Treatment Facility (RTF) services with an emphasis on transition planning.
- Ensure coordination of care between behavioral health providers and with the primary care physician.
- Ensure proper involvement of children/family services agencies or juvenile justice agencies when needed.
- Facilitate coordination with schools.
- Facilitate physical health and behavioral health integrated care.
- Consider non-traditional services such as therapeutic services in Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy (MST), and Functional Family Therapy (FFT).
- Act as consultant to the treatment team when requested.

Community Care also provides written informational material for parents and resources on its website.

Precertification Team

Community Care maintains a dedicated team of care managers to conduct precertification reviews for acute levels of care. These care managers ensure that individuals' needs and strengths have been assessed, that the specific level of care requested meets medical necessity guidelines, and that the requested level of care provides the least restrictive environment for the member to continue the recovery process. In addition, the care managers on the precertification team may assist the member and provider in identifying options and facilitating diversion planning. These care managers will also facilitate coordination of care efforts based on the member's treatment history, current authorized services, and active crisis plan.

High Risk Intervention

This specific team of care managers works with members and their providers to resolve complex or high-risk factors which impact the member's ability to progress towards recovery. Face-to-face or telephone contact is focused on both the member and provider. Because medical conditions often co-exist with a behavioral health diagnosis, coordinating care with physical health practitioners is also a priority. This team's activities are driven by the needs and strengths of the individual member with frequent consultation with the Community Care professional advisors.

Performance Standards

Care managers focus on performance standards. Community Care created these standards with the goal of providing consistent, high-quality care to all members. A current list of the performance standards can be found on Community Care's website.

Care managers may refer to the performance standards as they are collaborating with a provider. Care managers ensure that:

- Clinical information given to the care manager meets the standards and guidelines for medical necessity review.
- All information is complete and up-to-date.
- Information is clear and specific.
- Performance standards for that specific level of care are met.

Because care managers collaborate closely with providers during the utilization management process, they can often provide additional oversight, consulting, and monitoring to those providers who may be having difficulty meeting network benchmarking standards.

For information about approval standards, see Appendix A for the Guidelines for Obtaining Approval for In-plan Services. Authorization is based on administrative and medical necessity guidelines. For information about medical necessity guidelines, click here or visit Community Care's website.

Peer Reviewers

Care managers may not deny care. If a member's behavioral health status does not meet medical necessity guidelines for the level of care or the services do not meet Clinical Practice Guidelines, the service is reviewed by a Community Care professional advisor (peer reviewers).

Community Care contracts with board-certified psychiatrists and addiction specialists, some with subspecialty expertise in providing child and adolescent or geriatric care and with state-licensed psychologists to serve as peer reviewers. Peer reviewers are thoroughly trained to evaluate whether proposed services meet quality criteria, medical necessity guidelines, and Clinical Practice Guidelines. Community Care peer reviewers perform the following services:

- Render objective decisions on the level of care (medical necessity) and the appropriateness and quality of care.
- Advise Community Care's Chief Medical Officer and Quality Management and Care Management Departments.
- Consult with providers on precertification, concurrent, and post-service reviews.

About Community Care HealthChoices Members

Community Care's HealthChoices members are individuals for whom Community Care has been contracted to manage behavioral health (mental health or drug and alcohol) services. Community Care offers a toll-free member line that is staffed 24 hours a day, seven days a week to address all member inquiries and concerns, including services covered, selecting a behavioral health provider, out-of-area care, and complaints. In accordance with quality standards, the member is able to speak to a customer services representative at any time of the day or night. Customer services representatives serve as the point of contact for members until they use a service other than routine outpatient behavioral health services, at which time a care manager is assigned.

Providers are asked to urge members who have questions about their behavioral health care to call the toll-free Community Care member lines. (Customer service phone numbers are listed by county in the contact information section of this manual.) In addition, every member receives and is encouraged to read the Community Care Member Handbook.

Member Rights & Responsibilities

Member rights and responsibilities are intended to serve as guidelines to help the member, provider, and others work cooperatively and effectively for the member's benefit. Member responsibilities are not a required standard of behavior and must always be considered in light of the nature of the member's strengths and needs, as well as the particular circumstances at the time. More information about member rights and responsibilities can be found on Community Care's website.

Member Help in Selecting Providers

Community Care customer services representatives assist members who ask for help in identifying a provider who will meet their needs. To obtain a selection of providers in the requested specialty, location, etc., the representative consults Community Care's PsychConsult® MCO database, which contains the most current information providers have supplied to Community Care. A representative may disclose the following information about prospective providers to help the member choose:

- Specialty
- Office location, telephone number, and office hours
- Gender
- Professional credentials
- Languages spoken by provider/provider staff if this information was disclosed on the credentialing/recredentialing or assessment/ reassessment application form

A representative may not disclose providers' malpractice limits and/or history, National Practitioner Data Base information, or Drug Enforcement Agency (DEA) number. A representative will not refer members to a provider who is not currently accepting new clients or indicate a preference of one provider over another. If the member requires additional assistance in selecting a provider, the call will be referred to a care manager. Members may ask to change their provider at any time. Members can also search for providers on the Community Care website.

Member Satisfaction

Member satisfaction is the highest priority for Community Care. Dedicated to improving the satisfaction of members, Community Care contracts with an outside survey company to conduct an annual Member Satisfaction Survey for members and family members of children and adolescents. The survey tool used is the expanded Experience of Care and Health Outcomes (ECHO) survey. Information from this survey is important to quality management programs.

Community Care also uses data about member complaints to assess member satisfaction with care and services. Community Care's Quality and Care Management Committee reviews and analyzes complaint data routinely. The Quality Department uses complaint information to:

- Identify opportunities for improvement
- Collaborate with providers to develop and monitor interventions to improve performance

The categories used to analyze member complaints include access to services, attitude and service, quality of care, cultural competence, and billing.

Member Complaints

Community Care's policy for the resolution of complaints has been developed to establish an objective review process to investigate and resolve all complaints in an appropriate and timely manner and to meet all county, state, URAC, and NCQA requirements. Community Care ensures impartial review by designating reviewers who are not associated with the issue being considered and have not already reviewed the issue.

- **Inquiry**: An inquiry is defined as any member's request for administrative services or information, or expressing an opinion. Whenever specific corrective action is requested by the member or determined to be necessary by Community Care, an inquiry is classified as a complaint.
- **Complaint**: A complaint is defined as a dispute or objection by a member or their representative. A representative, who may be the member's provider, must have proof of the member's written authorization in order to be involved and/or take action on the member's behalf. Complaints are concerned with participating health care providers, coverage (including contract exclusions and non-covered benefits), operations, or management policies of Community Care. If complaints have not been resolved by Community Care, then the member may file a second level or external complaint with Community Care, the Pennsylvania Department of Health, or the Pennsylvania Insurance Department. The term does not include a grievance.

Member Grievances

Community Care reviews requests from providers for behavioral health services to ensure that only medically necessary services are approved.

From time to time, a member, family member, or parent/guardian of a member will not agree with determinations of medical necessity. At such times, the member, their provider (with written permission of the member), or the parent/guardian (if the member is a minor or in foster care), have the right to file a grievance with Community Care. Grievances are available to address disagreements in adverse determination decisions. All Community Care personnel involved in this grievance procedure shall comply with all policies regarding confidentiality and conflict of interest to ensure that the confidentiality of member information is maintained.

Grievance

A grievance is a request by a member or their authorized representative, or by a health care provider with the written consent of the member or guardian, to have Community Care or a Certified Review Entity (CRE) reconsider a decision concerning the medical necessity and appropriateness of a health care service. If Community Care is unable to resolve the matter, a grievance may be filed regarding the decision that does any of the following:

- Disapproves full or partial payment for a requested health service.
- Approves the provision of a requested health care service for a lesser scope or duration than requested.
- Disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service. The term does not include a complaint.

For more detailed information about complaints, grievances, and fair hearings, please see Appendix H of the Department of Human Services Program Standards and Requirements.

About Being a Community Care HealthChoices Provider

Community Care's goals in developing and supporting a network of HealthChoices providers are to:

- Have a comprehensive range of providers to deliver all behavioral health services covered under HealthChoices regardless of participation in Federal Health Care Programs under Sections 1128 or 1128A of the Social Security Act.
- Offer an adequate number of practitioners and facilities appropriately dispersed throughout Community Care's service area to allow for easy and convenient access by members.
- Offer a sufficient number of specialist and ancillary providers to permit ample choice for referrals regardless of cost.

Community Care's goals are also to include providers who:

- Serve high-risk populations.
- Have demonstrated a commitment to public sector consumers.
- Are committed to implementing treatment services that are consistent with the principles of the Community Support Program (CSP), Department of Drug and Alcohol Programs (DDAP), and the Child and Adolescent Service System Programs (CASSP).
- Have worked to involve members and families actively in the design and implementation of treatment programs.
- Have understood the relevance of psychosocial assessments in the design and implementation of treatment.
- Represent both general and specific treatment skills.
- Will broaden access to assessment and treatment services, provided in a respectful and competent manner.

All providers of behavioral health services that are identified to participate in any of Community Care's networks are required to participate in a network management screening process prior to being offered an application. Community Care then reviews this information with its county partners prior to making a network inclusion decision. Community Care prospectively identifies member needs based on knowledge of prior services used, psychosocial factors, member and family suggestions, and provider experience. The geographic distribution and demographic characteristics of members are analyzed as well as the provider's ability to meet the assessed and expected member needs.

In the event that a provider is denied network inclusion, the provider is notified in writing by the Network Relations Department of the decision. A clear rationale for the decision and an explanation of the right to appeal is included.

Community Care contracts with the following types of providers of behavioral health services:

- **Practitioners** in individual or group practice (physicians, psychiatrists, addictionologists), doctoral or master's-level licensed clinical psychologists, doctoral or master's-level clinical psychiatric nurse specialists, doctoral or master's-level licensed social workers, and other master's or doctoral-level licensed behavioral health clinicians.
- **Facilities** (facilities and organizations).
- **Providers** (denotes information that applies to both practitioners and facilities).

The Community Care credentialing program is committed to:

- Careful selection, credentialing, and recredentialing of practitioners to ensure that members receive quality care and services from qualified professionals.
- Thorough assessment of facilities to ensure that members receive quality care and services in a full continuum of settings.
- Maintaining the confidentiality of provider-related information in the provider files as well as the Credentialing Committee:
  - All Credentialing Department staff and reviewers sign employee confidentiality statements.
  - All Credentialing Committee members sign confidentiality statements.
  - Each Credentialing Committee meeting is opened with a statement regarding the confidentiality of printed material and discussions related to providers.
  - Provider-specific materials prepared for the Credentialing Committee are proprietary and remain at Community Care following the Credentialing Committee meeting.
  - Provider files are maintained in locked file rooms at Community Care.
- Making available to providers, upon written request, the ability to view any materials, except recommendations, National Practitioner Data Bank (NPDB) responses, and other peer-review protected documents, submitted in relation to their applications.

The following sections provide information about providing quality care to Community Care members, including how to become a contracted provider, how to maintain standards for confidentiality, record keeping, provision of quality care, and other issues affecting providers.

Providers are encouraged to call the Provider Line at 1.888.251.2224 (available 24 hours a day/seven days a week) for assistance.

Practitioner Rights

Community Care's policies and procedures include the right of practitioners to:

- Review information submitted to support their credentialing application.
- Correct erroneous information.
- Receive the status of their credentialing or recredentialing application, upon request.
- Receive notification of these rights.

Credentialing, Assessment, Contracting

Practitioner Credentialing, Contracting, Recredentialing

For a practitioner, credentialing is the first step in Community Care's quality management process to ensure that members receive high-quality, responsive, and culturally competent care.

Practitioners who wish to provide services to members must complete the credentialing process before they are eligible to contract to provide services to members. The practitioner credentialing process includes evaluations of both the practitioner (such as licensing) and the site where services are to be provided.

Practitioner Credentialing Process

A practitioner is credentialed on the date in which the Credentialing Committee reviews and approves the candidate's completed application.

The Credentialing Committee ensures that practitioners initially meet and continue to meet Community Care's criteria and standards for participation in the network. The Credentialing Committee reviews practitioner credentials and information for initial credentialing and thereafter at least every three years.

The practitioner credentialing process involves the following major steps:

- Each credential (degrees, certifications, licenses) must be verified with primary sources (academic institution, certifying body, licensing board or agency, etc.).
- Each practitioner evaluating or treating children and adolescents under the age of 18 must submit a Pennsylvania State Police Criminal Background Check (Act 34), Pennsylvania Child Abuse History Clearance (Act 33), and FBI Background Check that are no older than five years from the date of submission.
- Each practitioner serving older (age 60 and older) or care-dependent adults must submit a Pennsylvania State Police Criminal Background Check that is no older than five years from the date of submission.
- The completed application (all credentials verified with primary sources) must be reviewed and approved within 180 days of the date the application was signed. If not, the application must be refreshed with Community Care by returning a copy of the original application with a new attestation to the practitioner to review for any changes or additions. This application must be returned to Community Care with a newly signed and dated attestation.

Verifying credentials with primary sources is performed by the Credentialing Department. This includes a review of information on sanctions or limitations with Medicare, Medicaid or state licensing agencies (NPDB, Cumulative Sanctions Report, Federal State of Medical Boards (FSMB), etc.). All criteria must be met and verified to consider the application complete for credentialing.

Change in Practitioner Information

Any change to information submitted by a practitioner during the credentialing and contracting process, or at any time thereafter, including information such as street and/or suite address and telephone and/or fax numbers, must be communicated to Community Care's Network Relations Department.

To prevent problems such as interruptions of referrals, failure to receive authorizations for services, or denial of payment for services provided to members, practitioners are asked to call their designated Provider Relations Representative, a list of which is provided on Community Care's website, with any change to practitioner information at least 30 days in advance of any such change. The Provider Relations Representative will request written documentation of the change through the completion of an Attachment A form in order to process this change in Community Care's database.

Please note: If a practitioner change involves adding or changing a contract service or a site where services are provided to Community Care members, the addition or change must be reviewed by the appropriate committee. If approved, the change must meet recredentialing standards and a site visit may be required before payment for services can be processed.

Practitioner Contracting

A practitioner may begin the contracting process after the practitioner completes credentialing by Community Care. Community Care seeks to contract with specific practitioners to provide specific behavioral health services at specific sites. (See the Guidelines for Obtaining Approval for In-plan Services in Appendix A of this provider manual.) Criteria considered for contracting include:

- The service needs of prospective members.
- The geographic and demographic distributions of members.
- The geographic distribution and cultural competencies of practitioners.
- Each practitioner's scope of services, capacity to serve members, and responsiveness to quality issues.

For any practitioner terminated from the network, up to a 60-day transition of care period may be initiated for members under that practitioner's care (see Transition of Care to another Community Care Provider).

Practitioner Recredentialing

Practitioners must be recredentialed not more than three years from the date of credentialing/last recredentialing. The Credentialing Department will notify practitioners in advance when it is time to start the recredentialing process, which is similar to the credentialing process with the additional consideration of quality information supplied by the Community Care Quality Management Department. An application for recredentialing is considered complete when it includes the following:

- Primary source verification of the practitioner's credentials (such as any new degrees or certifications since last credentialing/recredentialing, verification of current licensures, and malpractice and claims history).
- Provider Benchmarking (see Comprehensive Provider Evaluation Process) including analyses of member complaints, significant member incidents, and quality and/or compliance audits.

All practitioners must be recredentialed before their expiration date. Failure to be recredentialed before the expiration date will result in termination of the practitioner's contract with Community Care and will prevent payment for any services provided after the expiration date. A practitioner whose credentials with Community Care have expired cannot be authorized or paid for services provided after the expiration date. Practitioners are urged to start the recredentialing process as soon as the application is received. The Credentialing Department will remind practitioners periodically of application components that remain incomplete.

Facility/Organization Assessment, Contracting, Reassessment

Assessment of a facility (hospital, residential treatment facility, community mental health center, clinic, partial hospitalization program, or any other organization providing behavioral health care services in a community setting) is the first step in Community Care's quality management process to ensure members receive high-quality, responsive, and culturally competent care. A facility must complete this process in order to be eligible to contract to provide services to Community Care members. Assessment includes evaluations of the facility (such as licensing) and the site where services are to be provided. Community Care ensures that facilities initially meet and continue to meet Community Care's criteria and standards for participation in the network. Community Care assesses facilities upon initial application and thereafter at least every three years.

Facility/Organization Assessment

All facility criteria must be verified before the application for assessment is considered to be complete. A facility is considered to have completed its assessment on the date the Credentialing Supervisor and Chief Medical Officer or designee reviews the candidate's completed application, verifies that all criteria have been met, and signs the Facility Assessment Form. The facility assessment process involves the following major steps:

- Credentialing staff confirms the facility's licensure and facility's accreditation, if any, and status or standing of the facility with state regulatory bodies.
- Each location where the facility will offer services to Community Care members must "pass" a site visit unless the facility is accredited by The Joint Commission, Committee on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation of Services for Children and Families (COA), or supplies a complete licensing report from the appropriate licensing entity to Community Care. If, after assessment, a facility adds a location where Community Care services are to be provided and the new location has not been reviewed, a site visit may need to be conducted at this new location unless the site has been reviewed by the accrediting agency or a complete licensing report has been submitted. In lieu of a Community Care site visit, Community Care will accept a copy of the licensing site visit report indicating that the facility is in full compliance with all of the licensing regulations/standards.
- During the site visit, documentation must "pass" the review of treatment record keeping practices, which may include review of a blinded or mock up treatment record. The site visit includes a review of treatment record keeping practices using the Medical Record Review Form, which is performed to assess the adequacy of documentation/record keeping procedures.
- All facilities providing services to children and adolescents under the age of 18 must have a policy in place requiring the Pennsylvania Child Abuse History Clearance, Pennsylvania State Police Criminal Record Check and FBI Background Check for employees working with this population.
- All facilities providing service to older (age 60 and older) and care-dependent adults must have a policy in place requiring a Pennsylvania State Police Criminal Background Check for those individuals who may have direct contact with this population.
- The completed application (with all primary source verification completed, site visit(s), and treatment record keeping practices completed satisfactorily) must be reviewed and approved within 180 days of the date the application was signed. If not, the application must be refreshed with a newly signed authorization. To ensure that data accurately reflects current facility information, Community Care maintains the 180-day standard to complete this process. In the event that this process shall exceed 180 days, the facility will be sent a copy of the original application and be required to sign a new attestation to confirm that the data is accurate or indicate any changes in the original information on the application.

Primary source verification is performed by the Community Care Credentialing Department. Community Care Provider Relations staff conduct the site visit. Before the site visit is scheduled, the facility will be given a copy of the Non-Accredited Facility On-site Review Form that lists the criteria for assessing/reassessing a site, such as presence of fire extinguishers and handicapped-accessible restrooms. In addition, policies and procedures must be in place for a plan assessment of the provider's ability to provide urgent and routine care, to enroll additional patients in accordance with standards adopted by Community Care and a policy or policy statement regarding cultural awareness and diversity competence.

Change in Facility information

Any change to information submitted by the facility during the assessment and contracting process or any time thereafter, including information such as mailing address and telephone and fax numbers, must be communicated to Community Care's Network Management Department. To prevent problems such as interruptions of referrals, failure to receive authorizations for services, or denial of payment for services provided to members, facilities are asked to call their designated Provider Relations Representative, a list of which is provided on Community Care's website, at least 30 days in advance with any change to facility information.

Community Care will request written documentation of the change through the completion of an Attachment A form so that all Community Care Departments can be notified of the change.

Please note: If the facility change involves adding or changing a service or a site where services are provided to Community Care members, the addition or change must be reviewed. If approved, a site visit may be required before payment for services can be processed.

Facility Contracting

A facility may begin the contracting process after the facility completes assessment by Community Care. Community Care seeks to contract with facilities to provide specific behavioral health services in specific geographic locations. (See the Guidelines for Obtaining Approval for In-plan Services in Appendix A of this provider manual.)

Criteria considered for contracting include:

- The service needs of prospective members.
- The geographic and demographic distributions of members.
- The geographic distribution and cultural competencies of facilities.
- Each facility's scope of services, capacity to serve members and responsiveness to quality issues.

For any facility terminated from the network, up to a 60-day transition of care period (for routine ambulatory services only) may be initiated for members under that facility's care (see Transition of Care to another Community Care Provider).

Facility Reassessment

Facilities must be reassessed not more than three years from the date of assessment/last reassessment.

The Credentialing Department will notify facilities in advance when it is time to start the reassessment process, which is similar to the assessment process with the additional consideration of quality information supplied by the Community Care Quality Management Department. An application for facility reassessment is considered complete when it includes the following:

- Credentialing staff confirms any new licensures, facility accreditation and certifications, etc., since last assessment/reassessment, verification of current licensures, etc.
- Monitors facility performance (Provider Benchmarking, see Comprehensive Provider Evaluation Process), including analyses of member complaints, Significant Member Incidents and quality and/or compliance audits.

All facilities must be reassessed before their expiration date. Failure to be reassessed before the expiration date will result in termination of the facility's contract with Community Care and will prevent payment for any services provided after the expiration date. A facility whose assessment with Community Care has expired cannot be authorized or paid for services provided after the expiration date.

Community Care's Credentialing Department sends applications for reassessment before each facility's deadline. Facilities are urged to start the reassessment process as soon as the application is received. The Credentialing Department will remind facilities periodically of application components that remain incomplete.

Termination of Provider from the Network

Community Care may terminate a provider from the network without cause or with cause.

Termination without Cause

The Provider Agreement may be terminated without cause by either party at any time upon 90 days prior written notice to the other party. Such notice shall clearly state the effective date of such termination. All terms and provisions of this agreement shall remain in effect until the effective date of termination except as otherwise provided.

Termination with Cause

Action to terminate a provider with cause may be initiated when Community Care becomes aware of any of the following:

- Serious issue regarding the provider's quality of care.
- Revocation or suspension of a provider's license or other legal credential authorizing the provider to practice in any state or jurisdiction.
- Revocation or suspension of Drug Enforcement Agency (DEA) registration or Controlled Dangerous Substance (CDS) certificate.
- Professional review action by any state or jurisdiction issuing a professional license or any federal agency, professional organization, or other identified regulatory organization.
- Contractual violation, including, but not limited to:
  - Breach of confidentiality.
  - Failure to comply with terms of a corrective action plan.
  - Material misrepresentation of information on the provider application for credentialing/recredentialing or assessment/reassessment.
  - Conviction of a felony.
  - Cancellation or failure to renew or maintain professional liability insurance in the amounts acceptable to Community Care.

The Provider is notified in writing via certified mail of the action to initiate termination with cause, including the reason for this action. Included in this correspondence is an explanation of the process to request an appeal of the decision to terminate with cause.

Notification and Process to Appeal Adverse Determinations Regarding Network Participation

Providers are notified in writing of any determination affecting their continued participation in the provider network, including credentialing/recredentialing or assessment/reassessment, suspension of new referrals, or termination from the network. This written notification will include the reason for the decision and an explanation of the appeal process, if any.

The appeal process is as follows:

- Within 30 days from the date of the notification, the provider must send a letter, fax, or email to the Community Care Chief Medical Officer (CMO) to request to appeal the decision.
- The CMO will schedule an Appeal Committee meeting to be held within 30 days of receiving the provider's request.
- The provider will be informed of the date, time, and place of the meeting as well as the provider's right to be present at the hearing, to be represented by an attorney or any other person of the provider's choice, to present relevant information, and to request a different date and time for the hearing should the provider be unable to attend as scheduled.
- The provider will receive written notification of the Appeal Committee's decision within two business days of the date of the decision.

The decision of the Appeal Committee is final.

Confidentiality and Disclosure Policies

Community Care has developed policies concerning confidentiality to guide Community Care staff and providers in collecting, using, and disclosing information that is necessary and appropriate to provide high quality services efficiently, whether the information was created by Community Care or acquired in connection with our business activities. The confidentiality policies are intended to meet all requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) and apply to, but are not limited to, all member information, provider information (including credentialing/assessment, contracting, and benchmarking), quality management program documents, and meeting minutes.

The following sections highlight Community Care's confidentiality policies and procedures that may apply to providers (who are "contractors" of Community Care and may also be "representatives" of Community Care). For more detailed information, please go to Appendix B and Appendix C.

General Confidentiality Provisions

Community Care agents and contractors (including providers) potentially having access to confidential information are required to sign Community Care's Statement of Confidentiality agreeing to be bound by Community Care's strict confidentiality policies and procedures, or must conform to equivalent provisions as determined by Community Care staff or legal counsel. Breach of the Statement of Confidentiality or equivalent is grounds for immediate termination with cause.

What Constitutes Confidential Information

Community Care considers the following data and information to be confidential:

- Member-identifiable data and information; all data and information where the member is, or could possibly be, identified.
- Explicitly identifiable data include, but are not limited to, member name, Social Security number, medical record number, health plan beneficiary numbers, account numbers, certificate/license numbers, or other identifier that can be directly linked to a specific individual.
- Implicitly identifiable data include, but are not limited to, member address, telephone number, fax numbers, email addresses, date of birth or other such information that, alone or in combination with other available information, can lead to identification of a specific individual.
- Practitioner-specific data and information, including but not limited to, that used for network development, credentialing, performance evaluation, quality assurance, quality improvement, and peer review.
- A practitioner's name, professional degree, status as a member of Community Care's practitioner network, business address, business telephone number, and specialty/specialties or self-identified areas of special interest are not considered confidential when disclosed for legitimate business purposes.
- Data and information related to a practitioner's racial, cultural or ethnic background, age, religious affiliation, sexual orientation, and ability to communicate in languages other than English, is confidential unless the practitioner explicitly authorizes the release of this information.
- Practice/group-specific and facility-specific data and information, including that used for but not limited to, network development, organizational assessment and contracting, performance evaluation, quality assurance, and quality improvement.
- A facility or group practice name, status as a participant in Community Care's network, business address, business telephone number, and services offered are not considered confidential when disclosed for legitimate business purposes.

Community Care's business data and information considered to be confidential includes, but is not limited to:

- Salaries.
- Policies and procedures.
- Finances.
- Business plans.
- Practitioner, practitioner group, and facility participants in Community Care's network when such information is not being released for legitimate business purposes.
- Proposals to potential or current customers.
- Information disclosed to Community Care in confidence by a third party.
- Information including quality assurance, quality improvement and performance evaluation data and information where practitioners, practitioner groups, or facilities are not individually identifiable.

Keeping Information Confidential

- Community Care's agents, contractors (including providers), employees, staff, and volunteers may not access or view confidential data or information unless required by their duties or responsibilities for, or on behalf of, Community Care.
- Community Care's agents, contractors (including providers), employees, staff, and volunteers may not discuss confidential data and information in an area where individuals, including other Community Care agents, contractors, employees, staff, and volunteers who do not have the right to know about the information, may overhear the information.
- All confidential data and information must be maintained in a manner that prevents access by individuals who do not have a right to access the data and information.
- All physical media, including but not limited to, paper, magnetic and optical, used to store confidential data and information must be stored under a double-lock system.
- All physical media containing confidential information that are still in use by Community Care agents, contractors (including providers), employees, staff and volunteers at the end of the day must be locked in that individual's desk or in another secured storage area.
- All desks or secured storage areas must be in areas with keyed entry, maintaining a minimum of a dual-key system.
- All physical media containing confidential information that are no longer needed by Community Care agents, contractors, employees, staff and volunteers must be returned to locked master storage at the end of the day.
- All electronic media containing confidential information must be password-protected.

Transferring Confidential Information

The transfer of confidential information for legitimate business purposes between Community Care's agents, contractors (including providers), employees, staff, and volunteers in their official capacities as representatives of Community Care is considered an internal transfer, even though they may be in different physical locations. The transfer of confidential information other than to Community Care's agents, contractors, employees, staff, and volunteers in their official capacities as representatives of Community Care is considered an external transfer and must be made in accordance with Community Care's Authorization to Disclose Information (see Disclosure of Member-Identifiable Information).

- The internal transfer of all confidential data and information must be conducted in a manner that limits potential access by individuals who do not have a right to access the data and information. When not hand-carried and personally delivered to the recipient, physical media containing confidential data and information must be placed in a sealed envelope marked "Confidential."
- Confidential data and information sent by fax must bear a prominent confidentiality notice similar to the following: "This fax transmission contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this message in error, please notify the sender by fax or telephone and destroy this document."
- Confidential data and information sent by email must be flagged as confidential and bear a confidentiality notice similar to the following within the message: "This email contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this email in error, please notify the sender by return email, securely delete this file and any electronic or magnetic copies and destroy any paper copies."

Destroying Confidential Information

Confidential data and information no longer required for legitimate business purposes must be destroyed in a secure manner. Paper records must be thoroughly shredded. Magnetic files must be deleted in a manner that does not permit the files to be undeleted, for example, by reformatting a floppy disk using the "secure" format option. Either optical storage media must have the files securely deleted or, if this is not possible, the storage media must be destroyed.

Committee Oversight of Confidentiality

Community Care's privacy officer and the Compliance Department are responsible for approving and periodically reviewing all policies and procedures related to confidentiality and for identifying, developing and implementing mechanisms to oversee the implementation, and application of Community Care's confidentiality policies and procedures.

Detailed descriptions of these responsibilities can be found in Appendix B.

Collecting & Using Member-Identifiable Information

Community Care collects and uses member-identifiable data and information routinely in the performance of its work. Purposes for which data and information are routinely collected include:

- Verification of member eligibility for services.
- Management of behavioral health benefits, including prospective, concurrent, and retrospective reviews and decisions regarding coverage for requested treatment.
- Coordination of care.
- Billing.
- Adjudication of claims.
- Performance measurement and improvement ("quality assurance").
- Compliance audits.
- Prevention and disease management activities.
- Provider credentialing.
- Investigating and resolving inquiries and complaints.
- Processing appeals.
- Complying with regulatory requirements and accreditation standards.

Community Care is responsible for notifying members of Community Care's routine collection and use of member-identifiable data and information for the purposes just described. The use of member-identifiable information for purposes other than those listed requires written authorization from the member or representative, unless use of the information is permitted or required by applicable law or a valid court order.

Informing Members about Confidentiality

Community Care prepares information for members that describes Community Care's confidentiality policies and procedures. This information covers key points of the information contained in Community Care's Confidentiality Policy, such as:

- Collecting and using member-identifiable Information.
- Handling of member-identifiable Information.
- Ability to give informed authorization.
- Member access to utilization records.
- Disclosure of information.
- An accounting of disclosure of member protected health information (PHI) to members.
- Amending PHI by the member.

Information about confidentiality is disseminated to members in:

- Member "Rights and Responsibilities."
- Member instructions on how to obtain care, appeal a coverage decision, and access customer services support.
- The member complaint process.

Information about confidentiality is sent to members annually via member newsletters and in the Member Handbook. Community Care's Notice of Privacy is also posted on their website.

Ability to Give Informed Authorization for Release of Member-Identifiable Information

Community Care obtains special authorization from members or representatives to release member-identifiable information, as described in the procedure for Disclosure of Information (see Disclosure of Member-Identifiable Information). Community Care has made the following determinations regarding the giving of valid authorization for the release of member-identifiable health information:

- A member who has reached the age of majority as identified by Community Care's eligibility data is capable of giving informed authorization for release of information on his or her own behalf unless Community Care has received notification that the member has been adjudicated incompetent.
- The natural or adoptive parent of a minor member, as identified by Community Care's eligibility data, is capable of giving informed authorization for release of information on behalf of the minor member unless Community Care has been informed that the parent has been adjudicated incompetent, the parent is not the legal guardian of the minor member, or the minor member has been legally emancipated.
- An emancipated minor member is capable of giving informed authorization on his or her own behalf. If not already on file with Community Care, Community Care will request proof of the minor member's status from the minor member before honoring the authorization for release of member information.

Community Care expends all reasonable effort to develop and maintain an accurate and efficient system for identifying who is eligible to give valid authorization for release of member identifying information. Having established such a system, Community Care reasonably relies on the absence of information indicating that a member or parent of a minor member has been adjudicated incompetent or that a parent is not a minor member's legal representative, for accepting an authorization for release of information as valid. Verifying that a member or parent of a minor member is competent would place an undue burden on Community Care and in most instances would require a breach of confidentiality.

When Community Care is informed that a member is unable to give special authorization for the release of information, Community Care will accept authorization from and/or release records to, a representative legally authorized to approve (authorize) the release of, or to receive, a member's personal health information. Community Care requires written proof of the individual's status as a legally authorized representative of the member and that the status as a legally authorized representative covers the area for which the authorization for information is being sought.

Individuals capable of giving valid authorization for the release of member-identifiable health information are also entitled to have access to that information, except that parents or guardians of children age 14 years or over may not have access to the child's health information without the authorization of the child.

Member Access to Utilization Records

In accordance with HIPAA Section 164.524, members may request to access their utilization file. The member may request to view his/her information by contacting Community Care. Community Care will coordinate the processing of the request. The privacy officer will respond to the request within 10 days. The process for requesting information is outlined in Community Care's Confidentiality Policy.

Disclosure of Member-Identifiable Information

Community Care requests authorization from the member or member's legally authorized representative before disclosing member-identifiable data or information (except as described in the procedures for Collecting and Using Member-Identifiable Information and Disclosure without Authorization of Member or Member Representative. The member or the member's legally authorized representative has the right to deny the request to release member-identifiable information without consequence for the member or the member's coverage. If member-identifiable data and information are to be disclosed for purposes other than described in the procedures for "Collecting and Using Member-Identifiable Information" and "Disclosure without Authorization of Member or Member Representative," the authorization of the member or member's legally authorized representative is required.

Times when authorization of the member or member's legally authorized representative is required include:

- Before disclosing member-identifiable data and information for research purposes.
- Before disclosing the member's behavioral health signs, symptoms, diagnoses, or treatment to a primary care physician or other clinician not providing behavioral health care to the member.
- When disclosing the member-identifiable data and information that could foreseeably result in the member being contacted by another organization for marketing purposes.

Whenever member-identifiable information is disclosed, only that information necessary to accomplish the purpose of the disclosure is released.

Disclosure without Authorization of Member or Member Representative

Member-identifiable information can be disclosed without authorization of the member or the member's legally authorized representative in the following circumstances:

- When such disclosure to health care personnel, a health care facility, the member's identified significant other, or the police is required to prevent loss of life or injury to the member.
- When authorized by an appropriate and valid court order.
- When authorized by Community Care's legal counsel to meet the requirements of any applicable state or federal law.
- To report child abuse or neglect.
- To meet public health reporting requirements.
- To the Pennsylvania Department of Health, Pennsylvania Department of Human Services, and the Pennsylvania Insurance Department for the monitoring of health care systems, government programs, and compliance with civil rights laws.
- To federal officials for intelligence, counterintelligence, or other national security activities authorized by law.
- When required by Protective Services for the President and others.
- To military command authorities in order to provide medical information about a member serving in the armed forces.
- When it concerns Workers Compensation.
- To coroners and medical examiners.
- Information about inmates of a correctional institution or under the custody of a law enforcement official may be released to that institution or official.

Validity of Authorization to Release Member Information

Community Care considers an authorization to release member-identifiable information to be valid only if all of the following are met:

- The member or member's legally authorized representative is informed of the specific information to be released and the purpose(s) of the release in language which he/she can understand.
- The member or member's legally authorized representative is informed that the provision of care or treatment will not be affected by the decision of the member or member's legally authorized representative.
- The authorization is obtained in a manner that complies with applicable laws and regulations.

Written and Verbal Authorization for Release of Information

The authorization to release information should be in writing. However, under some circumstances it may be necessary to obtain authorization verbally. The use of a verbal authorization should be approved in advance by Community Care's legal counsel or, if circumstances indicate the need for a rapid decision about the acceptability of a verbal authorization, by a member of Community Care's senior management. The written authorization must include provision of the following information:

- The name of the person or entity providing the information.
- The specific information to be released.
- The purpose for the release.
- The individual or entity authorized to receive the information.
- The expiration date of the authorization.
- The signature of the member or member's legally authorized representative.
- The address of the member or member's legally authorized representative.
- The signature of the witness.
- The date of the authorization.

Two representatives of Community Care (such as employees, staff, or practitioner providers) must witness the entire process of obtaining verbal authorization to release information.

Handling of Practitioner-Specific Information

Community Care considers practitioner-specific data and information, including but not limited to, that information used for network development, credentialing/assessment, performance evaluation, quality assurance, quality improvement, compliance audits and peer review, to be confidential to the extent permitted by law.

A practitioner's name, professional degree, status as a member of Community Care's practitioner network, business address, business telephone number and specialty(ies) or self-identified areas of special interest are not considered confidential when disclosed for legitimate business purposes.

Data and information related to a practitioner's racial, cultural, or ethnic background; age; religious affiliation; gender; and ability to communicate in languages other than English is confidential unless the practitioner explicitly authorizes the release of this information. For example, if the practitioner volunteers the information on the credentialing/assessment form that the practitioner has the ability to communicate in languages other than English, this information may be used by Community Care to meet specific member needs or requests when making referrals.

Regarding files of practitioner information maintained at Community Care:

- Physical files are maintained in a locked room or locked file cabinet when not being used by credentialing staff or the Credentialing Committee.
- Practitioner files stored in electronic, magnetic, or optical format are protected with a secure password.
- Access to practitioner files is limited to credentialing staff, Credentialing Committee, network management staff, and the compliance staff.
- Upon request, practitioners may review information in their file, except for any information from the National Practitioner Data Bank (NPDB). Review of NPDB information is prohibited by federal statute.
- Practitioners are informed of the right to review information in their file through the cover letter in the application packages for credentialing/recredentialing or assessment/reassessment.
- Practitioners may obtain a copy of their file by making the request in writing. Credentialing staff will send a copy of the practitioner's file, marked "Confidential," to the practitioner within 10 business days of receipt of the written request for the file. NPDB information and peer review (peer reviewer) information is not included in the file sent to the practitioner.

Practitioners are notified by Credentialing staff of any information obtained during credentialing/recredentialing or assessment/reassessment activities that varies substantially from the information provided by the Practitioner.

Practitioners have the right to correct erroneous information by submitting corrections in writing or sending additional documents to the Credentialing Department. Credentialing staff document the verbal information or corrections provided by the practitioner, including the date and signature of the individual obtaining the information.

Provider Confidentiality

Community Care providers are responsible for maintaining confidentiality in the collection, use, and disclosure of member-identifiable information. Requirements are as follows:

- Member-identifiable data and information (such as medical records, appointment books, correspondence, laboratory results, billing records and treatment plans), whether paper-based or on removable electronic data storage media, must be maintained under lock and key, either in locked cabinets or in a locked area. The data storage area must be separate from public areas such as waiting rooms, areas where services are delivered, and any other areas accessible to unauthorized persons. When unlocked, paper records and removable computer storage media must be maintained in a secure location where they are not accessible and their content is not visible to unauthorized individuals.
- When computers are used to store member-identifiable information, they must be password-protected (unless all persons at the site are authorized access and the computers are in secure locations not accessible to unauthorized individuals). Computer monitors must be positioned such that they are not visible to unauthorized individuals.
- If electronic mail (email) is used to transmit member-identifiable data or information, the email must be flagged as confidential and a confidentiality notice must be prominently displayed at the beginning of the email that conveys a message substantively similar to the following: *"This email contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this email in error, please notify the sender by return email, securely delete this file and any electronic or magnetic copies and destroy any paper copies."*
- Fax machines must be located where faxes may not be intercepted or viewed by individuals not authorized to access member-identifiable information. When member-identifiable information is transmitted by fax, a confidentiality notice similar to the following must be prominently displayed on the cover sheet: "This fax transmission contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this message in error, please notify the sender by fax or telephone and destroy this document."

Please call the Provider Line (1.888.251.2224) for any authorization for release of information forms that might be needed in the care of members.

Record Keeping Standards

Community Care has established treatment record documentation guidelines, performance goals, and standards for availability of treatment records to facilitate accurate record keeping, communication between practitioners and coordination and continuity of care within the behavioral health continuum and the medical delivery system. Community Care expects providers to implement these treatment record documentation guidelines.

Each member's medical record must meet the following standards:

- The member's address, employer or school, home and work telephone numbers, emergency contacts, marital/legal status, authorization forms, and guardianship information is documented, as relevant.
- The member's name or identification number is present on each page.
- The responsible clinician's name and professional degree are documented.
- All entries are dated.
- The record is legible.
- Relevant medical conditions are listed, prominently identified, and updated.
- Presenting problems and relevant psychological and social conditions affecting the member's medical and psychiatric status are documented.
- Special status situations such as imminent risk of harm, suicidal ideation, or elopement potential are prominently noted, documented, and updated in compliance with written protocols.
- Past medical and psychiatric history is documented, including previous treatment dates, provider information, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.
- Allergies and adverse reactions are clearly documented.
- Medication(s) that have been prescribed, dosages of each medication, and the dates of initial prescription and of any changes in medication regimen.
- Current version of DSM diagnosis is documented.
- Complete developmental history is documented for children and adolescents.
- The following are documented:
  - Symptoms
  - Mental status
  - Member strengths and limitations
  - Compliance with treatment plan
  - Compliance with medication regimen, if appropriate
  - If the member has drug and alcohol issues (past and/or present), the results of the provider's inquiry as to the welfare of children and significant others living in the home
  - Progress towards treatment goals
  - Coordination of care information, as applicable
  - Date of next session
  - Discharge plan

Community Care expects providers to maintain an organized treatment record keeping system. The following elements are ***required*** components of an organized record keeping system:

- A unique treatment record for each member.
- Treatment record notes maintained in chronological or reverse chronological order.
- An organized system for maintaining documents for each member; for example, all diagnostic reports maintained together in a section of the folder.
- An organized filing system that provides easy access to unique member files.
- Consent to release information and informed consent documentation as appropriate.
- Treatment record documentation occurs as soon as possible after the encounter with special status situations, such as imminent harm, suicidal ideation, or elopement potential prominently noted.

Community Care expects all practitioners and facilities to provide treatment to members in a safe environment. All providers should assess a member for suicidal ideation and homicidal ideation throughout a member's treatment. If a member is being treated in an outpatient setting and expresses suicidal or homicidal ideation, the provider should take the appropriate actions to ensure that the member and others are safe, such as facilitating an inpatient hospitalization admission.

Upon admission for an inpatient psychiatric hospitalization, the initial evaluation completed by the facility psychiatrist should clearly document that the member was assessed for both suicidal and homicidal ideation. Additionally, members should be assessed for suicidal and homicidal ideation on an ongoing basis to ensure the member's safety, as well as the safety of others. Providers should also proceed with a Duty to Warn if indicated.

When a member is discharged from an inpatient hospitalization stay, a crisis plan should be developed by the facility and reviewed with the member upon discharge. The crisis plan should also include the phone number of the appropriate county services for mental health emergencies.

All medical records and reports completed by the provider for Community Care members are to be available, as appropriate, to practitioners and staff other than the treating practitioner; Community Care; the Centers for Medicare and Medicaid Services (CMS; formerly the Health Care Financing Administration (HCFA); National Committee for Quality Assurance (NCQA); or Pennsylvania Department of Health, licensing body, or regulatory agency; or other agencies as required by applicable law and regulations, for at least seven years after the initial date the provider delivered health care services to the member under contractual agreement with Community Care, regardless of termination of the contractual agreement.

The review of treatment record keeping practices, using a Medical Record Review Form is one component of the provider's credentialing site visit. Facilities not accredited by The Joint Commission, Committee on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation of Services for Children and Families (COA) must meet the record keeping standards established by Community Care. Record keeping must also meet all licensing regulations. The provider is sent the Medical Record Review Form instrument prior to the scheduled site visit.

The provider may prepare for the medical record review by designating an actual treatment record for review, preparing a blinded treatment record, or preparing a mock treatment record for review. A score of 80% is required to pass the medical record review. Providers are notified in writing if the score is below passing. When the score is below passing, the provider must submit a written corrective action plan. A follow-up medical record review will be scheduled within six months to monitor implementation of the provider's corrective action plan.

In addition, quality staff assess completeness of treatment records by using one or more of the following methods:

- Reviewing a sample of treatment records on-site at the practitioner's office.
- Obtaining a sample of treatment records from practitioners via mail or fax to Community Care.
- Reviewing treatment records sent to Community Care for other reasons.

Community Care's performance goal for completeness of treatment record documentation is 80%. Aggregate results of the assessment of treatment record documentation are communicated periodically to providers.

Clinical Practice Guidelines

Community Care utilizes clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. These evidence-based guidelines are reviewed annually, updated as appropriate, and approved by Community Care's Quality and Care Management Committees and Board Quality Improvement Committee (BQIC). Annually, Community Care measures performance against each of the clinical practice guidelines via claims data or record reviews. Providers are notified of the results of these measurements via provider newsletters or web-based communications. Currently, the following guidelines are being utilized:

- American Psychiatric Association *Practice Guideline for the Treatment of Patients with Major Depressive Disorder (Third Edition)*, October 2010.
- National Institute on Drug Abuse (NIDA) *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition),* December 2012
- American Academy of Pediatrics ADHD: *Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/ Hyperactivity Disorder in Children and Adolescents*, as well as its supplemental information *Implementing the Key Action Statements, November 2011*.

To obtain a copy of the APA guidelines, contact the American Psychiatric Association, 1400 K Street NW, Washington, DC 20005 or visit the website.

To obtain a copy of the NIDA guideline, contact the National Institute of Drug Abuse, National Institutes of Health, 6001 Executive Boulevard, Room 5213, Bethesda, MD 20892. The guideline may also be obtained via the NIDA website.

For information about our practice guideline measurements, contact Community Care at 1.888.251.2224.

New Technologies

Community Care provides for a systematic assessment of new technologies and new applications of existing technologies for behavioral health care, including clinical interventions, procedures, devices, and certain types of pharmacological treatments. Community Care's New Technology Subcommittee, chaired by the Chief Medical Officer, meets as needed to consider new technologies proposed for inclusion in a benefits package. In those instances in which Community Care does not make the final decision on the inclusion or exclusion of a technology in the benefits package, Community Care assesses the new technology and makes a recommendation to the appropriate decision-making body. To submit a new technology request for review, talk with a Community Care care manager. The care manager will forward your request to Community Care's Chief Medical Officer for review.

Significant Member Incident Reporting

A Significant Member Incident (SMI) is an unexpected and undesirable incident that has an adverse impact on the outcome of care. The detail of each SMI is promptly reviewed to determine needed follow-up and to coordinate communication between Community Care, the provider, and county agencies, as appropriate, to avoid unnecessary duplication of reports.

SMIs include, but are not limited to:

- Death while in treatment or within 30 days of treatment.
- Serious or potentially lethal suicide attempt.
- Apparent homicide by member while in treatment or within 30 days of treatment.
- Apparent sexual assault perpetrated by member while in treatment or within 30 days of treatment.
- Apparent serious physical assault perpetrated by member while in treatment or within 30 days of treatment.
- Sexual contact with a member occurring at a provider site.
- Physical assault on a member occurring at a provider site.
- Sexual contact between a member and provider not occurring at a provider site.
- Physical assault on a member perpetrated by a provider not occurring at a provider site.
- Allegation of sexual contact by member against provider.
- Allegation of physical abuse by member against provider.
- Member injury due to restraint or seclusion.
- Any restraint that does not adhere to guidelines in the PA Code and other bulletins or notifications of licensing bodies.
- Police called to provider site.
- Arrest while in treatment or within 30 days of treatment.
- Medication error requiring medical intervention.
- Fire at provider site requiring emergency services of the fire department.
- Elopement from facility or facility-supervised activity.
- Injury or illness on provider site requiring medical attention.
- Elopement while on therapeutic leave/pass.

Community Care has developed a plan for significant incidents that ensures prompt review of the detail related to each incident and determining needed follow-up. This process will coordinate communication between the provider, Community Care, the county, and/or the oversight agency, as applicable.

Providers should report SMIs to Community Care within 24 hours of the incident occurring or of the provider learning of the incident. There are various ways to report SMIs to Community Care:

- Completing the online form and faxing to the Community Care office according to the member's county of eligibility (see list of fax numbers by county/Community Care office)
- Calling or faxing the member's care manager with the pertinent SMI information
- Calling the assigned provider representative, a list of which is provided on Community Care's website

The information to be reported to Community Care should include at a minimum:

- Date SMI occurred
- Member name and identification number
- Provider name and contact number
- Nature of the SMI

Providers are expected to report all cases of child abuse to the appropriate reporting agency as defined by law. The ChildLine phone number for reporting suspected cases of child abuse is 1.800.932.0313; or go to www.compass.state.pa.us/cwis to report online. Also, to report elder abuse or abuse of adults with disabilities call the 24-hour, statewide Protective Services Hotline at 1.800.490.8505.

Identifying and monitoring SMIs is part of the quality improvement activities, which Community Care performs as part of the comprehensive provider evaluation process (CPEP).

Provider Cultural Competency

Community Care has a vision for an effective and accessible system of behavioral health care that requires providers to be culturally competent. Assessment of cultural competency includes evaluation of the diversity of providers in the network and their documentation of all member informational materials (including audiovisual materials, training documents, service pamphlets and radio or television public service announcements). Cultural competency may also include having information about providers' experience/expertise in working with specific cultural groups, such as LGBT members or members of a particular faith.

Cultural competency is demonstrated by documentation that members with a primary language other than English have access to bilingual providers, appropriate interpreters, and/or translated written materials. Community Care expects providers to assess the cultural needs and strengths of all members in treatment; and this may be assessed through quality record reviews.

The Quality Management Department reviews all complaints received related to cultural competency of providers, conducts trend analyses, and determines appropriate follow-up when needed. Providers' commitment to cultural competence is essential to the ongoing development of a responsive system of care.

Comprehensive Provider Evaluation Process (CPEP)

Community Care believes that a successful partnership with providers includes collaboration with its provider network to improve the quality of the clinical care delivered to HealthChoices members. Community Care employs several methods to evaluate and improve the quality of care provided to members through the provider network. This process can be accomplished only through the involvement, participation, and collaboration of providers. It also ensures that Community Care begins this quality assessment from the time of application for network inclusion. Quantitative and qualitative performance data are necessary for a useful system of comprehensive provider evaluation.

Goals of the CPEP include:

- Facilitating the use of best practice clinical and quality standards by all individual practitioners and facilities providing care to members.
- Ensuring providers' care meets access standards.
- Facilitating culturally competent services to members.
- Striving to continually improve the practice standards of the provider network in both urban and rural areas.
- Utilizing both qualitative and quantitative measures to provide feedback to providers, county(ies), oversight entities, OMHSAS, and other stakeholders to ensure appropriate care.
- Identifying areas for improvement with subsequent opportunities for corrective action.
- Ensuring a safe and healthy environment for members with appropriate attention to the involvement of family and natural supports.
- Ensuring that providers practice within a collaborative environment conducive to recovery and resiliency principles.
- Obtaining feedback from members, families, and other stakeholders through a variety of forums.
- Providing select information to members, families, and other stakeholders.

In addition, the CPEP creates opportunities for providers to:

- Internally monitor themselves.
- Review claim reports about service activity.
- Review claim reports compared to aggregate claims reports of like providers.
- Identify trends.
- Improve the safety of their clinical environment.
- Participate in the investigation and resolution of member complaints.
- Promote appropriate family involvement.
- Ensure financial stability within their organizations.
- Promote their internal processes within a quality improvement framework.
- Establish policies that support performance standards and quality of care issues.
- Promote best practices.
- Review current practices with other providers.
- Implement evidence based practices.

The overall CPEP consists of several methods of evaluation to meet the stated goals. Data from each method may occur at various times throughout the year, and provider dialogue and intervention may occur when trends are identified.

These methods include:

- Credentialing/facility assessment and ongoing recredentialing/ facility reassessment.
- Compliance with Community Care Performance Standards.
- Compliance with IPRO data collection and improvement processes.
- Compliance with evidence-based practices.
- Completion of medical record reviews.
- Trending of Significant Member Incidents (SMIs).
- Demonstrated compliance with mental illness/substance abuse (MISA) screenings, coordination of care standards, and domestic violence screenings.
- Compliance with submission of requested reports including BHRS reporting.
- Timely return of quality improvement plans (QIPs).
- Cooperation with Consumer/Family Satisfaction Teams and interventions related to member concerns.
- Claims-based provider benchmarking reports.
- Complaint trending.
- Grievance trending.
- Licensure status monitoring.
- Identification of provider performance incidents; e.g., lack of adequate discharge planning, late submission of BHRS packets.
- Overall compliance with provider network contract.
- Results of Fraud, Waste and Abuse Department visits.

Community Care provides feedback through various quality activities to providers on an ongoing basis. In addition, Community Care analyzes aggregate network performance, making information available to providers through articles, committees, public forums, and individual provider meetings or site visits.

Certain information identified as a result of the CPEP related to individual providers may fall under protected, peer reviewed, and privileged information and will not be shared publicly. This information, however, will be shared with specific Community Care county contractors and/or OMHSAS.

Provider Satisfaction

Provider satisfaction is important to Community Care, and there are multiple ways in which providers can express both their satisfaction and dissatisfaction with Community Care's operations.

Community Care contracts with an outside survey company to conduct an Annual Provider Satisfaction Survey. The survey tool is designed to assess provider satisfaction in a variety of areas, including but not limited to utilization management, quality management, provider relations, complaint and grievance procedures, care management, customer service, and claims.

Providers are encouraged to take the time to complete the survey. Comments and feedback are welcome on the services providers have received from Community Care staff. Community Care is interested in how its services to providers can be improved. The results are reviewed both internally and with the Quality and Care Management Committee. The Committee identifies areas for improvement and interventions are developed to increase satisfaction in those targeted areas.

If a provider is dissatisfied with any aspect of Community Care's operations, the provider is urged to express their concern by calling the Community Care Provider Line at 1.888.251.2224. If an issue cannot be resolved informally, the provider may lodge a formal complaint either orally or in writing. If the complaint cannot be resolved immediately, Community Care will send a resolution letter within 30 days.

Community Care also utilizes a formal Provider Advisory Committee to receive feedback from providers. All Community Care providers are eligible, welcome, and encouraged to participate. If the provider is interested in becoming involved in this committee, the provider can call the Provider Line at 1.888.251.2224 to get more details.

There are other Community Care committees that include providers. If the provider would like to participate, please call the Community Care Provider Line (1.888.251.2224).

Provider Education

Community Care offers provider training on a variety of topics, with a focus on developing skills in managing care, meeting and exceeding performance standards, and ensuring cultural competence in delivery of behavioral health care services throughout the network. The person who will receive communication about these sessions is the designated contact person identified in the provider's network application. The provider should check with their Community Care provider relations representative for the name of this person or if the contact person (key contact) needs to be changed.

Providing Services to HealthChoices Network Members

Community Care has developed specific procedures for providers to follow in providing behavioral health services to HealthChoices members. These procedures:

- Verify that the services are covered.
- Ensure that every member receives the level of care that he/she requires.
- Provide member services in a seamless fashion.
- Ensure that care meets quality standards.

The following sections detail procedures for providing services. As a part of Community Care's commitment to quality improvement, these procedures are updated as needed. For any questions about providing services to Community Care members, please call the Provider Line at 1.888.251.2224 (24 hours a day/seven days a week).

Verifying Member Eligibility for HealthChoices Network Services

Community Care strongly recommends that all providers verify with the member his/her enrollment in HealthChoices. The provider can verify that an individual is eligible to receive services by calling the Provider Line at 1.888.251.2224. Due to the HealthChoices Behavioral Health Expedited Enrollment initiative, it is critical that all providers check EVS on any day in which services are being rendered.

Medical Necessity (Level of Care) Guidelines

On a member's initial visit, the provider will evaluate the member and determine what behavioral health services the provider believes the member needs. However, before providing these services, the provider must make sure the services meet medical necessity (level of care) guidelines.

Community Care's Care Management Department uses these guidelines in determining whether to issue an authorization (preapproval, precertification) for service (See Obtaining Approval to Provide Services).

If the member's clinical condition necessitates a level of care that is covered in the individual's benefit plan but that level of care is not available, the next highest covered benefit level of care will be authorized.

Mental health medical necessity guidelines (Appendix T) may be obtained on Community Care's website.

Chemical Dependency medical necessity guidelines, Pennsylvania Client Placement Criteria (PCPC) may be obtained on the Community Care website, or from:

Department of Health
Bureau of Drug and Alcohol Programs
Room 929, Health and Welfare Building
Harrisburg, PA 17108

Chemical Dependency medical necessity guidelines, American Society for Addiction Medicine (ASAM) criteria may be obtained from the ASAM Criteria website.

Some supplemental levels of care are not addressed in Appendix T. Community Care has developed supplemental medical necessity guidelines for these levels of care. For a complete list of these guidelines, please visit Community Care's website.

Obtaining Approval to Provide Services (Outpatient Registration, Precertification, Authorization)

The provider cannot be paid for any service unless Community Care has agreed with the medical necessity determination and has given the provider approval to provide the service. Approval is an agreement between the provider and Community Care that the care that the provider plans to provide to a specific member meets the applicable medical necessity guidelines.

Depending on the services the provider plans to provide to a member, the provider must:

- Register outpatient services with Community Care.
- Obtain precertification (preapproval) for services.
- Obtain authorization.

The Guidelines for Obtaining Approval for In-plan Services in Appendix A of this manual lists whether authorization, outpatient registration, or precertification is required to receive approval to perform the service. The forms and steps for registration or precertification are listed below. The provider may also reference the fee schedule attached to the contract for both approval and billing rules.

For Coordination of Benefits (COB), when Community Care is the secondary payer, Community Care must be notified telephonically upon a member's admission to any of the following levels of care:

- Inpatient Mental Health
- Acute Partial Mental health
- Medically Managed and Medically Monitored Inpatient Detoxification (4A & 3A)
- Medically Monitored Short-Term and Long-Term Residential Rehabilitation (3B & 3C)
- Halfway House

Providers must also complete and fax the Coordination of Benefits Primary Insurance Discharge Notification Form to Community Care within five business days of the member's discharge date in order to avoid any reimbursement problems.

Please note: Receiving authorization is not a promise that the claim will be paid; other criteria must be met. Refer to the Billing Section of this Provider Manual.

Outpatient Registration Procedure

Outpatient Registration (OPR) is used to register members for outpatient services and is available only to contracted providers registered with the state as:

- Psychiatrists
- Psychologists
- FQHC
- Outpatient Drug and Alcohol
- Outpatient Mental Health
- Other—Outpatient only

If the provider is contracted to perform outpatient mental health services for members, the provider may be authorized to perform a specific service for a specific member by registering with Community Care as described below.

OPR requests are to be submitted using Community Care's secure ePortal. Registering for an OPR account is a simple online process and can be done here. An online Getting Started Guide, short instructional videos, and frequently asked questions can be found here.

See Appendix D for Priority Populations and Appendix E for Performance Outcomes Management System (POMS) information.

Precertification/Preapproval Authorization Procedures*

Providers must obtain precertification/preapproval before providing the following services to members:

Mental Health Services

- Acute Partial Hospitalization
- Behavioral Health Rehabilitative Services (BHRS)
- Community Treatment Teams (CTT)/Adult Assertive Community Treatment (ACT)
- Diversion and Acute Stabilization/Respite
- Electroconvulsive Therapy
- Family-Based Mental Health Services (FBMHS)
- Family-Focused Solution-Based
- Family Functional Therapy
- Individualized Residential Treatment/CRR
- Inpatient Hospitalization
- Multisystemic Therapy (MST)
- Multidimensional Treatment Foster Care (MTFC)
- Psychiatric Rehabilitation
- Psychiatric Rehabilitation Clubhouse
- Psychological/ Neuropsychological Testing
- Residential Treatment Facilities (RTF)
- School-Based Partial Hospitalization Program
- Summer Therapeutic Activities Program

Chemical Dependency Services

- Halfway House 2B
- Acute Partial Hospitalization Program
- Partial (sleepover) Hospitalization Program
- Medically Managed Rehabilitation (hospital-based) 4B
- Medically Monitored Rehabilitation (short-term, non-hospital) 3B
- Medically Monitored Rehabilitation (long-term, non-hospital) 3C
- Medically Managed Detoxification (hospital-based) 4A
- Medically Monitored Detoxification (non-hospital) 3A

To obtain precertification/preapproval authorization for these services for a member, the provider can call the Community Care Provider Line at 1.888.251.2224, 24 hours a day/seven days a week to review medical necessity guidelines with a care manager. If approved, an authorization number will be generated for a certain time frame and number of units of service. When requesting inpatient care, the Community Care precertification team staff will take clinical information from behavioral health professionals. The provider will be given a "good faith authorization" if it appears the member will meet medical necessity guidelines for an admission, with the number of days to be authorized. If it appears that medical necessity guidelines are not met, the behavioral health professional will be informed of this issue.

The actual authorization will not be provided until the member has arrived at the accepting hospital or facility and a physician has accepted the member for admission, unless the member is being transported by ambulance. If medical necessity guidelines are not met, a Community Care professional advisor will be consulted.

Precertification information can be provided by behavioral health professionals only. Other social services staff such as CYF, foster care, and school personnel will be advised to take the member to an admitting facility, a nearby Emergency Department, or a crisis service for evaluation.

PLEASE NOTE: For certain services requiring precertification (see below), there are required documents that must be submitted before an authorization is given. The specific process and documentation requirements will be explained by the care manager during the precertification call and/or via a scheduled provider training session. Providers may also visit Community Care's website as an additional provider resource.

- Behavioral Health Rehabilitative Services (BHRS)—packet submission required
- Family-Based Programs—packet submission required
- Family-Focused Solution-Based—packet submission required
- Multisystemic Therapy (MST)—packet submission required
- Multidimensional Treatment Foster Care (MTFC)—packet submission required
- Individualized Residential Treatment/CRR—packet submission required
- Psychological/Neuropsychological Testing—testing request form required
- Residential Treatment Facilities (RTF)—packet submission required
- School-Based Partial Hospitalization Program—packet submission required

**There may be contract-specific differences for some levels of care. Contact your provider representative or care management team for contract detail.*

Standards for Member Access to Services (Appointments) and Provider Availability

Community Care standards require that members be given access to covered services in a timely manner, depending on the urgency of the need for services, as follows:

- Behavioral health life-threatening emergencies
- Behavioral health non-life-threatening emergencies
- Urgent behavioral health conditions
- Routine outpatient services

Community Care monitors access data on a routine basis.

Behavioral Health Emergencies

A behavioral health emergency is the sudden onset of acute symptoms of sufficient severity in which the absence of immediate medical or clinical attention could result in seriously jeopardizing or endangering the mental health or physical well-being of the member or of a third party. Behavioral health emergencies are of two types:

- A life-threatening behavioral health emergency is a behavioral health condition that results from a mental illness or substance use disorder. There is reason to believe the member is, or may become, homicidal or suicidal or the member or member's victim may suffer a disabling or permanent physical injury as a result of the member's behavior or condition. The assessment that a life-threatening emergency exists is based upon statements or behavior, member self-report, or information obtained subjectively or objectively, and clinical judgment.

  Care is required immediately for life-threatening emergencies.

- A non-life-threatening behavioral health emergency is a behavioral health condition that results from a mental illness or substance use disorder from which the member may suffer significant physical or emotional deterioration resulting in hospitalization or partial hospitalization unless an intervention is made within one hour.

  Care is required within one hour for non-life-threatening emergencies.

Emergency services do not need precertification (preapproval) by Community Care. Community Care expects that the emergency room, mobile crisis service, or outpatient provider will take immediate action for the safety of the member and others and will register with Community Care for outpatient services as soon as the situation is stabilized.

If Community Care is contacted regarding a member's need for an emergency service, Community Care will provide a referral to an emergency provider, help arrange emergency transportation through the member's physical health managed care organization (PH-MCO), and ensure that emergency services are made available immediately or within one hour of the contact. A customer service representative may follow up with the provider to ascertain compliance with this standard for access to services.

Urgent Behavioral Health Conditions

Urgent behavioral health conditions of either of the following constitute an urgent situation:

- As a result of a mental illness or substance use disorder, a member is experiencing signs, symptoms, or impairment in functioning that would likely require an intensive level of care within 24 hours if treatment is not provided.
- A member expresses a readiness for, or amenability to, treatment if initiated within a 24-hour period.

Access to care for urgent behavioral health conditions must be provided within 24 hours.

Routine Outpatient Services

A routine outpatient service exists if the member exhibits signs or symptoms of a mental illness or substance use disorder that indicate the need for assessment and/or treatment without evidence of imminent or impending risk to the member or others or of an acute, significant change in level of functioning.

Access to routine services must be provided within seven days.

The member may directly schedule an appointment with the provider, who will use medical necessity guidelines to determine the level of service that is needed and will complete registration with Community Care within 72 hours (with a grace period up to 30 days) of the initial outpatient visit or request precertification, depending on the proposed treatment plan.

If the member contacts Community Care directly, a care manager or customer service representative will help the member find an available appointment in the required timeframe.

If the member prefers an alternative appointment time that falls beyond the prescribed timeframe, the provider should document this in the provider's appointment records.

As part of Community Care's outreach efforts, Community Care may contact a provider or a member to ensure that certain appointments, such as ambulatory follow-up appointments after inpatient care, are kept.

Availability Standards

Community Care monitors availability by category of service, through its GeoAccess reporting capabilities, to ensure access to a provider:

1. Within 30 minutes for urban areas.
2. Within 60 minutes for rural areas.

These measures are included in the Quality Management Work Plan.

Coordination of Care, Referrals, Transition of Care to Other Providers

A member can receive safe, comprehensive health care only when all providers of services communicate and work together to educate and encourage the member to comply with treatments and participate in available prevention programs.

Community Care's Expectations for Exchange of Information with Primary Care Physicians and within the Behavioral Health Continuum to Facilitate Continuity and Coordination of Care

Coordination of Care with the member's primary care physician or other behavioral health provider is always expected and particularly important when the member is prescribed a medication or treatment that may have an impact on the member's health or interact with medication or treatment prescribed by the PCP or psychiatrist. Members for whom coordination of care is indicated include (but are not limited to):

- Those with a chronic or serious medical illness.
- Those with a newly prescribed psychotropic medication and who have been taking medication for a medical condition.
- Those requiring multiple medications to treat serious and persistent mental illness.
- Those receiving medication with a history of medication compliance problems.
- Pregnant women who require medication to manage a behavioral health condition.
- Those with a substance abuse problem prescribed medication for a physical or behavioral health problem, especially when the medication may be habit-forming or have the potential for abuse.

To promote needed communication with the PCP or other behavioral health provider, Community Care requires that the provider tells each member about the importance of involving his or her PCP or other behavioral health provider. Community Care also expects that the provider will follow up with the PCP or other behavioral health provider. The provider must obtain the member's written authorization to initiate communication. Providers are also expected to take a holistic approach to promote the importance of the integration of the PH-MCO services as a part of the member's comprehensive recovery plan when applicable.

Exchange of Information with the PCP, PH-MCO, and other behavioral health specialists is monitored on a routine basis from record review data. Results are made available to providers via the Provider Line or Community Care's website.

Referrals for Other Behavioral Health Services

When the provider determines that a member requires behavioral health services that are not within the scope of their practice, the provider should call the Provider Line at 1.888.251.2224 and ask a care manager for help identifying Community Care-contracted providers who can provide those services.

Transition of Care to another Community Care Provider

When a Community Care provider contract is terminated, Community Care may allow up to a 60-day transition-of-care period or through the acute phase of the disorder, whichever is less, for members under the terminated provider's care.

Billing Manual: Introduction

Community Care has designed a claims payment process that ensures prompt and accurate payment for services. In this handbook, the provider will find the requirements and explanations for each component of the billing process.

Prompt and accurate claims payment is one of the most important tasks of any managed care company, and Community Care is committed to excelling in this area. Community Care's ability to pay claims is directly related to the manner in which the provider bills for services. If claim forms are incomplete or incorrect, claims for services that should be reimbursed may be denied. Providers should pay careful attention to the processes used for capturing services and billing since a healthy cash flow is critical to any organization's ability to provide service.

This billing manual is prepared as a guide to policies and procedures for individual practitioners, group practices, programs, facilities, and hospitals to reference when billing Community Care for HealthChoices members.

Community Care endeavors to make billing and claims payment as straightforward a process for providers as possible. Community Care's Provider Reimbursement Department is available for questions by calling 1.888.251.2224 and following the prompts to Provider Reimbursement. The Provider Reimbursement Line is staffed from 8:00 a.m. to 12:00 p.m. and from 1:00 p.m. to 4:30 p.m., Monday–Friday. If calling between 12:00 p.m. and 1:00 p.m., the provider will receive a message advising that the Provider Reimbursement Line is closed. The provider can check the status of the claim on Provider Online or call the Provider Reimbursement Line back during the hours of operation. Questions related to claims **must** be directed to the Community Care Provider Reimbursement Department.

The essentials of completing claim forms are related to ensuring that all of the blocks on the specific claim form are populated based on the instructions provided in this manual. It is important to note that for the HealthChoices program, these instructions are based on Medical Assistance requirements rather than on the usual standards for billing commercial and other insurance payers.

Before Providing Care

Checking Eligibility

Community Care manages the behavioral health care benefits for HealthChoices members in the provider's area. Members must be Medicaid-eligible to enroll with HealthChoices. Members are instructed to carry their Medicaid Access Card for eligibility verification.

As a provider, it is important to ensure that an individual is a current HealthChoices member before providing services. **No matter what authorization is received, if the member being provided services is not eligible for Medical Assistance/HealthChoices on the date services are rendered, Community Care will not be able to pay the provider.**

The provider can verify eligibility in a number of ways. The provider must use their 13-digit PROMISe Provider Identification Number.

- The provider can check eligibility directly by calling 1.800.766.5387 or
- Swipe the member's Access Card.

EVS Software, the MA HIPAA-compliant PROMISe™-Ready software referred to as Provider Electronic Solutions Software, replaces OMAP's past EVS Software. It is available free of charge by downloading from the OMAP PROMISe™ website.

Please remember that EVS is utilized to determine if a member is eligible and **cannot** be utilized as the main source for TPL information or confirmation.

Obtaining Authorizations

An authorization is an agreement that the care the provider wants to provide to a specific member meets medical necessity for that level of care. It is not a promise to pay a claim. If the provider has not secured an authorization and/or is experiencing difficulty obtaining an authorization, the provider must not hold/pend the claim(s). Community Care does not require the authorization number to populate on the claim form. Providers who hold/pend the claim submission process are at risk to receive timely file denials. Submitting a claim without obtaining an authorization should be an **exception** and **not** a routine occurrence.

While most services require an authorization or registration notification for claims payment, not all services require preapproval or precertification. (Refer to Appendix A for the Guidelines for Obtaining Approval for In-Plan and Supplemental Services.)

The care management clinical staff is available 24 hours a day, seven days a week to provide precertification or preapproval for urgent services. For non-urgent services, care managers are available Monday through Friday during the hours of 8:30 a.m. to 5:00 p.m. The Care Management Department is available at any time by calling 1.888.251.2224 and selecting the appropriate options from the menu. Community Care's after-hours coverage ensures providers will always have access to clinical personnel for clinically urgent situations.

While an authorization number is generated at the time of approval, this number is not required to appear on the billing form for consideration of payment. Community Care's information system can match the provider's bill to the appropriate authorization when the procedures outlined in this Billing Manual are followed.

An authorization is **not** a guarantee of payment. All of the billing aspects of the service must be correct for the claim to be paid including meeting the timely file submission guidelines.

Even though an authorization may be issued to provide services, Community Care cannot pay claims for a member who is not eligible for coverage by Medical Assistance at the time services were rendered. Because eligibility or enrollment status may change at any time, Community Care strongly recommends that the member's eligibility status be confirmed or verified at the time of each visit. Failure to verify eligibility may result in claim denial.

Billing

Provider claims should be submitted on one of the two standard claim forms that are accepted by Community Care: the UB-04 (Inpatient Services) or the CMS-1500 (Outpatient Services). In addition, Community Care accepts claims that are submitted electronically via a claims clearinghouse and through Community Care's web-based application, Provider Online. As part of the Health Insurance Portability and Accountability Act (HIPAA), providers are required to use the standards set by the Act, 837I (Inpatient Services) and 837P (Outpatient Services). Providers are strongly encouraged to submit claims to Community Care electronically. For those providers who do not bill electronically, original red-lined claim forms are required.

Non-Participating (Non-Par) Contracted Providers

Please refer to the non-par contract for the appropriate procedure/modifier codes and follow the claim submission requirements outlined in this billing section. Non-par claims can be submitted electronically or via Provider Online. Please contact the Provider Reimbursement Department at 1.888.251.2224 with any questions.

Claims Filing

Claims are to be submitted as soon as possible, *once the applicable authorizations have been obtained* and services have been rendered.

If the provider is having difficulties obtaining the authorization, the provider should submit the claim to ensure that they are within the timely file deadline; claims should not be held. It is easier and much faster to submit a claim correction on the denial for "no authorization" than it is to file for an "exception to timely file." Community Care does not require the authorization number to be populated on the claim; however, submitting without the authorization should be an exception and **not** a routine occurrence.

Timely Filing Guidelines by Contract

Original and corrected claims must be received with the county-specific timely file guidelines listed below.

- **Allegheny**—90 days, 180 days to complete claim process
- **Berks**—60 days, 120 days to complete claim process
- **Blair**—90 days, 180 days to complete claim process
- **Carbon/Monroe/Pike**—90 days, 180 days to complete claim process
- **Chester**—60 days, 180 days to complete claim process
- **Erie**—90 days, 180 days to complete the claim process
- **Lycoming/Clinton**—90 days, 180 days to complete the claim process
- **North Central**—90 days, 180 days to complete claim process (North Central includes Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne Counties)
- **Northeast**—90 days, 180 days to complete claim process (Northeast includes Lackawanna, Luzerne, Susquehanna, and Wyoming Counties)
- **York/Adams**—90 days, 180 days to complete claim process

Coordination of Benefits (COB) Timely File

Secondary claims received outside of timely file guidelines of the respective HealthChoices contracts must be received within 30 days from the paid date indicated on the primary insurance remittance advice. COB claims received more than 365 days from the date of service or inpatient date of discharge will be denied as untimely.

COB Timely File applies to all contracted counties.

Timely File Submission Requirements

Requests for an exception to the Timely File guidelines must include documentation explaining why the exception is warranted.

The following items must be included with the appeal request:

- Providers must forward a letter on company letterhead outlining the details related to the reason(s) a Timely File appeal is being requested and plan of correction.
- Claims **must** be on file prior to submitting a request for a Timely File appeal.
- A copy of the original billed claim (CMS-1500 or UB-04).
- The claim submitted must be a **clean** claim, meaning all required fields are populated correctly, according to this billing manual.
- The claim submitted must be **correct**, meaning all required fields are populated according to this billing manual.
- The claim/form number must be at the top of each claim form or block 22 on the CMS-1500 or block 64 on the UB-04.
- The authorization must be in place.
- The member must be eligible for the date(s) of service billed.
- If the claim was billed electronically, a copy of the electronic confirmation "997" report is required to be included with the appeal documents.
- Providers must show proof of follow-up every 30–45 days. Failure to complete Timely File follow-up is **not** an acceptable reason for requesting a timely file exception.
- Claims must be on file and denied timely in order to submit a timely file appeal.

Mail Timely File requests to the address listed below:

Community Care Behavioral Health Organization Provider Reimbursement
Department—Timely File
339 Sixth Avenue, Suite 1300
Pittsburgh, PA 15222
Attention: Place the Name of the Respective Project Coordinator

Submitting Primary Claim Forms

Depending on the type of service that is being provided, the provider must bill Community Care through Electronic Data Interchange (EDI), via a claims clearinghouse, through Community Care's web-based application, Provider Online, or on paper utilizing the applicable claim form (UB-04 or CMS-1500).

Providers of inpatient services and accredited residential treatment facility (RTF) will submit claims via one of the following methods:

- EDI claims—837 institutional file
- Provider Online—UB screens
- Paper Claims—UB-04
- Three-digit revenue code required

Individual practitioners or other providers providing outpatient services (ambulatory, non-hospital residential and non-accredited residential treatment facility) will submit claims via one of the following methods:

- EDI claims—837 professional file
- Provider Online—HFCA screens
- Paper Claims—CMS-1500
- Procedure code required

Providers should mail **original** paper claims to:

Community Care Behavioral Health Organization
P.O. Box 2972
Pittsburgh, PA 15230

Do not ever mail paper claims Certified to the address listed above.

EDI Claims Processing Information

Claims Clearinghouse Submissions:
Payer Name—Community Care BHO
Payer ID #—**23282**

Providers have two options to submit claims electronically. The first of which is for claims to be submitted via a claims clearinghouse. Providers using this method must execute a contract with one of the clearinghouses listed below. Community Care is certainly willing to work with any other clearing-house that may express interest in doing so. Direct questions regarding a clearinghouse to the Provider Line.

- Relay Health (McKesson)
- EMDEON (WebMD)
- Xactimed/MedAssets
- Gateway EDI/ TriZetto
- Practice Insight
- PNC Bank

EDI (Claims Clearinghouse) Requirements
The EDI process for submitting claims to Community Care is the same as when submitting claims to other insurance carriers via EDI. The EDI-specific fields will vary depending on the EDI software with which the provider's billing system operates. However, the required fields for EDI claims submissions to Community Care through a claims clearinghouse are:

- Community Care's Payer ID "**23282**"
- NPI number
- Member's Medicaid Identification Number
- Payer's name "Community Care BHO"
- Member demographics
- Provider demographics
- Claim detail

Community Care's Web-Based Application, Provider Online

The second method for claims to be submitted electronically is the utilization of Community Care's web-based application, Provider Online. Providers are required to complete a non-disclosure agreement prior to receiving any access to the Provider Online website. Providers must use Microsoft Internet Explorer 6.1 or greater when utilizing the Provider Online website.

For further instructions visit Provider Online.

Provider Online enables providers to:

- Check the status of a claim online.
- Provide an alternative to the use of a claims clearinghouse in the submission of an 837 claim file electronically.
- Provide a vehicle for providers to key claims directly into the system via an *Online batch*.
- Submit claim corrections.
- **Do not submit COB (coordination of benefits) claims via Provider Online**

Internet access is required to use Provider Online. Providers can query the claims system in real time, increasing the speed at which vital information can be obtained. A provider can use Provider Online to query claims status and not choose to submit claims through the application.

The status of any claims submitted to Community Care can be queried via Provider Online, regardless of the manner in which it was submitted.

Providers considering using Provider Online for direct submission of their 837 files must submit two 837-test files; both files must pass the testing phase before the provider will be given access to submit their 837 files via Provider Online into Community Care's production environment. Upon requesting a non-disclosure form for this access, Community Care will provide documentation on the 837 requirements and complete directions on the testing process.

Electronic files can be submitted any time of day or night 24 hours a day, seven days a week from the provider's clearinghouse or via Provider Online.

The daily process runs five days a week Monday through Friday, 7:00 a.m. to midnight. Monitors will not process any claims from midnight until 7:00 a.m., Monday through Friday.

The monitors will process on Saturdays between 7:00 a.m. and 11:30 a.m. and on Sundays from 9:00 a.m. to 6:30 p.m. All output will be available prior to the respective cutoff times or after 7:00 a.m., Monday through Friday.

If a provider experiences issues related to their Provider Online password or account please forward an e-mail to the Community Care Provider Online Help Desk at CCBH_ProvClaims@ccbh.com.

All other questions related to any other issue other than Provider Online passwords or accounts must be directed to the Provider Reimbursement phone lines at 1.888.251.2224. Do not e-mail or contact the Community Care Provider Online Help Desk as they can only assist a provider with their Provider Online password or account issues.

Below is a listing of Community Care upfront rejections for EDI claim submissions, at the claim level:

- Billing NPI either missing or invalid (less than nine characters)—Detail reject error code/description = MCN0001/Missing or Invalid Billing NPI
- Missing Principal Diagnosis Code—Detail reject error code/description = MCN0002/Diagnosis Required
- More than 99 detail lines—Detail reject error code/description = MCN0003/Max 99 Service Line Exceeded
- Missing Diagnosis Pointer—Detail reject error code/description = MCN0004/Missing Diagnosis Pointer
- Missing Quantity Professional Claim—Detail reject error code/description = MCN0005/Invalid Quantity Professional Claim
- Missing Quantity Institutional Claim—Detail reject error code/description = MCN0006/Invalid Quantity Institutional Claim
- Missing Procedure Code—Detail reject error code/description = MCN0007/Missing Procedure Code
- Missing Subscriber Last Name—Detail reject error code/description = CN0008/Missing Subscriber Last Name
- Invalid Charge Amount—Detail reject error code/description = MCN0009/Invalid Charge Amount
- Missing Subscriber ID #—Detail reject error code/description = MCN0010/Missing Subscriber ID #
- Missing Place of Service—Detail reject error code/description = MCN0011/Place of Service Missing
- Invalid Diagnosis Code—Detail error code/description = CLM0314/Non Valid Diagnosis, or missing a required Diagnosis Code
- Missing or Invalid Billing Tax ID—Detail error code/description = MCN0013/Missing or Invalid Billing Tax ID

General Claims Submission Rules/Requirements

All claim forms must contain:

- Member ID number (10-digit MA Recipient ID)
- Tax ID number.
- NPI number.
- ICD–10 Behavioral Health Diagnosis Range; Chapter V Mental Health and Behavioral Disorders F00–F98.
- Diagnosis code F99 is not an appropriate or acceptable diagnosis *unless* the diagnosis code is billed with an acceptable procedure code. Please refer to Provider Alert #14 9-14-2015—Appropriate Use of Diagnosis Code F99
- Procedure codes which appear on the Community Care Fee Schedule.
- "Billing Units" as defined on the Community Care Fee Schedule.
- The date span (to-from) should be equal to the total number of units billed for the room and board revenue codes.
- Data must be within the lines of the applicable claim form box.
- Font should be Arial and the size should be between 10 and 12. Acceptable paper claim forms include the UB-04 for institutional claims and the CMS-1500 for professional claims.
- Revenue Code which appears on the Community Care Fee Schedule.
- Do not submit inpatient secondary (COB) claims in an 837 file.
- Do not submit secondary (COB) claims via Provider Online. EOBs and ANSI codes cannot be attached and/or included.

Paper claims must be completed as outlined in this manual or the claims cannot be scanned into the claims processing system. It is preferred that paper claims be submitted on the standard red and white forms, as black grid lines (copied forms) will interfere with the scanning process. Claims that are not completed correctly may be denied. The Explanation of Payment (EOP) for the claim in question will include a denial code that indicates why the claim could not be paid. When submitting paper primary or secondary claims do not paper clip, staple, or use labels.

Required Claim Fields

The "required" column indicates the columns that must be completed on each and every claim. ***Note: Any claim field marked required must be populated on the claim form or payment will be denied.***

CMS-1500

Listed below are instructions for completing the specific fields on the CMS-1500 for Community Care.

Block #	Field Name	**Required** / Not Required
1	Payer Identifier	Not required
1 a	**Member Number = 10-digit Medicaid recipient ID**	**Required**
2	**Member Name** *(last name, first name, middle initial)*	**Required**
3	**Member's Date of Birth** *(mm/dd/yy)*	**Required**
3	Sex	Not required
4	**Insured's Name** *(last name, first name, middle initial)*	**Required for COB**
5	**Member's Address**	**Required**
6	**Member's Relationship to Insured** *(Always check box for self)*	**Required**
7	**Insured's Address**	**Required for COB**
8	RESERVED FOR NUCC USE	Not required
9	**Other Insured's Name** *(last name, first name, middle initial)*	**Required for COB**
9 a	**Other Insured's Policy or Group**	**Required for COB**
9 b	RESERVED FOR NUCC USE	Not required
9 c	RESERVED FOR NUCC USE	Not required
9 d	**Insurance Plan Name or Program Name**	**Required for COB**
10 a–c	Member's condition related to employment, auto accident, and other accident	Not required
10 d	CLAIM CODES *(Designated by NUCC)*	Not required
11	Insured policy, group or FECA number *(if applicable)*	Not required
11 a	Insured's date of birth and sex	Not required
11 b	OTHER CLAIM ID *(Designated by NUCC)*	Not required
11 c	Insurance plan name or program name *(if applicable)*	Not required
11 d	**Is there another health benefit plan?** *(Check block Yes or No)* **(If Yes, complete items 9, 9a, and 9d)**	**Required**

12	**Member's or Authorized Person's Signature** *(All invoices must have either the recipient's signature or the words "Signature Exceptions" or "Signatures on File" and the date)*	**Required**
13	Insured or authorized person's signature	Not required
14	Date of current illness, injury, or pregnancy (LMP)	Not required
15	Other date	Not required
16	Date client unable to work in current occupation	Not required
17	Name of referring physician or other source *(if applicable)*	Not required
17 a	Name of referring physician or other source	Not required
17 b	NPI	Not required
18	**Hospitalization dates related to current services—FROM**	**Required**
18	**Hospitalization dates related to current services—TO**	**Required**
19	Additional Claim Information	Not required
20	Outside Lab	Not required
20	Outside Lab Charges	Not required
21	**Diagnosis Code** *(ICD-10 BH Diagnosis Code Range 'F Series')*	**Required (ICD-10)**
21	**ICD Indicator** *(ICD-10 diagnosis code)*	**Required (ICD-10)**
22	**Resubmission Code/Original Referral Number** *(required when submitting a corrected claim)*	**Required**
23	Prior Authorization Number	Not required
24 a	**Date of Service—FROM**	**Required**
24 a	**Date of Service—TO**	**Required**
24 b	**Place of Service** *(see Community Care's fee schedule)*	**Required**
24 c	EMG	Not required
24 d	**Procedure Code** *(Enter the applicable procedure codes & modifiers from Community Care's Fee Schedule.)*	**Required**
24 d	**Modifier**	**Required**
24 e	**Diagnosis Code Pointer** *(Enter the diagnosis reference letter as shown in block 21 to correlate the diagnosis code to the procedure or service performed.)*	**Required**
24 f	**Total charges being billed for the line**	**Required**
24 g	**Total days/units billed for the line** *(Two digit maximum per line, 99; No decimal point)*	**Required**
24 h	EPSDT Family Plan *(if applicable)*	Not required

24 i	ID Qual	Not required
24 j	**Rendering Prov NPI#**	**Required**
25	**Federal tax ID number** *(Used for income tax purposes. It **must** be associated with the vendor information on the provider's contract with Community Care.)*	**Required (A, B, C, D, E, R, G, H, I, J, K, L)**
26	**Provider's Patient Account Number**	**Required**
27	Accept Assignment	Not required
28	**Total charges** *(Enter the total sum of 24F lines 1–6 in dollars and cents. No decimal point)*	**Required**
29	**Amount paid by other insurance, if applicable** *(Enter total sum of 24K lines 1–6 in dollars and cents.)*	**Required for COB**
30	RESERVED FOR NUCC USE	Not required
31	**Name of physician, clinician, or facility named on the authorization for the service and the date**	**Required**
32	Name and address of facility where services were rendered	Not required
33	**Provider's vendor name, address, ZIP code, and telephone number** *(Enter the name that should appear on the checks and the address where the checks should be mailed. This information should match the vendor information on the Community Care contract.)*	**Required**
33 a	**NPI #**	**Required**
33 b	Unlabeled	Not required

UB-04

Listed below are instructions for completing the specific fields on the UB-04 claim form for Community Care.

Block #	Field Name	**Required** / Not Required
1	**Name of provider**	**Required**
2	Pay to data	Not required
3 a	**Patient control number**	**Required**
3 b	Medical record number	Not required
4	**Type of bill**	**Required**
5	**Federal tax ID number** *(Is used for income tax purposes; It **must** be associated with the vendor information on the provider's contract with Community Care.)*	**Required**
6	**From**	**Required**
6	**Through**	**Required**
7	Unlabeled	Not required
8 a	**Patient name ID**	**Required**
8 b	**First name**	**Required**
8 b	**Last name**	**Required**
8 b	**Patient name**	**Required**
9 a	**Patient address**	**Required**
9 b	**City**	**Required**
9 c	**State**	**Required**
9 d	**ZIP code**	**Required**
9 e	**Country code**	**Required**
10	**Birthdate**	**Required**
11	Sex	Not required
12	**Admission**	**Required for all INPATIENT claims**
13	**Admission hour**	**Required for all INPATIENT claims**
14	**Admission type**	**Required for all INPATIENT claims**
15	**Source of admission**	**Required for all INPATIENT claims**
16	**Discharge hour**	**Required for all INPATIENT claims**

17	Discharge status	Required for all INPATIENT claims
18	Cond. Code 1	Not required
19	Cond. Code 2	Not required
20	Cond. Code 3	Not required
21	Cond. Code 4	Not required
22	Cond. Code 5	Not required
23	Cond. Code 6	Not required
24	Cond. Code 7	Not required
25	Cond. Code 8	Not required
26	Cond. Code 9	Not required
27	Cond. Code 10	Not required
28	Cond. Code 11	Not required
29	Accident state	Not required
30	Unlabeled	Not required
31 a	Occur. Code 1	Not required
31 a	Occur. Date 1	Not required
31 b	Occur. Code 5	Not required
31 b	Occur. Date 5	Not required
32 a	Occur. Code 2	Not required
32 a	Occur. Date 2	Not required
33 b	Occur. Code 6	Not required
33 b	Occur. Date 6	Not required
33 a	Occur. Code 3	Not required
33 a	Occur. Date 3	Not required
33 b	Occur. Code 7	Not required
33 b	Occur. Date 7	Not required
34 a	Occur. Code 4	Not required
34 a	Occur. Date 4	Not required
34 b	Occur. Code 8	Not required

34 b	Occur. Date 8	Not required
35	Occur. Span	Not required
36	Occur. Span	Not required
37 a	Unlabeled	Not required
37 b	Unlabeled	Not required
38	Responsible party	Not required
39	Value Amount	Not required
39	Value Code	Not required
40 a	Value Amount	Not required
40 a	Value Code	Not required
41 a	Value Amount	Not required
41 a	Value Code	Not required
42	**Rev. Code**	**Required if authorized**
43	Description	Not required
44	**HCPCS & Modifier/Rate/HIPPS**	**Required if authorized**
45	Service Date	**Required** *Note: Not required if confinement claim (determined by referencing Type of Bill info)*
46	**Service Units**	**Required**
47	**Total Charges**	**Required**
48	Non-covered Charges	Not required
49	Unlabeled	Not required
50 a	**Payer Name—Primary**	**Required**
50 b	**Payer Name—Secondary**	**Required**
50 c	**Payer Name—Tertiary**	**Required**
51 a	**Plan ID—Primary**	**Required**
51 b	**Plan ID—Secondary**	**Required**
51 c	**Plan ID—Tertiary**	**Required**
52	Release information	Not required

53	Assignment of benefits	Not required
54	Prior payments	Not required
55	Est. Amt. Due	Not required
56	**NPI #**	**Required**
57	Other provider ID	Not required
58 a	**Insured's first name**	**Required**
58 a	**Insured's last name**	**Required**
58 a	**Insured's name**	**Required**
58 b	Insured's first name	Not required
58 b	Insured's last name	Not required
58 b	Insured's name	Not required
59 a	P. Rel.	Not required
60 a	**Member's unique ID** *(10-digit Medicaid recipient ID for primary HealthChoices claims)*	**Required**
60 b	Cert. SSN HIC ID no.	Not required
61	Group name	Not required
62	Ins. group no.	Not required
63	Treatment authorization code	Not required
64	**Doc control number** *(Required when submitting a corrected claim)*	**Required**
65	Employer name	Not required
66	**Diagnosis version qualifier (ICD Indicator)** *(ICD-10 diagnosis code Chapter V, F Series)*	**Required (ICD-10)**
67	**Principal diagnosis code** *(ICD-10 BH Diagnosis Range Chapter V, F Series)*	**Required (ICD-10)**
67 a–q	**Diag. Code**	**Required**
68	Unlabeled	Not required
69	**Adm. diagnosis code**	**Required**
70	**Patient reason diagnosis code**	**Required**
71	PPS code	Not required
72	Ext cause of injury	Not required
73	Unlabeled	Not required
74	Prin. procedure code	Not required

74	Prin. procedure date	Not required
74 a	Other procedure code	Not required
74 a	Other procedure date	Not required
74 b	Other procedure code	Not required
74 b	Other procedure date	Not required
74 c	Other procedure code	Not required
74 c	Other procedure date	Not required
74 d	Other procedure code	Not required
74 d	Other procedure date	Not required
74 e	Other procedure code	Not required
74 e	Other procedure date	Not required
75	Blank	Not required
76	Attending phys. NPI # and name	Not required
76	Qual.	Not required
77	Operating	Not required
78	Other	Not required
79	Other	Not required
80	Remarks	Not required
81	Code	Not required

ICD-10 Billing Instructions

ICD-10 Outpatient Services: CMS-1500

- ICD-10 Chapter V: Mental and Behavioral Disorders "F01.51–F99"
- ICD-10 Diagnosis Codes are 3–7 digits.
- Digit 1 is alpha, Digit 2 is numeric.
- Digits 3–7 are alpha or numeric.
- Decimal is used after the third character.

ICD-10 Inpatient Services: UB-04

- ICD-10 Diagnosis Codes are 3–7 digits.
- Digit 1 is alpha, Digit 2 is numeric.
- Digits 3–7 are alpha or numeric.
- Decimal is used after the third character.

Third Party Liability (TPL)—Coordination of Benefits (COB)

In instances when a Community Care HealthChoices member has primary insurance coverage, HealthChoices is always the payer of last resort. Community Care providers are required to verify primary insurance as well as bill the primary insurance before billing Community Care. If the provider fails to bill a HealthChoices member's primary insurance company or third party payer first, the claim will be denied by Community Care.

When the provider receives the Explanation of Payment (EOP) for claims that are denied because Community Care's records indicate the member in question is covered by another payer, the provider may call the Community Care Provider Line (1.888.251.2224) prior to submitting a claim to confirm a member's other insurance coverage. Community Care will provide the provider with details associated with the member's other coverage.

- **HealthChoices is the *payer of last resort***—All other applicable insurance **must** be billed prior to submitting a claim to Community Care.
- The primary payer's EOP/EOB must include the denial legend/key code.
- The date of service and billed/charge amount must mirror the date of service and billed/charge amount submitted to the primary insurance.
- When submitting a paper secondary claim, do not paper clip or staple the EOB to the claim.
- Neither a provider nor a HealthChoices member can elect to avoid the requirements of the primary carrier.
- Providers who are not part of the primary carrier's network should redirect the member in-network or seek an out-of-network arrangement with the primary carrier.
- If the primary denied for medical necessity, the provider **must** follow the denial procedures of the primary carrier and exhaust all Act 68 grievance levels to obtain payment. If the denial is upheld, Community Care will conduct a retrospective clinical review prior to making an authorization determination.
- Community Care will pay the Patient Liability/Patient Responsibility (Co-Insurance/Deductible) or up to the Community Care fee amount.

Basic facts to make proper COB billing easier:

- Obtain insurance information from the member for every applicable policy:
  - Carrier name
  - Insured's name
  - Policy number
  - Telephone number
- Contact insurance carrier to verify benefits:
  - Confirm policy effective date
  - Confirm benefits (mental health and/or drug and alcohol)
  - Confirm billing information
- Follow the guidelines of the primary carrier:
  - Verify the provider, group, and/or facility is contracted in the primary network
  - Obtain necessary authorizations
  - Render service
  - Bill service to primary carrier
- Community Care is always the payer of last resort:
  - The provider cannot elect to ignore the existence of another carrier.
  - Bill all other carriers before submitting to Community Care.
  - Primary denial must reflect an acceptable non-covered reason and not failure to follow the primary carrier's guidelines.
- Payment received from Primary Carrier:
  - Explanation of Benefits (EOB) indicates a Patient Liability.
  - Bill all third party carriers that may precede Community Care.
  - Community Care is the last payer:
    - Applicable authorization **must** be obtained.
    - Submit claim to Community Care with a copy of the Primary Insurance EOB.
    - Community Care will pay the Patient Liability/Patient Responsibility (Co-Insurance/Deductible) or up to the Community Care Fee Schedule amount.
    - COB claims received outside of the initial timely file guidelines must be received within 30 days from the date printed on the primary EOB.
    - COB claims received more than 365 days from the date of service or inpatient date of discharge will be denied as untimely.
    - When submitting a paper secondary claim do not paper clip or staple the EOB to the claim or labels.
- Denials received from primary carrier which are **not** acceptable:
  - Primary denial indicates insurance guidelines were **not** followed to obtain primary coverage.
    - Not reimbursable by Community Care
  - Primary denial indicates no auth or precertification obtained.
    - Not reimbursable by Community Care
- Providers are required to complete the following steps, if the primary EOB indicates the service is denied, due to medical necessity:
  - Exhaust all appeal levels with the carrier.
  - If an appeal is granted by the carrier, submit the claim to Community Care with the following information:
    - Copy of Original EOB
    - Copy of 2nd Level Appeal Decision
    - Claim form: CMS-1500 or UB-04

Acceptable denials received from primary carrier:

- Service not covered by plan.
- Yearly benefit is exhausted.
- Lifetime benefit is exhausted.
- Applied to deductible.
- Applied to out-of-pocket.
- Pre-existing condition, service not covered.
- Coverage terminated.

Acceptable documentation of primary denial:

- EOB stating non-covered reason, including denial reason code and description.
- Letter from carrier advising non-covered reason.
- If Medicare exhausted, include a copy of the HIQA screen with the claim submission.
- Screen print from primary carrier's system showing non-covered status.
- COB claims received outside of the initial timely file guidelines must be received within 30 days from the date printed on the primary EOB.

Secondary Electronic Claim Submission

Only secondary outpatient claims can be submitted electronically via an 837 professional file. Electronic files can be received either via a claims clearinghouse or submitted directly via Community Care's Provider Online website in an 837 professional file format only. If submitting secondary EDI files directly to Community Care, providers are required to submit one small test file of 2–3 claims. Below are Community Care's secondary EDI requirements:

- OIC Paid
- Deductible
- Coins
- Copay
- ANSI code

OIC adjustment reason codes for reference

Professional Claims

Community Care requires the submission of all COB relevant data.

- The NM1 segment containing the name and ID of primary insurance company.
- The SVD segment and all supporting CAS segments at the service level.
- The primary insurance allowed amount at the service level is very helpful, but not required.

Understanding Claim Corrections

If the provider receives a payment that they believe is an underpayment or an overpayment the provider will need to initiate a claim correction. Clarification of denials can be obtained by calling the Provider Line (1.888.251.2224) and following the prompts for Provider Reimbursement. Community Care strongly recommends:

1. All claim corrections are submitted electronically (837I, 837P, or Prelog).
2. Community Care will accept a UB-04 or CMS-1500 form with "Corrected Claim."
3. The form/claim number must be written on the top of the UB-04 or CMS-1500 form.
4. The provider must indicate which components of the original claim form they are correcting by drawing a line through or circling the error.
5. Make sure the correction is clearly identified.
6. Community Care **cannot** process a claim correction based on **any Provider's Accounts Receivable listing, Community Care remittance advice, or a Provider Online screen print**.

Claim Correction Requirements:

- Many of the services covered by Community Care can be rendered multiple times on the same date of service. When the same service has been rendered multiple times (same procedure code and modifier), the total number of units rendered should be combined on one line on the claim form or the provider can submit as separate lines on the same claim form by place of service. However, if a claim is submitted for a service and then subsequent units are discovered, the subsequent units **must** be submitted as a claim correction to the original submission (e.g., three units originally billed, an additional four units sent to provider's billing office—a "corrected claim" for seven units should be submitted to Community Care).
- Any time the provider receives a denial for a "duplicate claim," the provider should verify that the service is a true duplicate and not a claim submission for subsequent units on the same day of service.
- If there is an issue with the claim related to the modifier, a "corrected claim," reflecting the correct procedure code and modifier, must be submitted to update the original claim.
- To correct any inadvertent error in billing, the provider must submit a "corrected claim" to update the original claim.
- To reverse a denied claim, a "corrected claim" **must** be submitted with the additional information to update the original claim.
- A request to void a claim should occur only if the service billed **was never rendered**.
- **Do not void a claim prior to submitting a claim correction.**
- Providers who mail paper corrected claims are required to stamp or write the words "Corrected Claim" and the form/claim number on all corrected claims, regardless of the claim form type. This should **not** be done in red ink within the body of the claim. Red ink interferes with the scanning process. Black ink does not.
- Providers who mail paper corrected claim forms are required to populate Block 22 of the CMS-1500 or Block 64 of the UB-04 with the original claim/form number.

- All claim corrections are subject to the timely file guidelines.
- Community Care strongly recommends all claim corrections be completed electronically.
- Corrections and/or voids cannot be completed until the original claim has finalized.
- Never void a claim unless the service was never rendered.

Submitting Claim Corrections

Community Care can accept claim corrections via three methods:

- EDI (preferred method)
- Provider Online
- Paper Claim Corrections

Provider Online—Claim Corrections

Community Care strongly encourages providers to complete claim corrections via Provider Online, Community Care's web-based product. Submitting claims corrections to Community Care via Provider Online expedites the processing of and ensures the accuracy of completing the claim correction process. Secondary claim corrections cannot be submitted via Provider Online. Access the Provider Online User Guide here. The Provider Online User Guide is located under the Reference Library. To obtain access to Provider Online, please call the Provider Line 1.888.251.2224 and follow the prompts to the Provider Reimbursement Department.

Paper Claim CMS-1500—Claim Corrections

Provider is required to write "Corrected Claim" at the top of each CMS-1500 when submitting a corrected claim to Community Care. Draw a line through or circle the incorrect information and write the correct information directly on the CMS-1500.

Include the original claim/form number on the CMS-1500 when submitting a claim correction at the top of the CMS-1500 or Block 22 Original Ref number.

UB-04—Claim Corrections Type of Bill (Form Locator 4)

Provider is required to write "Corrected Claim" at the top of each UB-04 when submitting a corrected claim to Community Care.

Form Locator 4-Type of Bill must represent the appropriate three-digit code. Please refer to the information provided below. Draw a line through or circle the incorrect information and write the correct information directly on the UB-04.

Include the original claim/form number on the UB-04 when submitting a claim correction at the top of the UB-04 or Block 64—Document Control Number.

UB-04—Claim Corrections—Type of Bill (Form Locator 4) Applicable to Provider Online, Claims Clearinghouses & Paper Claims

This three-digit code gives three specific pieces of information.

First Digit (identifies the type of facility)

- 1—Type of Facility—Hospital

Second Digit (classifies the type of care)

- 1—Bill Classification—Inpatient

Third Digit (indicates the sequence of this bill in this particular episode of care)

- 1—Admit through Discharge Claim
- 2 —Interim—First Claim
- 3—Subsequent Interim Claims
- 4—Last Interim Claim
- 7—Replacement of a Prior Claim
- 8—Claim Voids

Mail paper claim corrections to:

Community Care Behavioral Health Organization
Attn: Claims Corrections
339 Sixth Avenue, Suite 1300
Pittsburgh, PA 15222

EDI
Payer Name: Community Care BHO Payer ID: # 23282
Community Care strongly urges providers who submit via a clearinghouse confirm receipt of their 997 report. Within three to five days after confirming receipt of the 997 report, providers can review claim status via Provider Online.

Unless Provider Online lists a check number and a check date, the claim has not been finalized. Please do not call the Provider Line to request payment or denial information unless a check number and check date is populated.

Paper claims mailing address:

Community Care Behavioral Health Organization
P.O. Box 2972
Pittsburgh, PA 15230

Receipt of paper claim submissions can be verified 14 days after submission by accessing Provider Online.

Community Care strongly recommends providers use Provider Online to confirm payment or denial status.

Unless Provider Online lists a check number and a check date, the claim has not been finalized. Please do not call the Provider Line to request payment or denial information unless a check number and check date is populated.

Refunds

In most instances, Community Care will adjust the claim and recover the overpayment through the remittance process. The provider must contact the Provider Line **before** sending a refund check to confirm that the overpayment cannot be recovered through the remittance process (e.g., fiscal year is closed, provider no longer submitting claims for county from which to recover overpayment).

Community Care Billing Glossary

Act 62	Autism Insurance Law, PA Act 62 of 2009.
Adjudicate	When a claim is processed and the result is 'posted/paid,' the claim has adjudicated.
ANSI Codes	American National Standards Institute adjustment reason codes are claim adjustment reason codes to communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.
Authorization Rules	The definition and parameters of the service as listed on the Community Care Fee Schedule.
Chapter V 'F' Series	Classification of mental and behavioral health disorders in the International Classification of Diseases 10th Revision.
Clean Claim	Medical billing term for a complete submitted insurance claim that has all the necessary correct information that allows it to be processed and paid promptly.
CMS-1500	Also known as the Health Insurance Claim Form is the uniform claim form to submit outpatient/ancillary charges.
Co-insurance	The amount of an insurance payment the insured is responsible for, also known as health care cost sharing.
Community Care HealthChoices Member	Person receiving Medical Assistance through a county serviced by Community Care for behavioral health services.
Community Care Member Number	The Member's 10-digit Recipient Number issued by Medical Assistance.
Community Care Procedure Code	The code assigned to a service and defined on the Community Care Service Code Fee Schedule.
Community Care Modifier	Two character code attached to procedure code to identify a different service, allow a unique rate, or facilitate reporting.
Community Care Provider	A contracted private practitioner, agency, facility, or hospital that provides care to a Community Care member.
Consecutive Billing Days	A continuous run of days in which the same procedure code was rendered to the same member by the same Community Care behavioral provider (does not have to be by the same clinician within your agency).
Coordination of Benefits (COB)	Coordination of Benefits (COB) allows plans that provide health coverage for a person with Medicaid to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).
Contractual Obligation (CO)	Amount for which the provider is financially liable.
Date of Service (DOS)	The date the service was rendered.
Deductible	A specified amount of money that the insured must pay before an insurance company will pay a claim.
EDI	Electronic Data Interchange; the computer software system used to encode and transmit claims data electronically.

EFT	Electronic Fund Transfer
ERA	Electronic Remittance Advice
EVS	Eligibility Verification System; used by providers to verify members' HealthChoices or Medicaid eligibility.
Federal Tax ID Number	The number used to identify your agency on your Federal Income Tax returns.
Form Number/ Claim Number	Claim system generated eight-digit number which appears on the Community Care Remittance Advice and Provider Online claim detail screen. Providers are required to include this number when completing all claim corrections.
ICD-10	The International Classification of Diseases 10th Revision. Effective 10/1/2015.
Member Eligibility	Member is covered for behavioral health by Community Care on the date of service. Can be verified through EVS by using card swipe machine or calling 1.800.766.5387. If member is ineligible, claim will deny, even if services were authorized.
MA Provider ID Number	The 13-digit number assigned by the Commonwealth.
NPI Number	National Provider Identification Number (mandatory as of May 23, 2008).
OIC	Other insurance carrier.
OPR	Outpatient Registration; Community Care's method for notification by providers of members receiving "outpatient" services.
Patient Responsibility	The amount of money that a person with health insurance is required to pay after payment is made by the insurance carrier, which represents the patient co-pay, co-insurance, and deductible amounts.
Provider Online	Community Care's web-based application for submitting primary claims directly and for checking the status of claims.
Third Party Administrator (TPA)	An organization that processes insurance claims for certain aspects of an employee benefit plan for a separate entity.
Third Party Liability (TPL)	Another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid-eligible individual; that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment.
UB-04	Also known as the CMS-1450, the uniform claim form for submitting inpatient services/charges.
Unclean Claim	Medical billing term for non-complete submitted insurance claim; means key component of claim is missing and/or incorrect. This will result in a denied claim.
Unit of Service	The "billing unit" defined on the Community Care Fee Schedule. Note: Your "charge collection units" may need to be converted to "billing units."
Usual Charge	The amount charged by your agency, to all payers, for the service being rendered.
Vendor	This is the name and address that appears on the Community Care Remittance Advice. The Vendor is associated with a Federal Tax ID defined by the provider. The Vendor information on the claim form must match the information on the provider's contract or the claims will deny.
835 File	Electronic remittance file
837 File	Electronic claims file.

Community Care Glossary

(Billing-related terms can be found here.)

Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Also, recipient (i.e., Community Care member) practices that result in unnecessary cost to the Medicaid program.
ASAM	American Society for Addiction Medicine.
Authorization	An agreement that the services planned for a specific member meet medical necessity/level of care guidelines. A provider must receive authorization to provide the services for a claim to be honored, but receiving authorization is not a promise that the claim will be paid (other criteria must be met).
BH-MCO	Behavioral Health Managed Care Organization, e.g., Community Care Behavioral Health Organization.
BHRSCA	Behavioral Health Rehabilitation Services for Children and Adolescents (formerly referred to as EPSDT or "wraparound").
BPI	Bureau of Program Integrity (Commonwealth of Pennsylvania).
CASSP	Child and Adolescent Service System Programs.
CMS	Center for Medicare and Medicaid Services (previously HCFA/Health Care Financing Administration).
Community Care HealthChoices Member	A person receiving Medical Assistance through a county serviced by Community Care for behavioral health services.
Community Care Provider	A contracted private practitioner, agency, facility, or hospital that provides care to a Community Care member.
Complaint	An oral or written expression of dissatisfaction from a member or provider that initiates a formal investigation process.
Coordination of Benefits (COB)	Coordination of Benefits (COB) allows plans that provide health coverage for a person with Medicaid to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).
DHS	Department of Human Services; the state agency that administers HealthChoices and other Medicaid programs.
DOH	Department of Health; the state agency responsible for licensing and inspecting health care facilities and services and setting quality standards for providing care to HealthChoices (Medicaid) members.
Emergency	The sudden onset of a behavioral health condition manifesting itself by acute symptoms of sufficient severity, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical or clinical attention could result in seriously jeopardizing or endangering the mental health or physical well-being of the enrollee or seriously jeopardizing or endangering the physical well-being of a third party.
EOB	Explanation of Benefits; statement to a provider showing the status of that provider's outstanding claims with the insurer issuing the EOB (a.k.a. EOP—Explanation of Payment).
EVS	Eligibility Verification System; used by providers to verify members' HealthChoices or Medicaid eligibility.

Expedited Member Grievance	A medical necessity determination grievance regarding an inpatient, acute partial, acute residential, or other urgent or emergent service, as determined by the member or provider.
ICM	Intensive Case Management; a Community Care HealthChoices (Medicaid) covered service that includes coordination of multiple levels and types of services for a member with complex or rapidly changing care needs.
MCO	Managed Care Organization (see BH-MCO and PH-MCO).
Member Eligibility	Member is covered for behavioral health by Community Care on the date of service. Can be verified through EVS by using card swipe machine or calling 1.800.766.5387. If member is ineligible, claim will deny, even if services were authorized.
NCQA	National Committee for Quality Assurance.
OMHSAS	Office of Mental Health and Substance Abuse Services; a component of the Department of Human Services that administers policies regarding mental health and substance abuse issues.
OPR	Outpatient Registration; Community Care's method for notification by providers of members receiving 'outpatient' services.
PCP	Primary Care Physician.
PCPC	Pennsylvania Client Placement Criteria (for chemical dependency).
PH-MCO	Physical Health Managed Care Organization.
PROMISe	Provider Reimbursement and Operations Management Information System; Office of Medical Assistance Program's information management system that produces provider Medical Assistance enrollment numbers. The Office of Mental Health and Substance Abuse Services and Community Care require provider enrollment through the Office of Medical Assistance prior to rendering behavioral health services.
Provider Online:	Community Care's web-based application for submitting primary claims directly and for checking the status of claims.
RC	Resource Coordination; a case management service to meet a member's need for multiple services and supporters.
Routine	Routine outpatient services, other than psychological evaluations, are identified related to member need when a behavioral health condition requires assessment and/or treatment but there is no apparent imminent or impending risk to the member or others and no evidence that the member has significant function impairment.
RTF	Residential Treatment Facility
Supplemental Services	These services may be paid for by Community Care but are not HealthChoices in-plan services.
Urgent	The onset of a mental and/or nervous or substance abuse condition manifesting itself by serious symptoms such that the mental health or physical well-being of the enrollee will deteriorate unless the enrollee is treated by the provider within 24 hours, or in a case in which the enrollee believes that urgent assessment is required.

Appendix A: Guidelines for Obtaining Approval for In-Plan & Supplemental Services

Coming Soon

Appendix B: Confidentiality Policies and Procedures

Policy

Community Care, our staff and agents, shall protect the confidentiality of all confidential data and information to which they have access. "Confidential" information is defined as any information from which the member could be identified. The purpose of this policy is to assure that all data and information obtained by Community Care, and our representatives, are maintained and used with the degree of confidentiality and security that the data and information warrant. In addition Community Care shall follow all federal, state, and other regulatory guidelines about privacy and security of protected health information (PHI).

Procedure

General Confidentiality Provisions

Community Care has designated the privacy officer to oversee company policies and procedures regarding confidentiality and privacy. The specific functions for which the privacy officer is responsible include but are not limited to:

- Annual review of all confidentiality policies.
- Annual training of Community Care employees on confidentiality.
- Follow-up to concerns of members or providers regarding confidentiality.

The Fraud, Waste, and Abuse (FWA) Department will assist the privacy officer with these responsibilities as required and requested.

Community Care employees, staff, and volunteers are required to sign Community Care's "Statement of Confidentiality" agreeing to be bound by strict confidentiality policies and procedures, including all federal and state laws, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Signed "Statements of Confidentiality" are maintained by Community Care's FWA Department. Community Care business associates potentially having access to confidential information are required to sign Community Care's "Statement of Confidentiality" agreeing to be bound by Community Care's strict confidentiality policies and procedures or must conform to equivalent provisions as determined by Community Care staff or legal counsel.

Breach of the "Statement of Confidentiality" or equivalent is grounds for immediate termination.

When Community Care becomes aware of a breach in confidentiality:

- The privacy officer will alert senior management of the breach of confidentiality.
- An investigation regarding the breach of the member's (or provider's) confidentiality will be conducted by, or under the direction of, the privacy officer.
- All necessary staff will be interviewed.
- Any physical material involved will be reviewed.
- Findings will be reported to senior management.
- If applicable, Community Care will alert the Secretary of Health and Human Services, and any other state or federal government agencies, and the physical health plan when necessary, of the breach in confidentiality.

At times, Community Care may have interns, residents, or students who may be exposed to the member's protected health information during his/her rotation. They are required to sign Community Care's "Statement of Confidentiality" in the beginning of their rotation and review all confidentiality policies and procedures.

Education related to the principles and procedures for maintaining confidentiality is required for all Community Care employees, staff, and volunteers at the time of hire and annually thereafter. When an employee, staff, or volunteer has a significant change in his/her job title or assignments, his/her director/supervisor will review all confidentiality policies that pertain to his/her new assignments at the time of the transition.

Documentation of confidentiality training will be maintained in the employee's personnel file located in Human Resources Department (HIPAA Section 164.530(b)(1)).

Community Care considers the following data and information to be confidential:

- Member-identifiable data and information: that is, all data and information where the member is, or could possibly be, identified.
- Explicitly identifiable data include, but are not limited to, member name, social security number, medical record number, health plan beneficiary numbers, account numbers, certificate/license numbers, or other identifier that can be directly linked to a specific individual.
- Implicitly identifiable data include, but are not limited to, member address, telephone number, fax numbers, electronic email addresses, date of birth or other such information that, alone or in combination with other available information, can lead to identification of a specific individual.
- Practitioner-specific data and information, including but not limited to, that used for network development, credentialing, performance evaluation, quality assurance, quality improvement, and peer review.
- A practitioner's name, professional degree, status as a member of Community Care's practitioner network, business address, business telephone number, and specialty/specialties or self-identified areas of special interest are not considered confidential when disclosed for legitimate business purposes.
- Data and information related to a practitioner's racial, cultural or ethnic background, age, religious affiliation, sexual orientation, and ability to communicate in languages other than English, is confidential unless the practitioner explicitly authorizes the release of this information.
- Practice- or group-specific and facility-specific data and information, including that which is used for but not limited to, network development, organizational assessment and contracting, performance evaluation, quality assurance, and quality improvement.
- A Facility or group practice name, status as a participant in Community Care's network, business address, business telephone number, and services offered are not considered confidential when disclosed for legitimate business purposes.

Community Care's business data and information considered confidential includes but is not limited to:

- Salaries.
- Policies and procedures.
- Finances.
- Business plans.
- Practitioner, practitioner group, and facility participants in Community Care's network when such information is not being released for legitimate business purposes.
- Proposals to potential or current customers.
- Information disclosed to Community Care in confidence by a third party.
- Information including quality assurance, quality improvement and performance evaluation data and information where practitioners, practitioner groups, or facilities are not individually identifiable.

Community Care has an array of security provisions to protect confidential data and information, including:

- Differential access based on job responsibilities to information maintained in Community Care's information system.
- Physical lock and key arrangements.
- Electronic security systems.
- Mandatory compliance with Community Care's Statement of Confidentiality.

The following provisions are in effect for all Community Care representatives:

- Divulging computer passwords and security system pass codes is prohibited.
- Building access codes and keys may not be shared with any individual who does not have the right to such access codes or keys.
- All computers that have the ability to access confidential data or information must be:
  - Protected with a confidential log-in password.
  - Turned or logged off at the end of the workday.
  - Protected with a confidential screen saver password in the event that the computer is turned on and logged on while the computer user is away from his or her work area.

Community Care's agents, contractors, employees, staff, and volunteers may not access or view confidential data or information unless required by his/her duties or responsibilities for, or on behalf of, Community Care. The "Statement of Confidentiality" includes a statement that an employee has access to sensitive and confidential information and by signing this statement he/she agrees not to access information from any source(s) that is not needed to perform his/her job duties.

Another part of the "Statement of Confidentiality" is that only the minimum necessary information is used by any employee at Community Care to perform his/her job duties. Community Care's expectations are that only the minimum amount of information needed by our employees is used.

Community Care's Compliance and IS Departments oversee and monitor employee access to member confidential data. Community Care's agents, contractors, employees, staff, and volunteers may not discuss confidential data and information in an area where individuals, including other Community Care agents, contractors, employees, staff, and volunteers who do not have the right to know about the information, may overhear the information.

- All confidential data and information must be maintained in a manner that prevents access by individuals who do not have a right to access the data and information.
- All physical media, including but not limited to paper, magnetic, and optical, used to store confidential data and information must be stored under a double lock system.
- All physical media containing confidential information that are still in use by Community Care agents, contractors, employees, staff, and volunteers at the end of the day must be locked in that individual's desk or in another secured storage area.
- All desks or secured storage areas must be in areas with keyed entry, maintaining a minimum of a dual-key system.
- All physical media containing confidential information that are no longer needed by Community Care agents, contractors, employees, staff, and volunteers must be returned to locked master storage at the end of the day.
- All electronic media containing confidential information must be password protected.

The transfer of confidential information for legitimate business purposes between Community Care's agents, contractors, employees, staff, and volunteers in their official capacities as representatives of Community Care, is considered an internal transfer, even though they may be in different physical locations. The data they receive may be decoded or "aggregate data" to protect the member's health information.

The internal transfer of all confidential data and information must be conducted in a manner that limits potential access by individuals who do not have a right to access the data and information. Each director will determine the specific access and confidential information his/her employees will need to access, in order for them to carry out his/her job duties. (HIPAA Section 164.504(f)(2)(iii)

- When not hand-carried and personally delivered to the recipient, physical media containing confidential data and information must be placed in a sealed envelope marked "*confidential*." Confidential data and information sent by fax must bear a prominent confidentiality notice similar to the following: "*This fax transmission contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this message in error, please notify the sender by fax or telephone and destroy this document.*"
- Confidential data and information sent by email must be flagged as confidential and bear a confidentiality notice similar to the following at the beginning of the message: "This email contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this email in error, please notify the sender by return email, securely delete this file, and any electronic or magnetic copies, and destroy any paper copies."
- Protected health information will not be transmitted via email.
- Confidential data and information no longer required for legitimate business purposes must be destroyed in a secure manner.
- Paper records must be thoroughly shredded.

- Magnetic files must be deleted in a manner that does not permit the files to be undeleted; for example, by reformatting a floppy disk using the "secure" format option.
- Optical storage media must either have the files securely deleted or, if this is not possible, the storage media must be destroyed.
- If the receiver does not have the necessary means to destroy this information, they must return the information back to Community Care in order for it to be destroyed.
- The transfer of confidential information other than to Community Care's agents, contractors, employees, staff, and volunteers in their official capacities as representatives of Community Care is considered an external transfer and must be made in accordance with Community Care's procedure on Disclosure of Information.

Oversight of Confidentiality Practices

Community Care's privacy officer is responsible for:

- Approving and annually reviewing all policies and procedures related to confidentiality.
- Identifying, developing, and implementing mechanisms to oversee the implementation and application of Community Care's confidentiality policies and procedures.

At least annually, the privacy officer, in collaboration with the FWA Department, will evaluate ways to:

- Reduce the collection of member-identifiable data and information.
- Aggregate or de-identify (the process of separating medical information from personal identification such as, removing a name or social security number in order to prevent the identification of a specific member) such data and information as close to the collection point as possible by surveying Community Care representatives, conducting focus groups with Community Care representatives, and reviewing complaints.

Community Care has identified circumstances necessitating special protection of member-identifiable data and information as described in the procedure on Handling of Member-Identifiable Information. Community Care acknowledges that additional circumstances necessitating such special protection may also arise (HIPAA 164.522). All requests for special protection of member-identifiable data and information not addressed in the policy referenced above shall be referred to the privacy officer.

- The privacy officer will consider the request and determine whether the request should or should not be honored.
- If the privacy officer determines that the request should be honored he/she will send the member a letter within 30 days including:
  - Notify the requestor of his/her decision.
  - Determine the mechanism to adhere to the request.
  - Update the procedure on Internal Handling of Member-Identifiable information to reflect the addition.
- If the privacy officer determines that the request should not be honored he/she will send the member a letter including:
  - The decision.
  - The reason for the denial.

- A description of the appeals process.
- The right to, and process for, filing an appeal.
- The name, or title, and the telephone number of the contact person for the next step.

All member and practitioner concerns regarding confidentiality shall be logged as complaints and processed through Community Care's complaint and appeals process (HIPAA Section 164.530(a)(1)(ii)).

- The privacy officer will be notified by the Complaint and Grievance Department about complaints regarding privacy or confidentiality.
- The privacy officer or his/her designee will maintain a log with all complaints or grievances dealing with confidentiality and privacy.
- The privacy officer or his/her designee will work with the Complaint and Grievance Department on resolving complaints dealing with confidentiality and privacy.
- The privacy officer is responsible for reviewing requests for access to member-identifiable data and information from all sources (internal, external, and business associates) and may enlist the cooperation of the FWA Department and medical director as appropriate.

In determining the time frame within which to conduct such a review, the privacy officer or medical director, if appropriate, will consider the potential benefit to the membership from the requested access to data and information. For example, health outcomes may be improved if access is granted to information on diagnosis so that a health management or preventive health program can be implemented.

In the event that Community Care would participate in a research study, the medical director, in collaboration with the privacy officer, is responsible for reviewing all requests to access confidential data associated with a research project.

- The medical director or his/her designee will request a description of the purpose for the requested information from the business associate.
- All requests for de-identified information will be recorded in the Request for De-identified Information log.
- Each request will be reviewed individually.
- For each request, Community Care will determine how this information will be de-identified.
- If Community Care is able to reduce the amount of information requested while still meeting a business associate's request, they will do so.
- Community Care will develop a code to de-identify this information (HIPAA 164.514(c). This code will be unique with each request for information. This code will not be released to the business associate, and each code will be kept in the Request for De-identified Information Log. Only the medical director or his/her designee will have access to this log.
- The medical director will present the request for information to the Outcomes Committee for final approval.
- When the privacy officer receives the decision from the Outcomes Committee; they will notify the requestor in writing, confirming if the requested information will be released, the manner in which it will be released, and how the information will be de-identified. If Community Care did not grant the request for information, a brief explanation of the reason will be given instead.

- Once this has all occurred, the member will be contacted by Community Care to see if he/she would like to participate in any active clinical research activity. Community Care is required to receive the member's authorization prior to the release of any information to a business associate for research purposes. If the member agrees to participate in the study and once the signed authorization is received from the member, the information will be released to the business associate conducting the research.
- If the member declines to take part of this study, his/her coverage will not be terminated with his/her refusal to participate.

Collecting and Using Member-Identifiable Information

Community Care collects and uses only the minimum necessary member-identifiable data and information routinely in the performance of our work. Community Care employees are required to sign a "Statement of Confidentiality" when hired, agreeing to be bound by Community Care's strict confidentiality policies and procedures and all federal and state laws.

Community Care considers the following as member-identifiable information, but it is not limited to that listed below. This information used alone or in any combination may identify the member (HIPAA 164.512(b)(2)(i).

- Name
- Address(es)
- ZIP Code
- Diagnosis(es)
- Treatment Dates
- Date of Birth
- Date of Death
- Telephone Number(s)
- Fax Number
- Electronic Mail Address
- Social Security Number
- Utilization Record ID Number
- Health Plan Beneficiary Number(s)
- Account Number(s)
- Certificate/License Number
- Driver's License Number
- Web Universal Resource Locators (URLs)
- Any unique identifying number, characteristic, or code that Community Care created that if external sources deciphered the code they could identify the member.

There are times when disclosures of protected health information are made on a routine and recurring basis, to providers for the purposes of treatment, payment, and health care operations. (HIPAA Section 164.514(d)(3)). These disclosures are a vital part of our daily performance and may not be restricted. The provider identification is verified by our caller ID system as well as by the provider supplying specific identifying information pertaining to the member; e.g., member ID and Social Security Numbers. Community Care staff identifies themselves to providers with their names, titles, and specific identifying information pertaining to the member. If at any time there is a question as to the identity of the caller, staff members are instructed to take the name of the caller, the facility that is calling, and a telephone number where the call can be returned. The contact and telephone number are verified before the call back is made and any information is divulged.

While Community Care does not maintain a medical record, Community Care does keep a utilization record. Per HIPAA (Section 164.501) a designated record set which Community Care refers to as a utilization record is – a group of records maintained by or for Community Care, used, in whole or in part, by Community Care to make decisions about the member or provider, which may contain the following but is not limited to:

- The medical and billing records about the member or provider.
- The enrollment, payment, claims adjudication, and case or medical management record systems maintained by Community Care.

In accordance with HIPAA Section 164.524, the member may request to restrict this information if desired. The member has the right to request at any time to restrict the collection, use, or disclosure of his/her protected health information. The member may write a letter to the privacy officer at Community Care, requesting to restrict the disclosure of his/her protected health information. The letter must include what specific information the member wants restricted, the member's signature, and it must be dated.

The privacy officer will review the member's request and will respond in 30 days in writing if this information is on site. If the information that the member is requesting is not on-site, Community Care will retrieve the information within 60 days.

If needed, Community Care may extend the retrieval an additional 30 days provided that the member is sent a written letter with an explanation for the delay, and provide a date in which Community Care will have this information. Community Care will only have one such extension of time for each request. If the restriction of protected health is ***granted***:

- The privacy officer will send a letter to the member informing him/her how Community Care will limit his/her information.
- The privacy officer will oversee the process to restrict the protected health information.
- This granted request for restriction of protected health information will be recorded in the Member's Request to Limit Protected Health Information Log, which is maintained by the privacy officer or his/her designee.
- The privacy officer will notify the manager of the file room to have the member's file pulled.
- The privacy officer or his/her designee will place on the front of the member's utilization record a sticker.
- The sticker will have in writing on it "Restricted Information."
- If this file is requested by an employee, the file room clerk must see the privacy officer, or his/her designee, to receive permission to process the request of this file.
- Once the employee is finished with this file and returns it to the file room, the file clerk must alert the privacy officer or his/her designee that the file has been returned.
- The privacy officer will notify all necessary department managers of the member's request to limit his/her protected health information.
- PsychConsult® will contain an alert notifying staff that this particular member's records are restricted.

If the Member's request is ***denied*** the privacy officer will:

- Record in the Member's Request to Limit Protected Health Information Log that the request was denied.
- Send the member a letter within 30 days of the decision including:
  - The decision.
  - The reason for the denial.
  - A description of the appeals process.
  - The right to, and process for, filing an appeal.
  - The name, or title, and the telephone number of the contact person for the next step.

Community Care has the right to deny any request made by the member:

- That will interrupt daily operations to carry out treatment, payment, and health care operations.
- If there is information subjected to the Clinical Laboratory Improvements Amendment of 1988, 42 U.S.C. 263a, to the extent the provision of access to the individual would be prohibited by law: or Exempt from the Clinical Laboratory Improvements Amendment of 1988, pursuant to 42 CFR 493.3(a)(2) (HIPAA 164.524).
- If the information was compiled for a civil, criminal, or administrative action or proceeding.
- If the information involves the member currently in a correctional institution.
- If the member's records are subject to the Privacy Act, 5 U.S.C. 552a, the member may be denied the right to restrict or limit the use of his/her information under this act.

The member has the right to have his/her denial reviewed by a licensed health care professional who was not part of the original decision to deny. The member must write a letter to Community Care's privacy officer requesting that his/her denial be reviewed. Community Care has designated our medical director to be the licensed health care professional to review this request. Community Care's medical director must determine in a reasonable time, whether or not to grant or deny the member's access request based on the above. A letter must be sent to the member with the medical director's decision.

If the medical director's decision is to grant the member's request to the restriction then proceed as above. If the opinion of the medical director is still to deny the request, a letter with this decision must be sent to the member including the reason for the denial, and an explanation of Community Care's complaint and grievance process, including the name, or title, and the telephone number of the contact person for the next step.

At any time the member may lift the restriction of his/her protected health information by writing a letter to Community Care's privacy officer requesting the restriction be lifted. Community Care provides to members the Notice of Privacy, which describes the uses and disclosures of protected health information. The Notice of Privacy is sent to all members. Community Care uses the following methods to notify subscribers of Community Care's routine collection and use of member-identifiable information:

- When Community Care is responsible for managing the enrollment process, subscribers are notified in writing at the time of enrollment of Community Care's routine collection and use of member-identifiable information.
- In most instances, Community Care is not responsible for managing the enrollment process. To ensure that all subscribers are notified of Community Care's routine collection and use of member-identifiable information, some of the following mechanisms are used:
  - The health plan may distribute the information to its members.
  - Members may be notified in Community Care's Member Handbook or via member newsletters that are mailed throughout the year with updated information.
  - The member may request to have this information sent to a different address or location then where they are currently residing. They may write a letter to the privacy officer at Community Care or call member services and inform us as to where they would like the information sent (HIPAA 164.522(b)).
  - A Notice of Privacy authorizing uses of member-identifiable information is posted on Community Care's website and members are informed of this posting via printed materials such as newsletters with a note that Community Care will provide the Notice of Privacy in written form upon request.

Whatever the communication mechanism, the following language, or equivalent, is used to notify subscribers of Community Care's routine collection and use of member-identifiable information: "*Community Care uses information about you and your dependents (if applicable) to enable us to verify eligibility for services; authorize treatment; pay claims; coordinate care; resolve inquiries, complaints, and appeals; improve the care and service rendered by Community Care and its network of practitioners and facilities; and meet regulatory requirements and accreditation standards. If we use information for reasons other than those described above, we will remove any portions of the information that could allow someone to identify you or your dependent, or we will contact you or your dependent to ask for written authorization to use the information.*"

Community Care does not disclose protected health information for underwriting purposes.

Handling of Member-Identifiable Information

All data and information where the member or subscriber is, or could possibly be, identified are confidential. An individual's status as the member or subscriber is considered confidential member-identifiable information.

- A treatment record is a confidential document that is the record of privileged communication between a member and a health care practitioner or facility.
- Community Care may obtain copies of treatment records for legitimate business purposes.
- Member-identifiable information may not be divulged by telephone without first verifying the identity of the other party.
- A case number or social security number and date of birth may be used to verify the identity of an individual claiming to be a member or subscriber.
- If there is suspicion about the identity of an individual, even when such person can supply a correct case number or social security number and date of birth, the Community Care representative should seek additional verification or request assistance from a supervisor or manager.
- The member requesting information about his or her treatment should be referred to the treating practitioner.
- Member-identifiable information may not be disclosed to the member's relatives or friends except as described in the Disclosure of Information policy and procedure.

Data and information derived from treatment records, utilization management records or other clinical sources shall not be considered confidential if they are de-identified or combined and aggregated with other data and information in a manner that precludes the identification of specific members. When considering the adequacy of such aggregation or de-identification to maintain the member's confidentiality, the Community Care representative disclosing the data or information must consider what other data or information may be available to the recipient that could enable the recipient of the information to identify the specific member.

Members have the right to request special limits on access to member-identifiable information. For example, the member who is also an employee of Community Care may request that information on his or her treatment be afforded special protection.

The following table describes circumstances that Community Care has determined create a right to special protection of member-identifiable data and information and the mechanism that Community Care has implemented to adhere to the request:

Reason for Special Protection of	Mechanism to Adhere to Request
• The subscriber is a staff member/employee (or a family member) or volunteer at Community Care	• No clinical information is maintained in Community Care's information system other than routine eligibility data • Clinical reviews are conducted by the medical director, designated professional advisor, or Chief Clinical Officer • Claims adjudication is handled

Informing Members about Confidentiality

Community Care prepares information, written at a 4th grade reading level, for members that describes Community Care's confidentiality policies and procedures. The information covers the following topics:

- Collecting and using member-identifiable information, including provisions for routine notification of the collection and use of member-identifiable data and information.
- Use of authorizations and ability to give informed authorization.
- Access to protected health information.
- Internal protection of protected health information across the organization.
- Member access to protected health information.
- Disclosure of Information.
- Protection of information disclosed to plan sponsors or employers.
- A member's Right to Amend Protected Health Information.
- Right to an Accounting of Disclosures of Protected Health Information.

If the member feels that his/her protected health information has been released or used inappropriately, they have the right to file a complaint. They may either file the complaint by calling member services or writing a letter to Community Care's Complaint and Grievance Department. They may also file a complaint with the Secretary of Health and Human Services who oversees the HIPAA regulations.

As part of the HIPAA regulations, members are notified via a Privacy Notice of Community Care's privacy policies and how Community Care limits and protects protected health information. The Privacy Notice is sent to all members detailing Community Care's privacy policies and how member confidentiality will be maintained. Changes made to the Privacy Notice or policies dealing with privacy and confidentiality will be sent to the member. Notification will be through the member's update/alert including a description detailing the change(s) and when the change will occur. Community Care will give the member a 60-day notice prior to the change becoming effective.

Ability to Give Informed Authorization

Community Care obtains special authorization to release member-identifiable information as described in the Disclosure of Information policy and procedure. Community Care considers the following individuals capable of giving valid authorization for the release of member-identifiable health information:

- The member, who has reached the age of majority as identified by Community Care's eligibility data is capable of giving informed authorization on his or her own behalf unless Community Care has received notification that the individual has been adjudicated incompetent.
- The legal guardian, natural or adoptive parent of a minor, as identified in Community Care's eligibility data is capable of giving informed authorization on behalf of the minor unless Community Care has been informed that the parent has been adjudicated incompetent, is not the legal guardian, or the minor has been legally emancipated.
- An emancipated minor is capable of giving informed authorization on his or her own behalf. If not already on file with Community Care, Community Care will request proof of the minor's status from the minor before honoring the authorization.
- A legally authorized representative is capable of giving informed authorization on behalf of the individual he or she represents. Community Care requires written proof of the individual's status as legally authorized representative and that the status covers the area for which the authorization is being sought.

Community Care extends all reasonable effort to develop and maintain an accurate and efficient system for member information.

- Having established such a system, Community Care reasonably relies on the absence of information indicating that the member or parent of a minor has been adjudicated incompetent and that a parent is not a minor's legal representative.
- Verifying the accuracy of the absence of such information would place an undue burden on Community Care and in most instances would require a breach of confidentiality.

When Community Care is informed that the member is unable to give special authorization for the release of information, Community Care will accept authorization from, and/or release records to, a representative legally authorized to release or receive the member's personal health information. Community Care requires written proof of the individual's status as a legally authorized representative and that the status covers the area for which the authorization is being sought.

Individuals capable of giving valid authorization for the release of member-identifiable health information are also entitled to have access to such information except as follows: Parents or guardians of children age 14 years or over may not have access to the child's health information without authorization from the child.

Member Access to Utilization Records/Protected Health Information

Community Care does not provide direct care or treatment to members. In the event that Community Care intends to become a direct provider of care and treatment, Community Care will develop policies and procedures that address:

- How members can access their medical records if permitted.
- A process whereby members may restrict, access, amend or have an accounting of their medical files that are under Community Care's control.

In accordance with HIPAA Section 164.524, the member may access his/her utilization record if desired. The member may request to view his/her utilization record by writing a letter to the privacy officer at Community Care.

- The privacy officer reviews the member's request and will respond within 30 days.
- If the information requested by the member is not on site, Community Care will retrieve the information within 60 days.
- If needed Community Care may extend the retrieval an additional 30 days provided that the member is sent a written statement with the reasons for delay and a date by which Community Care will have the information.
- Community Care will only have one such extension of time for the request.

If a member is ***granted*** access to review his/her records:

- The privacy officer will oversee the process to view the protected health information.
- This granted request to review records will be recorded in the Members' Request to Review Protected Health Information Log, which will be maintained by the privacy officer or his/her designee.
- The privacy officer and or his/her designee will discuss with the member:
  - The format in which this information will be presented
  - How and where this information will be viewed (the member may choose to review his/her records at Community Care or have the information mailed in an envelope marked confidential to an address that they have specified).
  - If the member would like a summary of the information, or copies.
  - That a nominal fee may be charged by Community Care for postage, copying, or preparation of the information (including the labor of copying the information requested).

If Community Care is unable to accommodate the member's request to view this information, the privacy officer will send the member a letter describing:

- The decision.
- The reason for the denial.
- A description of the appeals process.
- The right to file an appeal along with the process for filing.
- The name, or title, and the telephone number of the contact person for the next step.

Disclosure of Information

Except as described in the procedures on Collecting and Using Member-Identifiable Information, Community Care requests authorization from the member or the member's legally authorized representative prior to disclosing the member's protected health information to external sources.

Community Care will only disclose protected health information in accordance with the most restrictive consent, authorization or other written legal permission from the member, unless otherwise specified by the member (HIPAA 164.506(e)).

The member or the member's legally authorized representative has the right to deny the request to release member-identifiable information without any consequences to the member or the member's coverage.

If member-identifiable data and information are to be disclosed for purposes other than those described in the policies cited in paragraph 1 above, the authorization of the member or member's legally authorized representative is required (HIPAA Section 164.504). This includes, but is not limited to information:

- For research purposes.
- On behavioral health signs, symptoms, diagnoses, or treatment from a primary care physician or other clinician not providing behavioral health care.
- That could result in a member being contacted by another organization for marketing purposes.

There may be times when Community Care needs to disclose information about the member without receiving informed authorization. These situations include, but are not limited to (HIPAA Section 164.506(a)(3)(i)):

- Emergency situations where the member's life or other lives may be at risk.
- Community Care may disclose information for the purpose of identification and location of the member with or without his/her authorization in response to a law enforcement official's request for information to identify, or locate a suspect, fugitive, material witness, or missing person. The following information may be released under these circumstances (HIPAA 164.512(f)(2)):
  - Name and address.
  - Date and place of birth.
  - Social Security Number.
  - Date and time of treatment.
  - Date and time of death, if applicable.
  - Any description of distinguishing physical characteristics. (Height, weight, gender, race, hair/eye color, and any distinguishing traits, scars, tattoos, etc.)
- When there is a substantial barrier to communication with the member and Community Care's representative, using his/her professional judgment, believes the individual's consent to receive treatment is clearly inferred.
- When authorized by Community Care's legal counsel to meet the requirements of federal, state, and local law.

- For public health activities as required by law (HIPAA 164.512(b)(i)):
  - To prevent or control disease, injury, or disability.
  - To report births and deaths.
  - To report child abuse or neglect.
  - To report reactions to medications or problems with products.
  - To notify people of product recalls, repairs, or replacements.
  - To notify a person who may have been exposed to a disease or condition.
  - To notify the appropriate government authority if Community Care believes the member has been the victim of abuse, neglect, or domestic violence.
  - Disclosures to federal, state, or county agencies that oversee Community Care, such as governmental monitoring of the health care system, Medical Assistance, government programs, and compliance with civil rights laws.
  - In regard to the care or payment related to the member's health care (HIPAA Section 164.510(b)).

Under some circumstances, it may be necessary to obtain authorization verbally. The use of a verbal authorization should be approved in advance by Community Care's legal counsel or, if circumstances indicate a need for a rapid decision then by the member of Community Care's senior management team. If approved, two representatives of Community Care must witness the entire process of obtaining verbal authorization to release information.

Community Care considers an authorization to release information to be valid only if (HIPAA 164.508(c)):

- It provides the name of the person (s) providing the information.
- It is in a language the member can understand.
- There is a purpose for the release.
- The specific information to be released (dates of treatment, and the exact type of information to be released, i.e., mental health, drug and alcohol) is described.
- The member's full name at the time of treatment and correct identifying information; e.g., date of birth and Social Security Number.
- The individual or entity authorized to receive the information is described.
- The expiration date of the authorization.
- The signature of the member or the member's legally authorized representative (If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual).
- The release is obtained in a manner that complies with applicable law and regulations.
- There is a statement that treatment will not be affected if the member or member's representative refuses to sign the authorization.
- There is a witness signature.
- There is a date of expiration for the authorization.

- There is a written statement on the authorization form that once this information is released to the recipient, this information may be subjected to re-disclosure by the recipient and no longer protected by this rule.
- There is a statement on the authorization form that if this information is used or disclosed pursuant to the authorization, it may be subject to re-disclosure by the recipient and no longer be protected by this rule.
- There is a statement that the individual has the right to revoke this authorization in writing, including the exceptions to the right to revoke, and a description of the process for the individual to revoke the authorization.
- Community Care will not release the information unless the form is completed.
- Prior to releasing information of previously signed authorization to release information, Community Care will review all authorization forms that are still in effect to ensure that they are compliant with HIPAA regulations.
- If a previously signed authorization is compliant with HIPAA regulations Community Care will continue to release the information until the authorization expires.
- If the authorization is not HIPAA compliant, then Community Care will contact the member within 60 days to obtain a newly signed authorization that conforms to HIPAA regulations.

See the policy on Transition of Prior Consents and Authorizations for the complete procedure.

Community Care may use and disclose protected health information in order to improve business operations and services to members. Protected health information that had been de-identified and restricted may be released to business associates for activities such as, but not limited to: oversight, auditing, or improving Community Care's daily operations (HIPAA 164.504(f)(2)). Prior to releasing such information, business associates must sign a Business Associate Agreement. This agreement holds the business associate accountable for the protected health information that they will receive. Included in the agreement is (HIPAA Section 164.512(i)):

- A description of the permitted uses and disclosures of the limited protected health information by the recipient, consistent with the purposes outlined in his/her proposal or contract.
- The requirement to limit access to who may receive the data.
- The requirement that the business associate will not use or disclose this information other than as permitted by the agreement or otherwise required by law.
- The requirement that the business associate will take appropriate safeguards to prevent the use or disclosure of the information. If the business associate becomes aware that the information was tampered with or released mistakenly they must notify Community Care. Community Care will give the business associate an opportunity to investigate and rectify the situation.
- The requirement that the business associate will ensure that any agents, including a subcontractor, to whom the business associate provides the limited information, agrees to the same restrictions and conditions that apply to the business associate.
- The expectation that the business associate will not try to re-identify the information or contact members.

- An explanation that if the Secretary of Health and Human Services requests this information in order to oversee if Community Care is compliant with HIPAA regulations, the business associate will release the information to the Secretary.
- The requirement that, once the information is no longer needed the business associate will destroy it or return it to Community Care in order for it to be destroyed.
- A clause allowing the business associate contract to be terminated at any time if Community Care has reason to believe that the business associate has violated any of the above.

Community Care may disclose protected health information that has been de-identified to Business associates for business functions that have been contracted. Community Care requires the following of the Business associate contract (HIPAA Section 164.504(e)(ii)):

- The information given to them will not be used or further disclosed unless it is required or permitted by the contract or as required by the law (HIPAA Section 164.504(e)(ii)(A)).
- They will take appropriate precautions with the information they are given (HIPAA Section 164.504(e)(ii)(B)).
- In the event that someone discloses information they will report the breach to Community Care as soon as they become aware of it (HIPAA Section 164.504(e)(ii)(C)).
- They will ensure any additional agents, including subcontractors, to whom this information may become available to, follow the same restriction and conditions that apply to them (HIPAA Section 164.504(e)(ii)(D)).
- The member may access, amend, or have an accounting of the information that is released to a business associates.
- The information released by Community Care will be available if requested by the Secretary of Health and Human Services in order to track Community Care's compliance with HIPAA (HIPAA Section 164.504(e)(ii)(H)).
- At the termination of the contract or when this information is no longer needed, the business associate has the necessary means to destroy this information or have this information returned to Community Care in order for it to be destroyed (HIPAA Section 164.504(e)(ii)(I)).
- A business associate's contract may be terminated at any time if Community Care feels the business associate has violated any of the above (HIPAA Section 164.504(e)(iii)).

Community Care may disclose protected health information about victims of abuse, neglect, or domestic violence without an authorization to law enforcement officials or government agencies by a representative using his/her professional judgment (HIPAA Section 164.512(c)(1)). If Community Care releases such information, it will promptly inform the member that such a report has been made except when:

- Informing the member would put them in serious danger or harm.
- Community Care is unable to inform the member in which case the personal representative may be informed that Community Care released this information. However, if Community Care believes the personal representative is responsible for the abuse, neglect, or other injury then he/she would not be notified.

Community Care may disclose protected health information without an authorization to a law enforcement official:

- When required by law for the purposes of, but not limited to, investigating a complaint, civil, or criminal charges. (HIPAA Section 164.512(f)) The information requested must first be forwarded to Community Care legal counsel for review.
- In the event that the member has died, for the purposes of alerting the law, if Community Care has a suspicion that such death may have resulted from criminal conduct (HIPAA Section 164.512(f)(4)).
- If there is evidence of criminal conduct that has occurred on our premises (HIPAA Section 164.512(f)(5)).
- If the member (HIPAA Section 164.512(f)(6)) contacts Community Care about a crime (commission or nature of one), the location of such crime or the victim (s) of such crime; and the identity, description, and location of the perpetrator of such a crime.
- In this latter instance, the Community Care representative will notify his/her direct supervisor of the situation, and will call 911 to report this information.

Community Care does not collect information on the following, in regard to organ and tissue donation or the deceased member's wishes, information about decedents, information for fundraising purposes, or information for marketing purposes. In the event Community Care would collect information on any of the above, an appropriate policy and procedure will be drafted.

Disclosure of Information to Employers

Community Care does not share member-identifiable data or information with employers without the authorization of the subscriber, member or member's legally authorized representative and only the specific information requested will be released in accordance with all federal and state laws. All authorizations for the release of information will be verified by Community Care prior to the information being sent.

- Community Care recognizes that the member or member's legally authorized representative, and not a subscriber (unless the subscriber is also the member or the member's legally authorized representative) is the preferred individual from whom to obtain authorization to release member-identifiable information to an employer.
- Community Care also acknowledges, however, that current industry practice is for the subscriber, and not each member, to sign authorization forms and other documents at the time of enrollment. Requiring the signature of each member or member's legally authorized representative at the time of enrollment is impractical.
- Community Care accepts its role as an advocate of the members' rights and will work to effect change in the industry to increase protections for confidential member-identifiable data and information. Community Care follows all state and federal laws and regulations.

When Community Care is responsible for managing the enrollment process, Community Care obtains authorization from a subscriber at the time of enrollment to release the minimum member-identifiable data or information to the employer.

In many instances, Community Care is not responsible for managing the enrollment process. If Community Care manages behavioral health benefits through an agreement with a managed care organization (MCO), Community Care's policy is to release member-identifiable data or information to the MCO, knowing that in the absence of the MCO's agreement with Community Care, the MCO itself would be responsible for managing behavioral health benefits and would therefore have access to the member-identifiable data or information.

In any instance where Community Care must release member-identifiable data or information to an employer, whether self-insured or fully insured, Community Care must verify that the member has signed an authorization to release such data or information to the employer. Community Care will require that the employer agree in writing to protect all member-identifiable data and information from being used in any decisions affecting the member (HIPAA 164.504(h)(3)(iv)).

Many requests from employers for data and information can be fulfilled with data and information that are not member-identifiable:

- In instances where an employer requests member-identifiable information, Community Care will inquire as to the proposed use of the data and information and attempt to meet the need with data and information that are not member-identifiable, for example aggregated data or information.
- In instances where member-identifiable data or information is required, Community Care will ensure that an authorization for the release of information is signed by the member prior to releasing implicit data to the member's employer.
- In all instances, Community Care discloses only the minimal information necessary to accomplish the purpose of the disclosure.

Handling of Practitioner-Specific Information

Community Care considers practitioner-specific data and information, including but not limited to, that used for network development, credentialing, performance evaluation, quality assurance, quality improvement, compliance auditing and peer review confidential to the extent permitted by law.

- A practitioner's name, professional degree, status as the member of Community Care's practitioner network, business address, business telephone number, and specialty(ies) or self-identified areas of special interest are not considered confidential when disclosed for legitimate business purposes.
- Data and information related to a practitioner's racial, cultural or ethnic background, age, religious affiliation, sexual orientation, and ability to communicate in languages other than English, is confidential unless a practitioner explicitly authorizes to the release of this information.
- Community Care's credentialing and recredentialing applications request that such information be supplied at the discretion of a practitioner.
- The credentialing and recredentialing applications state that if such information is supplied, Community Care may use and disclose only the minimum amount of information to members or appropriate individuals for purposes of meeting a specific Member needs or requests when making referrals.
- Practitioner files are maintained in a locked room or locked file cabinet when not in use by credentialing staff or the Credentialing Committee. Practitioner files stored in electronic, magnetic, or optical format are protected with a secure password.
- Access to practitioner files is limited to the network management, compliance, and credentialing staff and the Credentialing Committee.
- Practitioners may review the information in his/her file upon request except for any information from the National Practitioner Data Bank (NPDB) and peer (professional advisor) review information. Review of NPDB information is prohibited by Federal statute.
- Each practitioner is informed of the right to review information in his/her file through the cover letter in the application packages for initial credentialing and recredentialing.
- A practitioner may obtain a copy of his/her file.
- The request must be in writing.

- Credentialing staff will send a copy of a practitioner's file to him/her within 10 business days of receipt of the written request for the file. This file when mailed will be sealed in an envelope marked confidential.
- NPDB information is not included.
- Peer review information is not included.
- Practitioners are notified by the credentialing staff of any information obtained during credentialing or recredentialing activities that varies substantially from the information provided by the practitioner.
- Practitioners have the right to correct erroneous information.
- Practitioners may submit any corrections in writing or additional documents to the Credentialing Department.
- Credentialing staff will document any verbal information or corrections provided by a practitioner in the file including the date and signature of the individual who obtains the information.

Informing Providers about Confidentiality

The following policies and procedures are included in Community Care's Provider Manual and updated as needed:

- General Confidentiality Provisions.
- Oversight of Confidentiality Practices.
- Collecting and Using Member-Identifiable Information.
- Informing Members about Confidentiality.
- Ability to Give Informed Authorization.
- Member Access to Utilization Records.
- Disclosure of Information.
- Disclosure of Information to Employers.
- Handling of Practitioner-Specific Information.
- Practitioner Office Confidentiality.

Practitioner Office Confidentiality

Member-identifiable data and information maintained in paper-based or removable computer storage media must be maintained under lock and key, either in locked cabinets or in a locked area.

- Member-identifiable data and information includes, but is not limited to, medical records, appointment books, patient reminder cards, correspondence, laboratory results, billing records, and treatment plans whether maintained on paper, magnetic disk or tape, optical disk, or any other removable storage medium.
- These paper-based records and removable computer storage media must be locked except at times when the practitioner or another member of the office staff, who is authorized to access treatment records, is present.
- When unlocked, these paper-based records and removable computer storage media must be maintained in a secure location where they are not accessible to unauthorized individuals.
- In addition, when unlocked, these paper-based records must be maintained in a manner that their content is not visible to unauthorized individuals.

Computers used to store member-identifiable data or information must be protected with a password.

- Password protection is not required if all persons at the practice site are authorized to access, for legitimate business purposes, the member-identifiable data or information stored on the computer; and the computer is located in a secure location not accessible to unauthorized individuals.
- When a computer is used to store member-identifiable data or information, the monitor is positioned such that it is not visible to unauthorized individuals.
- If email is used to transmit member-identifiable data or information, the email is flagged as confidential and a confidentiality notice is prominently displayed at the beginning of the email that conveys a message substantively similar to the following: "*This email contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this email in error, please notify the sender by return email, securely delete this file and any electronic or magnetic copies, and destroy any paper copies.*"
- Fax machines are in secured areas where faxes may not be intercepted or viewed by individuals not authorized to access member-identifiable data and information. If fax machines are used to transmit member-identifiable data or information, a confidentiality notice is prominently displayed on the fax cover sheet that conveys a message substantively similar to the following: "*This fax transmission contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this message in error, please notify the sender by fax or telephone and destroy this document.*"

Handling of Community Care's Business Information

Community Care's representatives and business associates may not release confidential business data and information (as described in the procedure on General Confidentiality Provisions) except for legitimate business purposes and within the framework of the representative's job responsibilities or the business associate's normal course of performing work for Community Care:

- As described in Community Care's policies, procedures, program descriptions and work plans, or as authorized by a member of Community Care's senior management.

All requests for confidential business information which are not explicitly addressed and authorized by Community Care's policies and procedures or other official documents should be referred to the manager of the department for documentation and follow-up. All statements to the media including press releases and interviews are made by or authorized by Community Care's Chief Executive Officer.

Subpoenas

Member-identifiable data and information must not be released if a subpoena is served without first consulting Community Care's legal counsel:

- The Community Care representative receiving the subpoena should immediately send the subpoena, via fax if necessary, to Community Care's legal counsel.
- If the Community Care representative receiving the subpoena is not a member of management, he or she should immediately contact his or her supervisor to act on the matter.
- Legal counsel, in conjunction with appropriate Community Care staff, employees, and the treating practitioner, will determine the appropriate course of action.
- When the information is needed to prevent further harm to the member, Community Care may release protected health information in response to a law enforcement official's request with or without the authorization of a member who is suspected of being a victim of a crime (HIPAA Section 164.512(f)(3)).
- Information may be released to law enforcement officials for court proceedings or an investigation, after it is forwarded to Community Care's legal counsel. Community Care will ensure that the proceedings and persons requesting the member's information have made a good faith attempt to contact the member, or his/her legally authorized representative, to inform him/her that their protected health information is being requested before it is released (HIPAA Section 164.512(e)).

If the officials are unable to locate the member and they have shown reasonable efforts in an attempt, then Community Care will release information if (HIPAA Section 164.512(e)):

- There is documentation to support our efforts in trying to find the member.
- A written notice was sent to the member's last known address and the member was given sufficient time to respond or raise objections.
- Once time has elapsed:
  - Proof that there are no objections filed by the member.
  - If there are any objections filed, they have been resolved through the court or an administrative tribunal.
- The information released is only to be used for the litigation or proceeding.

Once this information is no longer needed then, Community Care requires that requestor destroy the information, or to return it so that it can be destroyed.

A Member's Right to Amend Protected Health Information

In accordance with HIPAA (Section 164.526), the member has the right to amend his/her protected health information if desired. The member may request to amend his/her information by writing a letter to the privacy officer at Community Care including a reason why this information needs to be amended.

- The privacy officer will review the member's request and will respond in writing within 30 days.
- If the information requested is not on site, then Community Care will retrieve the information within 60 days.
- If needed Community Care may extend the retrieval an additional 30 days provided; that the member is sent a written statement with the reasons for delay and a date by which Community Care will have the information.
- Community Care will only have one such extension of time for action.

If the member is ***granted*** the right to amend his/her protected health information, the privacy officer will oversee the process to amend the protected health information.

- The privacy officer or his/her designee will record the granted request to amend protected health information in the Member Request to Amend Protected Health Information log, which will be maintained by the privacy officer or his/her designee.
- The privacy officer will inform the member that the original information will remain intact. The privacy officer or his/her designee and the member will discuss how this information will be amended; including what type of statement will be attached to all future releases such as "this information, as requested by the member, was amended." The privacy officer will notify the manager of the file room to have the member's chart pulled.
- A sticker will be placed on the front of the member's utilization record that says: "AMENDED PROTECTED HEALTH INFORMATION." The privacy officer or his/her designee will also write a brief statement to be included in the member's file, on how this information that was requested by the member was amended.
- There will be a flag in PsychConsult® to inform Community Care employees that this information was amended.
- Community Care's privacy officer will write a formal notification alerting all the necessary staff and providers that the member's protected health information was amended and include a brief statement on how and why.
- Once this process is completed the privacy officer or his/her designee will send a written letter to the member including that his/her request to amend his/her protected health information was granted, including a brief description on how it was amended.

If the member is ***denied*** the right to amend his/her protected health information the privacy officer, or his/her designee will:

- Record in the Member Request to Amend Protected Health Information Log that the request was denied.
- Send the member a letter including:
  - The decision.
  - The reason for the denial.
  - A description of the appeals process.
  - The right to, and process for, filing an appeal.
  - The name, or title, and the telephone number of the contact person for the next step.

- The member has the right to request in writing that Community Care attach a statement to all future releases such as "the member requested this information be amended and Community Care denied the request."
- The privacy officer or his/her designee will record in the Member Right to Amend Protected Health Information Log that the member requested a statement similar to the one above be attached to all future releases of information.
- The privacy officer or his/her designee will notify the manager of the file room to have this member's file pulled.
- A sticker will be placed on the front of the member's utilization record that says: "*See Privacy Officer Before Any Information Is Released To Outside Sources*." The privacy officer will need to see the information that is requested before it is sent to ensure that the statement a member requested is included with the information.
- The privacy officer or his/her designee will also write a brief statement to be included in the member's file that the member requested to amend his/her protected health information was denied.
- The member may also request that this statement be included with all future information to be released.

If the information the member is requesting to be amended is not the property of Community Care, the member will be referred to the originator of the documents. If the originator of the protected health information is unable to act on the request (for example, a practitioner who is no longer in practice), and Community Care's privacy officer feels the member's written request is legitimate Community Care will amend the information in its possession (HIPAA 164.526(a)(2)(i)).

Right to an Accounting of Disclosures of Protected Health Information

The member has the right to request that Community Care provide an accounting of disclosures of protected health information made by Community Care in the six years (or shorter time period) prior to the date in which the accounting is requested. (As per the HIPAA Section 164.528.) ***Community Care is not required to track disclosures prior to the implementation of the HIPAA Privacy Regulations.***

The member has the right to request an accounting of disclosures of his/her information by writing a letter to the privacy officer at Community Care.

- The privacy officer or his/her designee will review the member request and will respond in 30 days.
- If the information requested by the member is not on site, Community Care will retrieve the information within 60 days.
- If needed Community Care may extend the retrieval an additional 30 days provided; that the member is sent a written statement with the reasons for delay and a date by which Community Care will have the information.
- Community Care will have only one such extension of time for each request.

If ***granted***, Community Care will release to the member an accounting of his/her disclosed protected health information.

- The privacy officer or his/her designee will oversee the process to account for disclosures of protected health information.
- This granted request for an accounting of protected health information will be recorded in the Member Request to an Accounting of Protected Health Information Log, which will be maintained by the privacy officer or his/her designee.

- The privacy officer or his/her designee will notify the manager of the file room to have the member's chart pulled. The following will be included in the accounting of disclosures:
  - The date of the disclosure.
  - A brief description of the information that was released.
  - A statement on the purpose of the disclosure or a copy of the signed authorization.
  - The name of a person or provider who requested this information. (Community Care reserves the right to deny the request for an accounting of disclosure of information if divulging the name of the person who received information could be detrimental to the member or the person to whom the information was disclosed.)
  - A brief statement of Community Care's policy on Disclosure of Information.
  - If there was more than one authorized release of information during the requested time period then, the frequency, periodicity, or number of the disclosures made is included.
  - If the information was for, or in anticipation of, a civil, criminal, or administrative action or proceeding, Community Care will not release the information.
  - A flag will be placed in PsychConsult® to notify employees that the member asked for an accounting of disclosures.
- Once this information has been compiled, the information will be mailed in an envelope marked "Confidential" to the address that the member specifies.

Each year the first request for the accounting of information is free. After this, Community Care may charge a reasonable fee for preparing the information, as long as members are notified.

If the privacy officer determines that the request should not be honored, within 30 days he/she will send the member a letter including the decision; the reason for the denial; a description of the appeals process; the process for filing an appeal; and the name/title and phone number of the contact person for the next step.

Appendix C: Supplemental Confidentiality Policies & Procedures

Policy

It is the policy of Community Care to protect the confidentiality of member information in its administrative functions and among its contracted health care providers. Specific provider and member information is collected and used by Community Care to the extent necessary and appropriate to requirements relating to accountability functions and for the delivery of efficient and high quality care and services.

This Confidentiality and Disclosure Policy is intended to provide Community Care personnel with guidance concerning the disclosure of information relating to members, providers, services furnished to members, or other confidential information, whether the information was created by Community Care or acquired in connection with its business activities.

Responses to requests for information from utilization records must comply with applicable state and federal laws and regulations and The Health Insurance Portability and Accountability Act (HIPAA) regulations including 164.510 governing the release of such information. Responses to requests for information should reflect a customer service orientation but must also reflect an awareness of the potentially competing interests of different customers of Community Care; e.g., employer groups and enrolled members. This policy also concerns confidentiality regulations related to the assessment, diagnosis, referral, case management, counseling, and treatment of the member, as well as confidentiality related to the complaint and grievance process.

It is the policy of Community Care to adhere to all applicable laws, regulations and protections with respect to assuring the confidentiality of member information and with the specific requirements set forth at 42 CFR, Part 2 of the Federal Regulations, 255.5 of the Pennsylvania Drug and Alcohol Abuse Control Act, the confidentiality of HIV-Related Information Act, the Mental Health Procedures Act and the Mental Health and Mental Retardation Act of 1966 and all pertinent regulations. No information will be released without the specific authorization of the member except as noted in and consistent with the attached specific directives and exceptions:

- CPL 032 Confidentiality Policy.
- Authorization to Release Confidential Information Form.
- Patient Record Retention Policy.
- Policy on Release of HIV-Related Information.
- Policy on Release of Information Related to the Treatment of Minors.
- Policy on Release of Information Related to Mental Health Treatment.
- Policy on Release of Information Related to Drug and Alcohol Dependency and Treatment.
- Policy on Community Care Staff Having Knowledge of or a Relationship with the Member.

Procedures

Confidentiality: Terms and Disclosure Policy

Categories of Information—Community Care's legal obligations with respect to different types of information vary. For the purposes of this policy, information is grouped into the following categories:

- **Claims Information**—The member-identifiable information, both medical and non- medical, submitted by the member or the health care provider to Community Care on a claim form for the purpose of obtaining payment for medical services. Claims information includes information submitted to complete an incomplete claim form, but does not include medical records or information generated by Community Care in connection with utilization review, quality assurance, case management, compliance audits, or other managed care activities.
- **Medical Records**—All member-identifiable information within the member's medical file as documented by the attending physician or other medical professional and which is customarily held by the attending physician or provider hospital. Medical records may be sent (following HIPAA guidelines) to Community Care in connection with utilization, compliance, or quality assurance activities, or may be furnished as supporting documentation to claims information. In Pennsylvania, the original medical record is the property of the provider.
- **Utilization Record**—A group of records maintained by or for Community Care, used, in whole or in part, or for Community Care to make decisions about the member or provider that may contain the following but is not limited to:
  - The medical and billing records about the member or provider
  - The enrollment, payment, claims adjudication, and case or medical management record systems maintained by Community Care.
- **Aggregate Claim Information (ACI)**—All non-identifiable member information concerning medical claims.
- **Member File Information**—The member's enrollment application, records of communications between Community Care and the member, records of administrative correspondence, such as referral forms, between practitioners and Community Care concerning the member and the like. This information is typically maintained in what is called the "utilization record".
- **Community Care Proprietary Information**—Information about the way Community Care conducts business, including but not limited to trade secrets, confidential financial information, provider contract information, business associate agreements, and utilization management (UM) and quality management (QM) methodology created and utilized by Community Care. Community Care proprietary information also includes usual and customary database information and specific charge information. Descriptions of Community Care business practices routinely included in responses to Requests for Proposals or otherwise made available to the public are not proprietary information. Director level personnel, in consultation with legal services, are responsible for determining whether other information is proprietary.
- **Patient Identifiable Claim Information**—see Claims Information, Aggregate Claim Information (ACI), and Community Care Non-Medical Proprietary Information—Per state law Community Care is prohibited from releasing any claims information or status to HealthChoices members.

Confidentiality: Compliance with State and Federal Laws

Community Care complies with all state and federal laws and regulations pertaining to the disclosure of confidential member information and to assure that such confidential information is not released without proper documentation, appropriate authorization, and in accordance with HIPAA regulations to contract holders and their associates. Community Care publishes and distributes a DHS-approved Member Handbook to all Medical Assistance members. This handbook describes confidentiality protections including explanation of access to the member's clinical records by oversight agencies and access to records for quality and utilization oversight purposes. The Member Handbook also advises members about the appropriate release of information forms needed to send information in their utilization record to other providers of health care. In addition, Notice of Privacy statements are sent to all members in accordance with HIPAA privacy regulations.

Notice to Accompany Information Released Pursuant to Written Authorization for Disclosure

Each disclosure made to a third party with the member's written authorization must be accompanied by the following written statement: This information has been disclosed to you from records whose confidentiality is protected by federal and Pennsylvania law including the Health Insurance Portability and Accountability Act of 1996. These laws and regulations prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise authorized by such laws or regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Release of HIV-Related Information

Community Care is in compliance with the Pennsylvania Confidentiality of HIV-Related Information Act concerning disclosure of member information related to HIV status and treatment and to comply with the rules and regulations of the Health Insurance Portability and Accountability Act (HIPAA). Community Care will maintain the confidentiality of the member's HIV-related information as defined in the Confidentiality of HIV-Related Information Act. Confidential HIV-related information as so defined includes the following:

- Any information which concerns whether an individual has been the subject of an HIV-related test.
- Whether an individual has HIV, an HIV-related illness, or AIDS.
- Any information which "identifies or reasonably could identify" an individual as having HIV, an HIV-related illness or AIDS.
- Community Care will not release HIV-related information, as defined above, either verbally or in writing, without first obtaining the written authorization of the member or authorized legal representative. The written release must be accompanied by a notification prohibiting further disclosure without the written authorization of the member. The member must be informed of his/her rights of confidentiality as stated in the law. The release of information form contains a specific release of information of HIV related information with the member's/authorized legal representative's signature.
  - ***Exception***: Records may be disclosed without written authorization to the persons or entities defined in the following pertinent provisions of the Confidentiality of HIV-Related Information Act, attached. (Original copy on file. This is a reproduced statement of the act)

Limitations on Disclosure—No person or employee, or agent of such person, who obtains confidential HIV-related information in the course of providing any health or social service or pursuant to a release of confidential HIV-related information under subsection (c) on page 127 may disclose or be compelled to disclose the information except to the following persons:

- The subject.
- The physician who ordered the test, or the physician's designee.
- Any person specifically designated in a written consent as provided for in subsection(c) on page 127.
- An agent, employee or medical member of a health care provider, when the health care provider has received confidential HIV-related information during the course of the subject's diagnosis or treatment by the health care provider, provided that the agent, employee, or medical member is involved in the medical care or treatment of the subject. Nothing in this paragraph shall be construed to require the segregation of confidential HIV-related information from a subject's medical record.
- A peer review organization or committee as defined in the act of July 20, 1974 (P.L. 564, No. 193), known as the Peer Review Protection Act 1, a nationally recognized accrediting agency, or as otherwise provided by law, any federal or state government agency with oversight responsibilities over health care providers.
- A person allowed access to the information by a court order issued pursuant to Section 8.
- A funeral director responsible for the acceptance and preparation of the deceased subject.
- Employees of county mental health/mental retardation agencies, county children and youth agencies, county juvenile probation departments, county or state facilities for delinquent youth, and contracted residential providers of the above-named entities receiving or contemplating residential placement of the subject, who:
  - Generally are authorized to receive medical information.
  - Are responsible for insuring that the subject receives appropriate health care.
  - Have a need to know the HIV-related information in order to ensure such care is provided.

The above named entities may release the information to a court in the course of a dispositional proceeding under 42 Pa.C.S. §§ 6351 (relating to disposition of dependent child) and 6352 (relating to disposition of delinquent child) when it is determined that such information is necessary to meet the medical needs of the subject.

Release of Information Related to Treatment of Minors

Community Care complies with all applicable laws and regulations governing the confidentiality of and authorized disclosure of utilization records related to care provided to a minor, as defined under applicable law as a person under age 18. The obligation of Community Care to maintain the confidentiality of utilization records of minor members is governed by specific federal or state laws and regulations. Generally, a minor under the age of 18 may not consent to treatment or to release of records, except one who has graduated from high school, been married or pregnant, except as provided below:

- **Drug and Alcohol Abuse and Dependency Services.** The Pennsylvania Drug and Alcohol Abuse Control Act authorizes a minor suffering from the use of a controlled or harmful substance to consent to the provision of medical care or counseling related to diagnosis or treatment. The consent of the parent or legal guardian of the minor is not necessary to authorize medical care or counseling. Any physician or any agency or organization operating a drug abuse program that provides care and counseling to a minor may, but is not obligated to, inform the parents or legal guardian as to the treatment given or needed.
- If a minor consents to treatment or counseling related to the diagnosis or treatment of drug or alcohol abuse and dependency without the involvement of a parent or guardian, the written authorization of the minor will be obtained by Community Care prior to the release of patient utilization records.
- **Mental Health Services.** The Mental Health Procedures Act authorizes any person 14 years of age or older who believes that he/she needs treatment and understands the nature of treatment to consent to examination and treatment. A parent or guardian may consent to treatment of children less than 14 years of age. Community Care will not release the utilization records of any member without the written authorization of the person providing consent to treatment.
- **Significant Member Incidents: Reporting of Child Abuse.** In accordance with applicable law governing child abuse, providers are required to report all incidents of suspected child abuse. Community Care will ensure that a ChildLine phone number is made available to providers and conspicuously listed in the Provider Manual along with the appropriate forms for reporting and documenting suspected incidents of abuse.

Release of Information Related to Treatment of Mental Health

Community Care complies with pertinent provisions of the Mental Health Procedures Act, the Mental Health and Mental Retardation Act of 1966 and regulations promulgated by the Pennsylvania Department of Human Services and set forth in the Mental Health Manual at 55 Pa. Code §§ 5100.31 et seq. defining appropriate release of information related to mental health treatment. Persons seeking or receiving services from a mental health provider may expect that information will be treated with respect and confidentiality so that trust and confidence in therapeutic intervention may develop. Mental health records subject to this policy include, but are not limited to, written clinical information, observations and reports, or fiscal documents relating to the member which are required or authorized to be prepared by the Mental Health Procedures Act or by the Mental Health and Mental Retardation Act of 1966, and any central files and reports which are required to be maintained by the Department of Human Services or other statutes or regulations regarding services for mental health programs.

Community Care will not release the records of any member, 14 years of age or older, who understands the nature of the documents to be released and the purpose of releasing them without the written authorization of the member. For the member who lacks this understanding, any person chosen by the member may exercise this right (if that person is found by the administrative head of the facility or his designee to be acting in the member's best interest). If the member is less than 14 years of age or has been adjudicated legally incompetent, control over the release of records may be exercised by a parent or guardian.

- **Exception:** Records concerning persons receiving mental health treatment services may be released without the written authorization of the member only in those specific circumstances defined in 55 Pa. Code §§ 5100.32, § 5100.35, § 5100.36 and § 5100.38, attached. (This is a reproduction of the original document, 55 § 5100.32 Mental Health Manual Pt. VII.)

Nonconsensual Release of Information

- Records concerning persons receiving or having received treatment shall be kept confidential and shall not be released nor their content disclosed without the consent of a person given under § 5100.34 (relating to consensual release to third parties), except that relevant portions or summaries may be released or copied as follows:
  - To those actively engaged in treating the individual, or to persons at other facilities, including professional treatment of State Correctional Institutions and county prisons, when the person is being referred to that facility and a summary or portion of the record is necessary to provide for continuity of proper care and treatment.
  - To third party payers, both those operated and financed in whole or in part by any governmental agency and their agents or intermediaries, or those who are identified as payer or copayer for services and who require information to verify that services were actually provided. Information to be released without consent or court order under this subsection is limited to the names, dates, types, and costs of therapies or services, and a short description of the general purpose of each treatment session or service.
  - To reviewers and inspectors, including The Joint Commission and Commonwealth licensure or certification, when necessary to obtain certification as an eligible provider of services.
  - To those participating in Professional Standards Review Organization (PSRO) or utilization reviews.
  - To the administrator, under his duties under applicable statutes and regulations.
  - To a court or mental health review officer, in the course of legal proceedings authorized by the act or this chapter.
  - In response to a court order, when production of the documents is ordered by a court under § 5100.35 (relating to release to courts).
  - To appropriate departmental personnel § 5100.38 (relating to child or patient abuse).
  - In response to an emergency medical situation when release of information is necessary to prevent serious risk of bodily harm or death. Only specific information pertinent to the relief of the emergency may be released on a nonconsensual basis.
  - To parents or guardians and others when necessary to obtain consent to medical treatment.
  - To attorneys assigned to represent the subject of a commitment hearing.
- Current patients or clients or the parents of patients under the age of 14 shall be notified of the specific conditions under which information may be released without their consent.
- Information made available under this section shall be limited to that information relevant and necessary to the purpose for which the information is sought. The information may not, without the patient's consent, be released to additional persons, or entities, or used for additional purposes. Requests for information and the action taken should be recorded in the patient's records.

Release to Courts

- Each facility director shall designate one or more persons as a records officer, who shall maintain the confidentiality of client/patient records in accordance with this chapter.
- Records shall comply with the following:
  - Whenever a client/patient's records are subpoenaed or otherwise made subject to discovery proceedings in a court proceeding, other than proceedings authorized by the act, and the patient/client has not consented or does not consent to release of the records, no records should be released in the absence of an additional order of the court.
  - The records officer, or his designee, is to inform the court either in writing or in person that, under statute and regulations, the records are confidential and cannot be released without an order of the court. Neither the records officer nor the facility director has any further duty to oppose a subpoena beyond stating to the court that the records are confidential and cannot be released without an order of the court; however, nothing in this section shall be construed as authorizing such a court order.
  - If it is known that a patient has a current attorney or record for the given proceedings, that attorney shall be informed of the request of subpoena, if not already served with a copy, and shall be expected to represent and protect the client/patient's interests in the confidentiality of the records. The person whose record has been subpoenaed shall be notified of such action if they are currently receiving services and their whereabouts are known, unless served with a copy of the subpoena. Those currently in treatment shall also be advised that they may wish to obtain an attorney to represent their interests. In the case of persons no longer receiving services, the facility shall send this notification by certified mail to the last known address.
  - If a present or former patient sues a person or organization providing services subject to the act in connection with said patient's care, custody, evaluation, or treatment, or in connection with an incident related thereto, defense counsel for said service provider shall have such access to the present or former patient's records as such counsel deems necessary in preparing a defense. Counsel receiving such records shall maintain their confidentiality and shall limit the disclosure of the contents thereof to those items they deem necessary to allow counsel to prepare and present a proper defense.
  - All employees of a facility shall be informed of the rules and regulations regarding confidentiality of records and shall also be informed that violation of them could potentially subject them to civil or criminal liability. Training for employees regarding confidentiality remains the responsibility of the facility director.

Departmental Access to Records and Data Collection

- Notwithstanding, any part of this chapter to the contrary, employees of the department shall not be denied access to any patient records where such access is necessary and appropriate for the employee's proper performance of his/her duties. The facility director shall make such decision, and shall be responsible for limiting access to those portions, which are relevant to the request.
- Any conflict as to access by an employee to patient records at State Hospitals shall be resolved by the Regional Commissioner of Mental Health.
- Collection and analysis of clinical or statistical data by the department, the administrator, or the facility for administrative or research purposes may be undertaken as long as the report or paper prepared from the data does not identify any individual patient without his consent.

Child or Patient Abuse

Nothing in this chapter shall conflict with the mandatory statutory or regulatory requirements of reporting suspected or discovered child abuse or patient abuse. Whenever a conflict exists between the reporting requirements of the Child Protective Services Act (11 P.S. §§ 22012224), and the confidentiality of mental health records, the reporting requirements shall govern.

Release of Information related to Drug and Alcohol Dependency and Treatment

Community Care complies with the Pennsylvania Drug and Alcohol Abuse Control Act and applicable State regulations at 4 Pa. Code § 255.5(b) and Interpretative Guidelines issued by the Pennsylvania Department of Health, and federal regulations at 42 C.F.R., Part 2, concerning circumstances of permissible release of records containing information on alcohol and substance abuse and dependency. All member records containing information as to drug and alcohol abuse or dependency and treatment must be kept confidential. Such records may be disclosed only with the member's authorization and only (I) to medical personnel exclusively for purposes of diagnosis and treatment of the member or (II) to government agencies exclusively for the purpose of obtaining benefits due as a result of such drug or alcohol abuse or dependency. If the client has given written authorization for such release, certain information may be released to insurance companies and health plans to include (28 Pa. Code § 709.28 Confidentiality):

- Whether the person is or is not in treatment.
- The prognosis.
- The diagnosis(es).
- General peculiarities of the case.
- The provider may present his/her recommendations regarding the client's continuation with the treatment program.
- The nature of treatment.
- The structure of the program.
- The methodology of treatment and the treatment models that are utilized by the program.
- A brief description of progress.
- The provider may speak in general terms of the member's progress or lack of progress as it relates to recovery.
- The provider may speak in general terms of the clients understanding of the disease concept and their cooperation, or lack of, regarding the rules.
- A short statement of whether the person has relapsed into drug or alcohol abuse and the frequency of such relapse.
    - **Exception:** In an emergency where the member's life is in immediate jeopardy, patient records may be released without the member's authorization to proper medical authorities solely for the purpose of providing medical treatment.
- Disclosure may be made for purposes unrelated to such treatment or benefits only upon an order of court of common pleas after application demonstrating good cause for disclosure.

Community Care Staff Having Knowledge of, or Having, a Relationship with the Member

Community Care will ensure that no conflicts of interest exist between Community Care staff in/when dealing with member treatment decisions. A Community Care staff member that has any independent knowledge of, or a relationship with, the member for whom he/she is making coverage decisions, shall disclose that knowledge or relationship to his/her supervisor. The supervisor will decide on the appropriate process for making decisions for that member.

Confidentiality and Privacy Training for Community Care Staff

Training on confidentiality and privacy regarding member information and utilization records for Community Care staff will be conducted at hire and annually thereafter, with any change in job title/duties, or when significant changes in laws or policies regarding confidentiality warrant retraining. This training will be intended to provide Community Care personnel with guidance concerning the disclosure of information related to members, providers, services furnished to members, or other confidential information. The training sessions are designed to ensure understanding and adherence to all federal and state regulations related to confidentiality and member rights.

Learning objectives of training sessions are:

- To define and demonstrate the importance of confidentiality of Protected Health Information (PHI) within the MCO setting.
- To ensure confidentiality of all sensitive organization or member information.
- To review IS security controls (user ID and Password) that protect member-identifiable information.
- To learn how to verify the identity of a person requesting PHI.
- To identify areas where confidentiality may be an issues; e.g., telephone, written materials, public discussion, staff workstations, computer files, and databases.

Methods used during training sessions include:

- Online training session and exam.
- Signed confidentiality agreement (at hire).

Resources used during training sessions include:

- Statements of Confidentiality (Attached).
- CPL 032 and CPL 033, Confidentiality policies and procedures.
- State and federal statues and regulation.
- Director of compliance.
- Privacy officer.
- Compliance Department.

Persons responsible for participating in training sessions include: **All Community Care staff members participate in the training sessions.**

Staff shall be trained:

- Upon hiring.
- Annually.
- With any change in job title (if appropriate).

Topics for training session include:

- Information storage and retrieval.
- Record retention.
- Access to records.
- Confidentiality policies pursuant to all relevant state and federal regulations in compliance with CPL 032 policy sections listed below:
  - General Confidentiality Provisions.
  - Oversight of Confidentiality.
  - Collecting and Using Member-Identifiable Information.
  - Handling of Member-Identifiable Information.
  - Informing Members about Confidentiality.
  - Ability to Give Informed Authorization.
  - Member Access to Utilization Records.
  - Disclosure of Information.
  - Disclosure of Information to Employers.
  - Handling of Practitioner-Specific Information.
  - Informing Providers About Confidentiality.
  - Practitioner Office Confidentiality.
  - Handling of Community Care's Business Information.
  - Subpoenas.
  - A member's right to amend PHI.
  - A member's right to an accounting of disclosures of PHI.
- Confidentiality policies pursuant to all relevant state and federal regulations in compliance with CPL 033 policy sections listed below:
  - Confidentiality: Terms and Disclosure Policy
  - Confidentiality: Compliance With State and Federal Laws
  - Notice to Accompany Information Released Pursuant to Written Authorization for Disclosure
  - Release of HIV-Related Information
  - Release of Information Related to Treatment of Minors
  - Release of Information Related to Treatment of Mental Health
  - Release of Information Related to Drug and Alcohol Dependency and Treatment
  - Community Care Staff Having Knowledge of or a Relationship with the Member
  - Confidentiality and Privacy Training for Community Care Staff

- The Notice of Privacy Practices for PHI include:
  - Safeguarding the Member's Information.
  - Disclosure of Information for the purposes of Treatment, Payment and Health Care Operations.
  - Disclosures of Information:
    - When required by law.
    - For public health activities.
    - Health oversight activities.
    - Lawsuits and disputes.
    - Law enforcement.
    - Coroners, medical examiners, funeral directors, and organ donation.
    - Research purposes.
    - Serious threats.
    - National security and intelligence activities.
    - Protective services for the President and others.
    - Military and veterans.
    - Workers compensation.
    - Inmates.
  - Disclosures of Information in which the member's signature is required
  - The member's Rights Regarding PHI:
    - To request restrictions on the uses and disclosures of their PHI.
    - The right to choose how Community Care will contact them.
    - The right to inspect and copy PHI.
    - The right to request an amendment of their PHI.
    - The right to an accounting of disclosure.
    - The right to obtain a copy of this notice.
  - Privacy Notice.
  - How the member receives a copy of changes made to the Privacy Notice.
  - How the member may file a complaint about our Privacy Practices.
  - How the member may have questions or concerns regarding privacy or the Notice of Privacy addressed.
  - The effective date for the Notice of Privacy.
  - Reporting inappropriate use of member information.
- Non-Retaliation Policy.

Appendix D: Priority Populations

Mental Health—Adult

In order to be in the Adult Priority Group, a person must meet the federal definition of serious mental illness[1]; must be age 18+, (or age 22+ if in Special Education); must have a diagnosis of schizophrenia, major affective disorder, psychotic disorder, or borderline personality disorder (DSM-5 or its successor documents as designated by the American Psychiatric Association, diagnostic codes F31.XX, F06.XX, F60.3, F25.XX, F20.9, F32.XX); and must meet at least one of the following criteria:

A. Treatment History, or

B. Coexisting Condition or Circumstance

Treatment History

- Current residence in or discharge from a state mental hospital within the past two years; or
- Two admissions to community or correctional inpatient psychiatric units or residential services totaling 20 or more days within the past two years; or
- Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years; or
- One or more years of continuous attendance in a community mental health or prison psychiatric service (at least one unit of service per quarter) within the past two years; or
- History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services; or
- One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician; e.g., Area Agency on Aging, within the past two years.

Coexisting Condition Or Circumstance

1. Coexisting Diagnosis:
    a. Substance Use Disorder; or
    b. Intellectual Developmental Disability; or
    c. HIV/AIDS; or
    d. Sensory, Developmental, and/or Physical Disability; or
2. Homelessness[2]; or
3. Release from Criminal Detention[3]

In addition to the above, any adult who met the standards for involuntary treatment (as defined in Chapter 5100 Regulations—Mental Health Procedures) within 12 months preceding the assessment is automatically assigned to the high priority group.

[1]Adults with serious mental illness are persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. (See Reference for additional detail)
[2]Homeless persons are those who are sleeping in shelters or in places not meant for human habitation, such as cars, parks, sidewalks or abandoned buildings.
[3]Applicable categories of release from criminal detention are jail diversion; expiration of sentence or parole; probation or Accelerated Rehabilitation Decision (ARD).

Mental Health—Child And Adolescent

The Child and Adolescent **First Priority Group** includes persons who meet all four criteria below:

1. Age: birth to less than 18 (or age 18 to less than 22 and enrolled in special education services).
2. Currently or at any time in the past year have had a DSM-5 diagnosis (excluding those whose sole diagnosis is intellectual disability, substance use disorder, or a "V" code) that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
3. Receive services from the mental health system and one or more of the following:
    a. Intellectual Disability System
    b. Children and Youth Services
    c. Special Education
    d. Drug and Alcohol System
    e. Juvenile Justice System
    f. Physical Health Care System (the child has a chronic health condition requiring treatment).
4. Identified as needing mental health services by a local interagency team (e.g., CASSP Committee, Cordero Workgroup).

In addition to the above, any child or adolescent who met the standards for involuntary treatment within the 12 months preceding the assessment (as defined in Chapter 5100—Mental Health Procedures) is automatically assigned to this priority group.

Second Priority is associated with children at risk of developing a serious emotional disturbance by virtue of:

- A parent's serious mental illness
- Physical or sexual abuse
- Drug dependency
- Homelessness
- Referral to the Student Assistance Programs

Drug and Alcohol

The priority population for drug and alcohol treatment services includes:

- Pregnant females and women with children
- Intravenous drug users
- Adolescents
- People with severe medical conditions, such as tuberculosis or HIV/AIDS
- People with mental illness and a substance use disorder

Appendix E: Behavioral Health Managed Care Organizations (BH-MCOs) Performance/Outcome Management System (POMS)

The Department of Human Services (DHS) maintains and manages a POMS database, which serves as the basis for producing performance measures/indicators. DHS uses these indicators as its primary tool for evaluating the effectiveness of BH-MCO contractors in achieving a variety of systems-level outcomes. These outcomes are outlined in Appendix K of the HealthChoices Program Standards and covers dimensions such as increasing community tenure, use of less restrictive services, increasing vocational and educational status, and reducing criminal/delinquent activity. Please see the attached table for complete information related to each of the dimensions.

Providers contracted with Community Care are required to submit POMS data quarterly for all new members receiving behavioral health services during the quarter. Providers are expected to submit updates to POMS data every 180 days for members in continuous care. Providers will submit POMS data by electronic file submission using specifications developed by Community Care.

Community Care adheres to the Data Collection and Continuous Quality Improvement (CQI) processes as outlined in Appendix K of the HealthChoices Program Standards.

Outcome Dimensions

1. Increase Community Tenure and Less Restrictive Services*
   - Increase the appropriate use of behavioral health inpatient days
   - Decrease criminal incarcerations
   - Increase the appropriate use of MH residential care
   - Decrease out-of-home placements
   - Decrease homelessness
   - Decrease placement in C&Y custody
   - Increase residential stability

   **To be reported/compiled only for priority group consumers by age group (under age 21, 21-64, and age 65+)*

2. Increase Vocational and Educational Status*
   - Increase school attendance (full time regular classroom)
   - Increase school retention
   - Increase school performance
   - Improve school behavior
   - Increase vocational status for adults

   **To be reported/compiled only for priority group consumers by age group*

3. Reduce Criminal/Delinquent Activity*
   - Reduce number of arrests
   - Reduce positive drug screens
   - Improve probation/parole status
   - Reduce status offenses (focus on truancy)

   **To be reported/compiled only for priority group consumers by age group*

4. Improve Health Care*
   - Meet or exceed DHS's EPSDT screening
   - Increase % of consumers with annual physical exams
   - Reduce hospital medical ER use

   **To be reported/compiled only for priority group consumers by age group*

5. Increase "Penetration Rates" *(i.e., percent of enrollees who received behavioral health treatment through the behavioral health contractor)*
   - Increase appropriate utilization by priority group and type of service
   - Increase appropriate utilization by age and type of service

6. Increase Consumer/Family Satisfaction*

   **To be reported/compiled only for priority group consumers by age group*

7. Implement Continuous Quality Improvement (CQI) Actions
8. Increase Range of Services and Improve Utilization Patterns
   - Improve/increase the array of treatment, support, and rehabilitative service options
   - Decrease % of priority group consumers using only inpatient and/or ER services
   - Reduce inpatient re-hospitalization rate
   - Reduce rate of perinatal addictive disorders
   - Reduce "drop-out" rate

Appendix F: Companion Guide for Northeast Counties

Guidelines for In-Plan and Supplemental Services: Mental Health
NBHCC counties do not differentiate the benefit for levels of partial hospitalization mental health; all partial services follow a standard partial benefit and reimbursement.

Guidelines for Obtaining Approval for In-Plan and Supplemental Services: Chemical Dependency
Initial non-MD evaluation is not a covered service. Designated providers only.

NBHCC clinical parameters for Partial D&A are as follows:

- Must meet PCPC; Partial D&A services must be between three and four hours per day; maximum 12 hours per week. In general, member is not expected to be receiving other treatment (as opposed to support or rehabilitation) services in any other levels of care during partial hospital stay. Length of stay should not exceed four to six weeks unless approved by Community Care.

Overview of Quality Management
Quality Management Plans and Responsibilities will be developed in concert with NBHCC.

Acute Partial Hospitalization Standards
NBHCC counties do not differentiate the benefit for levels of partial hospitalization; all partial services follow a standard partial benefit and reimbursement.

Diversion and Acute Stabilization (DAS) Performance Standards
Diversion and Acute Stabilization (DAS) is not a covered service.

Drug and Alcohol Partial Hospitalization Performance Standards
D&A Partial Performance Standards do not currently apply. NBHCC counties do not differentiate the benefit for levels of hospitalization drug and alcohol outside of clinical parameters outlined on Page 10.

School-Based Partial Hospitalization Programs Performance Standards
School-Based Partial Performance Standards were developed for Approved Private Schools or Private Academic School Settings. NBHCC has established a differential code for partial hospital services within a school setting but will not differentiate the benefit or reimbursement.

Appendix G: Companion Guide for North Central Counties

Community Treatment Team Performance Standards
Community Treatment Teams (CTT) is not a covered service.

Diversion and Acute Stabilization (DAS) Performance Standards
Diversion and Acute Stabilization (DAS) is not a covered service.