Acute and Non-Acute Levels of Care

Q. What happens if a member has both Commercial Insurance and Medicare?
A. The member’s commercial insurance will be considered the primary payer, Medicare will be the secondary payer and Community Care would be the final payer. HealthChoices is always the payer of last resort.

Q. What is a pre-cert?
A. The pre-certification process is used to assess clinical information in order to determine Medical Necessity Criteria (MNC) for admission to acute levels of care.

Q. What is the pre-cert process?
A. The pre-cert is conducted telephonically (1-888-251-2224) with a care manager for all care that is non-ambulatory. Prior to calling to complete the pre-cert, the caller must have the clinical information, have completed a facility bed search (the location where the member will go) and have an MD medically clear the member and approve the admission. A pre-cert will not occur unless all information is presented to the care manager.

Q. Can a crisis worker complete a pre-cert?
A. A crisis worker can provide the clinical information for a pre-cert. However, in order to get the authorization number, the admitting facility must call when the member arrives to confirm that a medical doctor has approved the admission for inpatient mental health.

Q. What is Medical Necessity Criteria (MNC)?
A. Medical Necessity Criteria is used to make consistent decisions to authorize care and corresponds to the level and intensity of services.

Q. What if the member does not meet medical necessity criteria for admission?
A. Community Care care managers can not deny services, but will seek a Physician Advisor who will then contact the assessor for additional information/clarification.

Q. When will I obtain the authorization number?
A. Community Care will give an authorization number to the facility once the member arrives. Community Care also sends authorization numbers to an identified person at each facility on a weekly basis.

Q. What is the length of an authorization period for pre-cert and continued stay?
A. The length of time for an authorization will be clinically determined as per Medical Necessity Criteria for both mental health and drug and alcohol services.
Q. How do I complete a continued stay review?
A. Continued stay reviews for acute levels of care will be conducted telephonically with an assigned care manager.

Q. What is the process for obtaining authorization for Partial Hospitalization and Case Management (including Intensive Case Management (ICM), Resource Coordination (RC), and Blended Case Management)?
A. The provider will complete a notification form and fax to Community Care (1-866-901-8367)

Q. What is the length of an authorization period for both Partial Hospitalization and Case Management?
A. Authorizations will be given for 6 months at a time.

Q. What if I need more units?
A. If additional units are needed at any time during the authorization period, the provider needs to call the care manager to discuss the clinical rationale before the requested units will be authorized.

Q. What happens if the Eligibility Verification System (EVS) shows the member is not eligible with Community Care or the member loses eligibility while receiving an authorized service?
A. Authorization does not guarantee payment. If this happens, the provider needs to follow its county protocol for noninsured individuals. It is important for providers to regularly check EVS for member eligibility status.

Q. What if I have a complaint?
A. Contact Community Care, who is obligated under Act 68 to investigate any and all complaints. However, there are timelines for the process and a care manager will assist members and providers throughout.

Child and Adolescent Services

Q. What is a transition of care authorization?
A. Transition of care authorizations include existing services which began prior to July 1, 2007 and extend beyond this date.

Q. When can providers send transition of care authorizations to Community Care?
A. Providers can begin sending transition information anytime after June 13, 2006.

Q. If our contract with Community Care is not yet finalized, should we wait to send the transition of care information?
A. No, do not wait. Send the information anytime after June 13, 2006.
Q. What children’s services must be pre-authorized?
A. All Behavioral Health Rehabilitation Services (BHRS) — including Therapeutic Staff Support (TSS), Mobile Therapist (MT), Behavioral Specialist Consultant (BSC) and Summer Therapeutic Activity Program (STAP); Residential Treatment Facility (RTF) services — including Therapeutic Foster Care (TFC) and Community Residential Rehabilitation (CRR); Family Based Mental Health Services (FBMHS); and Inpatient admissions, Psychological/Neuropsychological Testing (outpatient services), and admission to Partial Hospitalization.

Q. Can services begin without a pre-authorization?
A. No, do not start to deliver services without an authorization from Community Care.

Q. Are there any services within Behavioral Health Rehabilitation Services (BHRS) in which providers can obtain an authorization after the service has been delivered?
A. Yes, you can seek an authorization for a Best Practice evaluation (either initial or continued stay) as well as for the prescriber’s attendance at the interagency meeting (either initial or continued stay). The authorization request form must be submitted to Community Care within 30 days of the actual service date.

Q. We have already developed packets for services to begin or continue on July 1, 2007, using the Fee-for-Service paperwork and timelines, what should we do?
A. Community Care will accept these packets; however, it is our expectation that providers will move toward Community Care forms and timelines as soon as possible.

Q. How do I know whether to submit continued-stay packets to the state or Community Care?
A. Providers need to check the Eligibility Verification System (EVS) daily during this transition time to determine if the member is a HealthChoices member who is eligible with Community Care. If so, the packet should be sent to Community Care.

Q. Will Community Care accept services that have been previously authorized by the state?
A. Yes, Community Care will automatically accept any services that have been authorized by the state. However, providers will need to forward to Community Care all the information that was submitted to the state as well as the State Notice of Decision.
Q. Where do I locate Community Care forms?
A. The forms are located on our website at www.ccbh.com. Please select forms specific to your level of care under the “North Central HealthChoices Providers” heading.

Q. How/where do providers send transition-of-care information as well as upcoming initial and continued-stay packets?
A. Behavioral Health Rehabilitation Services (BHRS) and Residential Treatment Facility (RTF) — including Therapeutic Foster Care (TFC) and Community Residential Rehabilitation (CRR) — information must be sent by mail to:

   Carbon, Monroe, Pike RTF Care Manager
   Or
   Carbon, Monroe Pike BHRS Care Manager
   Community Care Behavioral Health
   339 Sixth Avenue, Suite 1300
   Pittsburgh, PA 15222

Family Based Mental Health Services (FBMHS) information can be faxed to the attention of:
   Elaine Weissberg @ 1-866-901-8367

Q. Must we submit one Behavioral Health Rehabilitation Services (BHRS) or Residential Treatment Facility (RTF) packet per envelope?
A. Community Care has no restrictions on the amount of packets within each envelope.

Q. What is the Community Care Review process for Behavioral Health Rehabilitation Services (BHRS), Residential Treatment Facility (RTF) and Family Based Mental Health Services (FBMHS)?
A. Packets are date stamped upon receipt. A care manager will complete an administrative review to verify that all required documents are present. A clinical review follows to assess for Medical Necessity. Community Care will make a medical necessity determination within 2 business days from receipt of the complete packet. Written notification to the member (BHRS and RTF only) and provider will follow. Providers will be verbally notified within 48 hours if additional information is needed to make a medical necessity determination with written request following. The provider will have 5 business days to submit the requested information to Community Care, who will make a medical necessity determination within 2 business days.

Q. What is the length of time for authorizations?
A. Residential Treatment Facility (RTF) — including Therapeutic Foster Care (TFC) and Community Residential Rehabilitation (CRR) services — can be requested for up to 90 days.
Behavioral Health Rehabilitation Services (BHRS) can be requested for up to 4 months (defined as 18 weeks) and up to 12 months for those members with a diagnosis in the Autism Spectrum.

Family Based Mental Health Services (FBMHS) can be requested for a one-month period of time.

Q. How do we contact Community Care?
A. Provider Line: 1-888-251-2224
   Member Service Line: 1-866-473-5862
   TTY/TDD: 1-877-877-3580
   Spanish Line: 1-866-229-3187
   Website: www.ccbh.com

Network

Q. When will I receive my provider contract?
A. The provider contract will be issued once the credentialing process is completed.

Q. If the credentialing process is not completed by July 1, 2007 or the start date of the contract, will I be able to see members?
A. Yes, but a nonparticipating provider agreement will need to be completed for each member until the credentialing and participating provider contract process is complete.

Q. Who do I call with questions regarding credentialing or contracting status?
A. Contact your provider relations representative at 1-888-251-2224.

Q. How often will I be notified of authorizations?
A. Authorization and Outpatient Registration reports are mailed weekly. For some services, you will also be notified verbally at the time the service is authorized.

Q. Can the Authorization reports be sent to more than one location for large organizations?
A. No, the authorization reports are only mailed to one location and will be sent to the administrative address identified on your credentialing application. Contact your provider relations representative if you need to change the identified contact or address where authorization and outpatient registration reports are mailed.

Q. What do I do if I have a waiting list and can not see a member within the required access standards?
A. Contact the provider line (1-888-251-2224) to notify us and we can assist with locating a provider that can see the member within access standards.
Q. How do I register to complete Outpatient Registrations on the web site?
A. Please contact your provider relations representative or go to the Community Care website (www.ccbh.com) and print out the necessary forms.

Q. How much time will I have to enter Outpatient Registrations after January 1, 2007 for consumers already in treatment?
A. 90 days, although we suggest working on registering members as soon as possible to allow time for any problem resolution. We will work with providers to ensure a smooth transition for consumers already active in treatment as well as consumers that begin treatment after July 1, 2007.

Q. What happens when the member is in treatment with another provider?
A. Community Care will not reject the second registration, but it will be important for providers to address this from a clinical perspective (i.e., does it make clinical sense for members to be seeking services for the same type of care from more than one provider).

Q. What is a Serious Emotional Disturbance (SED) plan?
A. Children and adolescents with Serious Emotional Disturbance (SED) include those who meet all three criteria below:
   1. Age: Birth to less than 18 (or up to age 22 and enrolled in special education services).
   2. Currently or at any time in the past year have had a DSM-IV diagnosis (excluding those whose sole diagnosis is mental retardation or a “V” code) resulting in functional impairment that substantially interferes with or limits the child’s role or functioning in the family, school or community activities.
   3. Receive services from mental health and one or more of the following:
      a. Mental Retardation
      b. Children and Youth
      c. Special Education
      d. Drug and Alcohol
      e. Juvenile Justice
      f. Physical Health Plan (the child or adolescent has a chronic health condition requiring treatment)
      g. Identified as needing mental health services by a local interagency team, e.g., CASSP Committee, Cordero Workgroup.

Q. What happens if I forgot to check Eligibility Verification System (EVS)?
A. You will not get paid if the member is ineligible with Community Care on the date of service. Providers must check eligibility frequently to ensure that claims can be processed. The registration of a member will remain active even if the member loses eligibility for part of the year and then regains it later. Providers will not need to register members again if eligibility is re-established.
Q. How will I know which other providers are within the network?
A. Call the Customer Service Line to inquire. Provider directories will be available once the network is finalized.

**Quality Management**

Q. What is a Significant Member Incident?
A. A Significant Member Incident (SMI) or sentinel event is an unexpected and undesirable outcome that has an adverse impact on the outcome of care.

Q. What are the reporting timelines?
A. Serious incidents that put our members at significant immediate risk are to be reported by close of business day. All other incidents are to be reported to Community Care within 2 business days.

Q. What form do I use to report?
A. A provider may use its own reporting form, and if the provider does not have one, Community Care can provide one.

Q. Does this replace having to report incidents to my county?
A. No, Community Care’s Significant Member Incident (SMI) reporting process does not take the place of the reporting process a provider has established with its county.

Q. Where can I find more information on this topic of Significant Member Incidents (SMI)?
A. The SMI reporting process can be found in the Provider Manual which is available on Community Care’s website: [www.ccbh.com](http://www.ccbh.com)

Q. Will you come to my office and perform chart audits/record reviews?
A. Community Care performs chart audits/record reviews annually on various levels of care. If your level of care is selected, you will be notified by Community Care and a mutually agreed upon time will be arranged for this process. You will be given feedback on the review and at times, be asked for a “corrective action plan” if your rate is below an acceptable threshold.

Q. How quickly do I have to give an appointment for consumers requesting services?
A. Community Care follows the access standards promulgated by the Department of Public Welfare (DPW). For life threatening needs, care must be delivered immediately; for non-life threatening within 1 hour; for urgent needs within 24 hours; and for routine care within 7 calendar days. Community Care measures provider adherence to these standards.
Q. Do I have to cooperate with Consumer/Family Satisfaction Teams (C/FST)?
A. Yes, you have to cooperate with providing space and making consumers available to the teams when they ask. C/FST results are an important way to get feedback from consumers on their care. When you become a provider in the Community Care network, your contract obligations include this.

Q. How do I know how I am doing as a Community Care provider?
A. You are given feedback on your care delivery in a variety of ways. For example, you will be given feedback (including benchmarking) through the following processes: member complaints, significant member incidents, denials, record reviews, and utilization factors such as average length of stay, authorization and discharge functions. We believe that excelling in HealthChoices requires a collaboration between you and Community Care and we look forward to working with you in such a team approach.

Q. What activities are being measured in the Quality Department?
A. There are a variety of activities being monitored and measured within the department. We follow the continuous quality improvement (CQI) process and always look for areas to improve and then follow through with measurement and review until the process has been completed. You will get detailed information about our various activities via the provider manual and newsletters, as well as by visiting our website at www.ccbh.com. We also invite providers to be participants on our Quality and Care Management Committee to directly work on processes in tandem with consumers, the counties, Office of Mental Health and Substance Abuse Services (OMHSAS), and Community Care. If you would like to participate in these meetings and are committed to attending routinely (meetings occur at least quarterly), please contact Stephanie Fudurich at 412-454-2618.