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# Annual Updates

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<td>Renamed &quot;Confidentiality &amp; Disclosure Policies&quot; to &quot;Confidentiality&quot; and added content.</td>
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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 D and Appendix E). 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
# HealthChoices Contact Information

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

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TTY/TDD for People Who Are Deaf/Hard-of-Hearing (Dial 711): Request 1.833.545.9191
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 in Pennsylvania as an HMO 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](#).

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**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 various stakeholders including members, county/regional partners, and network providers. It 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.
Fraud, Waste, and Abuse Program Integrity Compliance

Community Care, in collaboration with our contract administrators, maintains a Fraud, Waste, and Abuse (FWA) compliance (Program Integrity) program in accordance with requirements, recommendations, standards, and guidance set forth by various regulatory and law enforcement agencies. These agencies include the Bureau of Program Integrity (BPI), Office of Mental Health and Substance Abuse Services (OMHSAS) of the Department of Human Services (DHS), and the Attorney General’s Medicaid Fraud Control Section (MFCS). The goal of the program is to detect, deter, and prevent FWA in Medicaid-funded Health-Choices behavioral health care.

The following definitions of FWA are consistent with the DHS Program Standards and Requirements Behavioral Health 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.

- **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.

**Preventing Fraud, Waste, and Abuse**

Community Care encourages providers to read this provider manual and review and comply with the Community Care FWA policies and procedures, provider alerts, performance standards, the provider agreement and all applicable laws and regulations. Call your local FWA clinical auditor or Community Care’s toll-free FWA hotline (1.866.445.5190) with questions about standards of care, policy, documentation and record keeping, or claims/billing procedures related to FWA concerns. Individual and agency providers are required to develop, maintain, and periodically produce a compliance plan that includes annual FWA training for him/herself and all staff within an agency. In addition, Community Care offers provider training on FWA and other topics.
Reporting Suspected Fraud and Abuse

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.DPW.TIPS (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

Suspected fraud and abuse may also be reported on the DHS website: http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/maprovidercompliancehotlineresponseform/index.htm. Information reported via the website or email can also be done anonymously. The website contains additional information on reporting fraud and abuse. Providers may also report FWA to Community Care or seek consultation regarding suspected FWA via email (CCBH_Fraud_Abuse@ccbh.com) or telephone (1.866.445.5190).

Fraud, Waste, and Abuse Auditing

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, waste 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 when billing exceptions are noted 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, oversight entities and may be sent to the BPI and MFCS.

In addition, the DHS’ Medcheck list, OIG’s LEIE list, US Department of Treasury (OFAC) Specially Designated Nationals (SDN) list, System for Award Management (SAM) and Death Master File (DMF) are used to verify that no providers or entities 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 home and 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 substance use disorder) 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, members can speak with a customer service representative at any time of the day or night. Customer service representatives serve as the point of contact for members. When members utilize a service other than routine outpatient behavioral health services, a care manager is assigned.

Providers are asked to encourage 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; they 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, billing and financial, cultural competence, and office site quality.
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, federal, 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 approved services are medically necessary and appropriate.

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:

- Denies 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.
- Denies 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 Community Care’s website or 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 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, 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 Certification (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 contracted 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. 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 Certification, 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

Provider agrees to access, use, and disclose Protected Health Information (PHI) and confidential information of Community Care members in compliance with all federal and state laws. Provider shall have policies and procedures in place to safeguard PHI and confidential information in accordance with all state and federal laws, including, but not limited to, the Health Information Portability and Accountability Act of 1996, as amended (HIPAA). Provider agrees to take reasonable efforts to limit the access, use, or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the access, use, or disclosure. Providers shall also treat as confidential any Community Care written policies and procedures, information regarding fees, provider agreements, and any other information designated as proprietary or that, by its nature, should be understood to be confidential or proprietary.

Provider agrees to report to Community Care any breach of unsecured PHI as quickly as possible, but in any event, within 2 business days from the discovery of the breach. This report shall include the name of each Community Care member affected and all required elements of the notification to be sent to the Community Care member.
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 \textit{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 adherence to each of the clinical practice guidelines via claims data or record reviews. Providers are notified of the results of these measurements via the BQIC and after completion of record reviews. The clinical practice guidelines are published annually in provider newsletters as well as posted on Community Care’s website under the provider and member sections. Currently, the following guidelines are being utilized:

- 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, 800 Maine Ave., SW, Suite 900, Washington, DC 20024 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.
- Date provider learned of the incident.
- Member name and identification number.
- Provider name and contact number.
- Details of the SMI, including other entities notified, such as ChildLine, APS, etc.

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 Competence

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 competence 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 competence may also include having information about providers’ experience/expertise in working with specific cultural groups, such as LGBTQI members or members of a particular faith.

Cultural competence 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; this may be assessed through quality record reviews.

The Quality Management Department reviews all complaints received related to cultural competence 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 Community Care, providers, and stakeholders to:

- Comprehensively monitor provider performance.
- Identify trends in provider performance.
- Promote internal processes within a quality improvement framework.
- Review current practices with other providers.
- Review service activity compared to aggregate claims reports of like providers.
- Improve the safety of the clinical environment.
- Ensure financial stability within the organization while increasing the quality of care provided.
- Establish policies that support performance standards and resolve quality of care issues.
- Promote best practices.
- Implement and monitor 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.

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 using the Member Eligibility lookup tool available in the ePortal. Please note that member eligibility reflected in the ePortal does not guarantee payment. Regardless of any authorization received, if the member being provided with 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 most current and accurate eligibility information is available through the EVS system. 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, 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 or when available via ePortal upon a member's admission to any of the following levels of care:

- Inpatient Mental Health
- Acute Partial Mental Health
- Medically Monitored Inpatient Withdrawal Management (3.7WM)
- Medically Managed Inpatient Withdrawal Management (4WM)
- Medically Managed Intensive Inpatient Services (4)
- Clinically Managed Population Specific High Intensity Residential Services (3.3)
- Clinically Managed High Intensity Residential Services (3.5)
- Medically Monitored Intensive Inpatient Services (3.7)

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
- CCBHC
- 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 B](#) for Priority Populations and [Appendix C](#) 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
- Community Rehabilitative Residence (CRR) Host Home
- 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
- Certified Recovery Specialists
- Peer Support Specialists
- Case Management
- Clinically Managed High Intensity Residential Services (3.5)
- Medically Monitored Intensive Inpatient Services (3.7)
- Clinically Managed Low Intensity Residential Services (3.1)

**Chemical Dependency Services**
- Acute Partial Hospitalization Program
- Intensive Outpatient (IOP) Services
- Partial (sleepover) Hospitalization Program
- Medically Monitored Inpatient Withdrawal Management (3.7WM)
- Medically Managed Inpatient Withdrawal Management (4WM)
- Medically Managed Intensive Inpatient Services (4)
- Clinically Managed Population Specific High Intensity Residential Services (3.3)
- Clinically Managed Populations Specific High Intensity Residential Services (3.3)
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 or when available via ePortal, 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
- Community Rehabilitative Residence (CRR) Host Home–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:

- Emergent behavioral health conditions:
  - Life-threatening
  - Non-life-threatening
- 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 way 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 should review the claim for status via Provider OnLine and then contact The Provider Reimbursement Department if they feel there is an inappropriate outcome to the claim. 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 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 contracted 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 several 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 a member’s eligibility. It should not 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 having trouble 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 of receiving 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 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—Revenue Codes only) or the CMS-1500 (Outpatient Services—Procedure Codes only). 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—Revenue Codes only) and 837P (Outpatient Services—Procedure Codes only). 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. Community Care will not accept copies of claims.

Claims Filing

Claims are to be submitted as a priority. If the provider is having difficulties obtaining an authorization, the provider should submit their 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 when there is a “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.

All claim submissions must be an original red and white background (front and back) claim form. Copies and color copies are NOT acceptable claim forms.

- **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)
- **Somerset/Bedford**—60 days, 180 days to complete claim process
- **York/Adams**—90 days, 180 days to complete claim process.
Coordination of Benefits (COB) Timely File

All claims must be received within in the timely file guidelines by the contract above. In the event a primary insurance carrier creates a situation where it is not possible to meet the county specific timely file guideline, there is a second window of opportunity.

- 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 outside the county contract timely file guidelines from the outpatient 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

All providers must follow the timely file requirements that are outlined under the timely filing guidelines by contract. Providers should only request an exception to the timely file guidelines as an exception and must include documentation to explain the extenuating circumstances. **All timely filing appeals must include a corrective action plan on how to prevent the issue from happening again.**

The following items must be included with the timely file appeal request:

- 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.
- Include a CAP with each timely file appeal.
- CAP must be drafted on your organization’s letterhead.
- Include an explanation as to how your organization intends on preventing the issue(s) from re-occurring.
- Include the date your organization expects to implement the CAP.
- Include the expected reimbursement amount of the timely file appeal, the total number of claim lines per county and the date span of the dates of service.
- Providers are afforded one appeal opportunity.
- The reason(s) for the timely file appeal must be specific.
  - Staffing issues is not an appropriate reason to submit a timely file appeal.

The following items must be included with the timely file appeal request:

- All providers are afforded an appeal opportunity.
- All providers must complete an appeal within 45 days from the date on the Community Care remittance advice.
- All providers must forward a letter on company letterhead outlining the details related to the reason(s) a timely file appeal is being requested and corrective action plan (CAP).
- Claims **must** be included with the original form number and must be on file and denied for timely file **prior** to submitting a request for a timely file appeal.
- A copy of the original billed claim (CMS-1500 or UB-04) with any necessary EOBs.
- 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 either at the top of each claim form or block 22 on the CMS-1500 02-12 or in block 64 on the UB-04.
- The authorization must be in place.
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

Non-Participating (Non-Par) Providers
Providers that have an out of network agreement are non-par providers. It is important that non-par providers understand the billing processes for Community Care. Non-par providers need to review the following:

- Signed contract(s) with the appropriate procedure(s)/modifier(s) or revenue code(s).
- Authorization is on file.
- Member eligibility for each date of service.
- National Standard Format Paper Claims/Outpatient CMS-1500 or Inpatient UB-04.
- Electronic 837 Professional (outpatient) or Institutional (inpatient) format.
- Submit claims within 365 days from the outpatient date of service or inpatient discharge date.
- It is recommended that inpatient continued stay claims are billed as interim claims.
- Any claim submissions received over 365 days from the date of service/discharge date will be denied for timely file, and not reimbursed.

Non-par providers can request access to Provider OnLine to view claims status only. If you are a non-par provider, and have further questions regarding claim submissions, please contact the Provider Reimbursement Department at 1.888.251.2224.

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 red background 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—HCFA screens
- Paper Claims—CMS-1500 (02-12)
- Procedure code and/or modifier(s) required
Providers should mail **original** paper claims **without staples, paper clips, or stickers** 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.

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

Community Care is certainly willing to work with any other clearinghouse that may express interest in doing so. Providers are to direct questions regarding a clearinghouse to the Provider Reimbursement Department at 1.888.251.2224.

**EDI (Claims Clearinghouse) Requirements**

The EDI process for submitting claims to Community Care requires the same information for claim submissions that other insurance carriers require 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/ALDA Identification Number  
- Payer’s name “Community Care BHO”  
- Member demographics  
- Provider demographics  
- Claim detail
Secondary Electronic Claim Submission—837 Professional Claims Only

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.

Below are Community Care's secondary EDI requirements for 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.
- Other Insurance Carrier (OIC) Paid Date
- Deductible
- Coins
- Copay
- ANSI code

**OIC adjustment reason** codes for reference

Community Care Provider OnLine Web-Based Application

Provider OnLine was created to provide timely and secure access to status claims. The application is available for providers 24 hours a day, 7 days a week for convenience. Provider OnLine access was also developed to:

- Provide an alternative to the use of a claims clearinghouse in the submission of an 837 file electronically.
- Provide a vehicle for providers to hand key claims directly into the system via an online batch system.
- Submit corrected claims.
- View status of any claim submitted to Community Care can be queried via Provider OnLine regardless of the way it was submitted.
- Submit electronic files and hand keyed claims can be submitted any time of day.
- Access to Explanations of Payment (EOP).
- Review eligibility.

It is important to note the following information related to all claim submissions when calling Provider Reimbursement with questions. Claims that do not have a check date issued are still in process.

- Claim status can only be given on finalized claims.
- COB claims cannot be submitted via Provider OnLine.

***Do not call the Provider Line unless a check number and check date is populated.***
When using Provider OnLine for claim submissions, and you are submitting claims on Friday before midnight, you will be able to view the claims Monday. Claims processing occurs Monday through Friday. **Staff are not available on the weekends for assistance.**

Provider OnLine requires two Account Administrators when submitting the Provider OnLine Account Administrator Application. The Account Administrators can enroll by following these steps:

- Go to [www.ccbh.com](http://www.ccbh.com)
- Click on "For Providers"
- Click on "Secure Sites"
- Click on "Community Care Provider OnLine Claims"
- Click the link to sign up or click [here](http://www.ccbh.com).

The role of the Account Administrator is to:

- Add Standard User functionality.
- Edit Standard User permissions.
- Manage role-based claims functionality.

Once the Account Administrator receives confirmation of approval for access to the website, the permissions will need updated under the Security Management tab after logging into the site. The Account Administrator can add/delete additional staff as Standard Users. The Account Administrator determines the permissions for each of these users.

The website menu for some users include tabs to review the following:

- User Guide
- Eligibility
- Claim Inquiry
- Authorization Inquiry
- Explanation of Payment
- Batch Upload for 837 Files
- Enter claims directly via Prelog
- Create Claim Batches
- Download Files
- Review Documents
- Security Management

All questions related to Provider OnLine, including locked accounts, must be directed to Provider Reimbursement by calling 1.888.251.2224, prompt 1, Monday through Friday from 8:00 a.m. to 12:00 p.m. and 1:00 p.m. to 4:30 p.m.
Below is a listing of Community Care upfront rejections for EDI claim submissions, at the claim level:

<table>
<thead>
<tr>
<th>Error Number</th>
<th>Error Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLM0126</td>
<td>Diagnosis code not on file.</td>
</tr>
<tr>
<td>CLM0265</td>
<td>Diagnosis not valid for Date of Service.</td>
</tr>
<tr>
<td>CLM0314</td>
<td>Non Valid Diagnosis, or missing a required Diagnosis Code</td>
</tr>
<tr>
<td>CLM0444</td>
<td>Invalid Diagnosis Code Qualifier</td>
</tr>
<tr>
<td>CLM0445</td>
<td>Invalid Surgical Proc Code Qualifier</td>
</tr>
<tr>
<td>MCN0001</td>
<td>Missing or Invalid Billing NPI</td>
</tr>
<tr>
<td>MCN0002</td>
<td>Diagnosis Required</td>
</tr>
<tr>
<td>MCN0003</td>
<td>Max 99 Service lines exceeded</td>
</tr>
<tr>
<td>MCN0004</td>
<td>Missing Diagnosis pointer</td>
</tr>
<tr>
<td>MCN0005</td>
<td>Invalid Quantity - Prof Claim</td>
</tr>
<tr>
<td>MCN0006</td>
<td>Invalid Quantity - Inst Claim</td>
</tr>
<tr>
<td>MCN0007</td>
<td>Missing Procedure Code</td>
</tr>
<tr>
<td>MCN0008</td>
<td>Missing Subscriber Last Name</td>
</tr>
<tr>
<td>MCN0009</td>
<td>Invalid Charge Amount</td>
</tr>
<tr>
<td>MCN0010</td>
<td>Missing Subscriber ID #</td>
</tr>
<tr>
<td>MCN0011</td>
<td>Place of Service Missing</td>
</tr>
<tr>
<td>MCN0013</td>
<td>Missing or Invalid Billing Tax ID</td>
</tr>
</tbody>
</table>
General Claims Submission Rules/Requirements

All claim forms must contain:

- Member ID number (10-digit MA recipient ID or 7-digit ALDA ID).
- Tax ID number.
- NPI number.
- ICD–10 Behavioral Health Diagnosis Range; Chapter V Mental Health and Behavioral Disorders F01.5–F98 and “O” Pregnancy series with accompanying F01.5-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 (09.14.2015): Appropriate Use of Diagnosis Code F99](#).
- Procedure Code(s) which appear on your Community Care Fee Schedule.
- Revenue Code(s) which appears on your Community Care Fee Schedule.
- “Billing Units” as defined on your Community Care Fee Schedule.
- The From and Through Dates (field #6 on UB-04) must equal to the total number of units billed for the room and board revenue codes.
- Data must be within the lines of the applicable paper claim form box.
- Font should be Arial and the size should be between 10 and 12. The only acceptable paper claim forms are the UB-04 for institutional claims (inpatient claims—revenue codes only) and the CMS-1500 for professional claims (outpatient claims—procedure codes only).
- 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.
- ORP Requirements for EDI and Paper Claim Submissions effective January, 1, 2018 can be found in [Provider Alert #1 (01.01.2018): Claims Requirements CMS-1500 & 837P Fields/UB-04 & 8371: Ordering, Referring, or Prescribing Physician](#).

Paper Claim Submissions

- Paper claims must be completed as outlined in this manual or the claims cannot be scanned into the claims processing system.
- Paper claims must be submitted on the standard red and white forms only. 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.
- Copies of paper claim forms will not be accepted.
Certified Community Behavioral Health Clinics (CCBHC) Billing Rules

This section only applies to the following providers when billing with this demonstration due to the specific billing requirements.

- Berks Counseling Center
- Cen Clear Child Services–Clearfield
- Cen Clear Child Services–Punxsutawney
- Pittsburgh Mercy Behavioral Health
- The Guidance Center
- Resources for Human Development

The CCBHC Demonstration is to be billed with the demonstration code and/or modifiers and the additional service lines that are under the core services. Review the following information when billing for the CCBHC Demonstration:

- All claims must be submitted via an 837 Professional format only
- Only one date of service is allowed on each claim
- The specified demonstration code and all other service line details must be submitted on one claim
- Valid NTE Segments for all CCBHC Service Lines:
  - NTE segments can occur as Claim or Line Notes
  - A corresponding NE is required for every zero billed CCBHC Service Line
  - NTE segments are not required or used by DHS for non-zero CCBHC Service Lines
  - Loop 2400 requires a corresponding NTE segment (zero paid only)
- Expanded NTE02 Layout for CCBHC Claims:
  - NTE*ADD*aabbccdde|ff|g|hhhhhhhhhhhh|ii|jj|kk|ll|mm~
  - aa = Category of Aid
  - bb = Category of Service
  - ccc = Billing Provider Specialty
  - d = Unused and should be 1 space
  - e = Out-of-Network Indicator
  - ff = ESPDT code
  - Every NTE01 must be set to “ADD”
  - Every NTE02 must represent the expanded CCBHC NTE format (zero paid only & see below)
  - EBP codes are limited to 5 for each service line
  - The Service Location identified by the Rendering Provider ID must be enrolled to provide the service indicated in the 2400 Loop
  - g = “C” for CCBHC service lines
  - hhhhhhhhhhhh = 13-digit MPI+Service Location of the Rendering Provider
  - ii = First EBP code (if applicable)
  - jj = Second EBP code (if applicable)
  - kk = Third EBP code (if applicable)
  - ll = Fourth EBP code (if applicable)
  - mm = Fifth EBP code (if applicable)
<table>
<thead>
<tr>
<th>Field Name</th>
<th>Length</th>
<th>Description</th>
<th>Usage</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category of Aid</td>
<td>2</td>
<td>Numeric. Leading zero if needed.</td>
<td>Required</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Category of Assistance</td>
<td>2</td>
<td>Numeric. Leading zero if needed.</td>
<td>Required</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Rendering Provider Specialty</td>
<td>3</td>
<td>Numeric. Leading zeros if needed.</td>
<td>Required</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>UNUSED</td>
<td>1</td>
<td>SPACE</td>
<td>Required</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Out-of-Network Indicator</td>
<td>1</td>
<td>Y or N</td>
<td>Required</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Vertical bar</td>
<td>Required</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Vertical bar</td>
<td>Required</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Service Line Type Indicator</td>
<td>1</td>
<td>Alphanumeric</td>
<td>Required</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Vertical bar</td>
<td>Required</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Rendering Provider ID + Service Location</td>
<td>13</td>
<td>Concatenated MPI and Service Location for the Rendering Provider (either CCBHC or DCO)</td>
<td>Required</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Vertical bar</td>
<td>Optional</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>EBP Code 1</td>
<td>2</td>
<td>Two-digit code, including leading zero.</td>
<td>Optional</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Vertical bar</td>
<td>Optional</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>EBP Code 2</td>
<td>2</td>
<td>Two-digit code, including leading zero.</td>
<td>Optional</td>
<td>33</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Vertical bar</td>
<td>Optional</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>EBP Code 3</td>
<td>2</td>
<td>Two-digit code, including leading zero.</td>
<td>Optional</td>
<td>36</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Vertical bar</td>
<td>Optional</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>EBP Code 4</td>
<td>2</td>
<td>Two-digit code, including leading zero.</td>
<td>Optional</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Vertical bar</td>
<td>Optional</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>EBP Code 5</td>
<td>2</td>
<td>Two-digit code, including leading zero.</td>
<td>Optional</td>
<td>42</td>
<td>43</td>
</tr>
</tbody>
</table>

COB information is expected at the service line detail with the applicable information:
- Related ANSI codes
- Contractual Adjustment/Obligation
- Deductible

Providers are expected to register a CCBHC authorization through the ePortal for the CCBHC demonstration and end date the authorization as needed.

CCBHC COB demonstration claims will be processed and paid according to the T1040 demonstration PPS rate, minus the primary carrier paid amount(s), and up to the CCBHC PPS rate.
Ordering, Referring and Prescribing Provider (ORP) Claim Information


Required Claim Fields

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

CMS-1500 (02-12)

Listed below are instructions for completing the specific fields on the CMS-1500 (02-12) for Community Care.

<table>
<thead>
<tr>
<th>Block #</th>
<th>Field Name</th>
<th>Required / Not Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Payer Identifier</td>
<td>Not required</td>
</tr>
<tr>
<td>1 a</td>
<td>Member Number = 10-digit Medicaid recipient ID / 7 Digit ALDA ID</td>
<td>Required</td>
</tr>
<tr>
<td>2</td>
<td>Member Name (last name, first name, middle initial)</td>
<td>Required</td>
</tr>
<tr>
<td>3</td>
<td>Member’s Date of Birth (mm/dd/yy)</td>
<td>Required</td>
</tr>
<tr>
<td>4</td>
<td>Sex</td>
<td>Not required</td>
</tr>
<tr>
<td>5</td>
<td>Insured’s Name (last name, first name, middle initial)</td>
<td>Required for COB</td>
</tr>
<tr>
<td>5</td>
<td>Member’s Address</td>
<td>Required</td>
</tr>
<tr>
<td>6</td>
<td>Member’s Relationship to Insured (Always check box for self)</td>
<td>Required</td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
<td>Required for COB</td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not required</td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name (last name, first name, middle initial)</td>
<td>Required for COB</td>
</tr>
<tr>
<td>9 a</td>
<td>Other Insured’s Policy or Group</td>
<td>Required for COB</td>
</tr>
<tr>
<td>9 b</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not required</td>
</tr>
<tr>
<td>9 c</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not required</td>
</tr>
<tr>
<td>9 d</td>
<td>Insurance Plan Name or Program Name</td>
<td>Required for COB</td>
</tr>
<tr>
<td>10 a-c</td>
<td>Member’s condition related to employment, auto accident, and other accident</td>
<td>Not required</td>
</tr>
<tr>
<td>10 d</td>
<td>CLAIM CODES (Designated by NUCC)</td>
<td>Not required</td>
</tr>
<tr>
<td>11</td>
<td>Insured policy, group, or FECA number (if applicable)</td>
<td>Not required</td>
</tr>
<tr>
<td>11 a</td>
<td>Insured’s date of birth and sex</td>
<td>Not required</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>Required/Not Required</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>11 b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>Not required</td>
</tr>
<tr>
<td>11 c</td>
<td>Insurance plan name or program name (if applicable)</td>
<td>Not required</td>
</tr>
<tr>
<td>11 d</td>
<td>Is there another health benefit plan? (Check block Yes or No) (If Yes, complete items 9, 9a, and 9d)</td>
<td>Required</td>
</tr>
<tr>
<td>12</td>
<td>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)</td>
<td>Required</td>
</tr>
<tr>
<td>13</td>
<td>Insured or authorized person’s signature</td>
<td>Not required</td>
</tr>
<tr>
<td>14</td>
<td>Date of current illness, injury, or pregnancy (LMP)</td>
<td>Not required</td>
</tr>
<tr>
<td>15</td>
<td>Other date</td>
<td>Not required</td>
</tr>
<tr>
<td>16</td>
<td>Date client unable to work in current occupation</td>
<td>Not required</td>
</tr>
<tr>
<td>17</td>
<td>Name of referring physician or other source (if applicable), and applicable qualifier</td>
<td>Required for ORP</td>
</tr>
<tr>
<td>17 a</td>
<td>Name of referring physician or other source</td>
<td>Required for ORP</td>
</tr>
<tr>
<td>17 b</td>
<td>NPI</td>
<td>Required for ORP</td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization dates related to current services—FROM</td>
<td>Required</td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization dates related to current services—TO</td>
<td>Required</td>
</tr>
<tr>
<td>19</td>
<td>Additional Claim Information</td>
<td>Not required</td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab</td>
<td>Not required</td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab Charges</td>
<td>Not required</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis Code (ICD-10 BH Diagnosis Code Range ‘F Series’)</td>
<td>Required (ICD-10)</td>
</tr>
<tr>
<td>21</td>
<td>ICD Indicator (use the indicator for ICD-10)</td>
<td>Required (ICD-10)</td>
</tr>
<tr>
<td>22</td>
<td>Resubmission Code/Original Referral Number (required when submitting a corrected claim)</td>
<td>Required</td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization Number</td>
<td>Not required</td>
</tr>
<tr>
<td>24 a</td>
<td>Date of Service–FROM</td>
<td>Required</td>
</tr>
<tr>
<td>24 a</td>
<td>Date of Service–TO</td>
<td>Required</td>
</tr>
<tr>
<td>24 b</td>
<td>Place of Service (see Community Care’s fee schedule)</td>
<td>Required</td>
</tr>
<tr>
<td>24 c</td>
<td>EMG</td>
<td>Not required</td>
</tr>
<tr>
<td>24 d</td>
<td>Procedure Code (Enter the applicable procedure codes &amp; modifiers from Community Care’s Fee Schedule.)</td>
<td>Required</td>
</tr>
<tr>
<td>24 e</td>
<td>Diagnosis Code Pointer (Enter the diagnosis reference letter as shown in block 21 to correlate the diagnosis code to the procedure or service performed.)</td>
<td>Required</td>
</tr>
<tr>
<td>24 f</td>
<td>Total charges being billed for the line</td>
<td>Required</td>
</tr>
<tr>
<td>24 g</td>
<td>Total days/units billed for the line (Two digit maximum per line, 99; No decimal point)</td>
<td>Required</td>
</tr>
<tr>
<td>24 h</td>
<td>EPSDT Family Plan (if applicable)</td>
<td>Not required</td>
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<tr>
<td>24 j</td>
<td>Rendering Prov NPI#</td>
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<tr>
<td>25</td>
<td>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.)</td>
<td>Required (A, B, C, D, E, R, G, H, I, J, K, L)</td>
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<tr>
<td>26</td>
<td>Provider’s Patient Account Number</td>
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<td>Accept Assignment</td>
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<td>28</td>
<td>Total charges (Enter the total sum of 24F lines 1-6 in dollars and cents. No decimal point)</td>
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<tr>
<td>29</td>
<td>Amount paid by other insurance, if applicable (Enter total sum of 24K lines 1-6 in dollars and cents.)</td>
<td>Required for COB</td>
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<td>30</td>
<td>RESERVED FOR NUCC USE</td>
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<tr>
<td>31</td>
<td>Name of physician, clinician, or facility named on the authorization for the service and the date</td>
<td>Required</td>
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<tr>
<td>32</td>
<td>Name and address of facility where services were rendered</td>
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<tr>
<td>33</td>
<td>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.)</td>
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<tr>
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<td>NPI #</td>
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<tr>
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UB-04

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

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<th>Block #</th>
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<td>Admission hour</td>
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<td>Admission type</td>
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<td>Discharge status</td>
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<td>Member's unique ID (10-digit Medicaid recipient ID for primary HealthChoices claims)</td>
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<td>Doc control number (Required when submitting a corrected claim)</td>
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<td>Principal diagnosis code (ICD-10 BH Diagnosis Range Chapter V, F Series)</td>
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Third Party Liability (TPL)–Coordination of Benefits (COB)

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 Reimbursement Department at 1.888.251.2224, prompt 1, Monday through Friday from 8:00 a.m. to noon and 1:00 to 4:30 p.m. prior to submitting a claim to confirm a member’s other insurance coverage. Community Care will provide the 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 paid/denied date, and the denial legend/key code.
- Copies of the primary carrier(s) EOP/EOB must be one-sided, not front and back copies due to the scanning process.
  - 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 to an in-network provider or seek an out-of-network agreement with the primary carrier.
  - If the primary denied for medical necessity, the provider must follow and exhaust all appeal procedures of the primary carrier.
  - If an inpatient appeal denial is upheld, the provider must request an clinical medical necessity authorization.
  - Community Care will pay the patient liability/patient responsibility (co-insurance/deductible) or up to the Community Care fee schedule amount.

COB Tips and FAQs:

- When a member presents or schedules an appointment, the provider must request they provide “all” other insurance information.
- Obtain other primary insurance information from the member for every applicable policy including:
  - Carrier name
  - Policy number
  - Insured’s name
  - Group number
  - Telephone number
- The provider must contact the insurance carrier(s) to verify benefits.
  - Confirm policy effective date
  - Confirm benefits (mental health and/or substance use)
  - Confirm if mental health and/or substance use benefits are carved out to a different carrier
  - Confirm billing information
Providers must follow all the guidelines for all the primary carrier(s) including:

- Verify the provider, group, and/or facility is contracted with the all primary, secondary, tertiary insurance carrier(s).
- Obtain necessary authorizations

Payment received from primary carrier will include the EOB which should include the legend, paid/denied date, and indicate a patient liability.

Providers are required to bill all third-party carriers for behavioral health services (primary, secondary, and/or tertiary) prior to submitting a claim. When submitting a COB claim, review the following:

- Applicable authorization must be obtained.
- Include legible copies of the primary insurance EOB with the legend.
- Community Care will pay the patient liability/patient responsibility (co-insurance/deductible) or up to the Community Care fee schedule amount.
- COB clean claims received outside of the initial county specific timely file guidelines must be received within 30 days from the date printed on the primary EOB in order to receive consideration of payment.
- Community Care will not reimburse services if the primary, secondary, and/or tertiary insurance guidelines were not followed (e.g., no authorization and/or out-of-network denial).

Providers are required to exhaust all appeal levels with all primary carrier if the primary EOB indicates the service is denied due to medical necessity.

COB claims received outside of the county specific timely file guidelines or received more than 30 days from the date on the EOB will deny timely. If an appeal is granted by the carrier, submit the claim to Community Care with the following information:

- Include legible copies of the primary insurance EOB with the legend.
- Copy of final appeal decision
- Claim form: CMS-1500 or UB-04
- 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, not failure to follow the primary carrier’s guidelines.

Community Care will only accept/process Original Claim Forms and supporting documentation which accompanies an original claim form (red and white—no copies). No documentation will be accepted without an original claim form.
Submitting Claim Corrections

Community Care can accept claim corrections via three methods:

- **EDI (preferred method)**
- **Provider OnLine (no COB claims)**
- **Paper Claim Corrections**

**EDI – Claim Corrections**

Community Care strongly encourages providers that submit claims via the 837 Institutional (revenue codes only) and 837 Professional (procedure codes only) format, submit corrected claims via the 837 format, including all relevant COB information. Electronic claim corrections expedite the processing and ensures the accuracy of completing the claim correction process. Please be sure to contact your EDI software vendor/clearinghouse to start submitting EDI claim corrections.

**Provider OnLine–Claim Corrections**

Community Care strongly urges providers to complete claim corrections via Provider OnLine to expedite the processing and ensure accuracy of the corrected claims process. Instruction for how to submit a corrected claim that does not have COB, see the User Guide located in Provider OnLine under the Documents selection.

If you need access to Provider OnLine, the Online Account Administrator can enroll here or go to www.ccbh.com, click on “For Providers,” then click on “Secure Sites.” If you are a Standard User, please discuss your security options with your Online Account Administrator.

Do not submit secondary claims via Provider OnLine.

**Paper Claim CMS-1500–Claim Corrections**

The 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 and completed Block 22 with Resubmission Code 7 along with the Form Number located on the Community Care Explanation of Payment.

**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.
Provider OnLine for Claim Status

Provider OnLine must be used for all claim status.

An Account Administrator is necessary for all provider offices. There must be two Account Administrators. The Account Administrators set up the accounts and access for Standard Users. If you are the Account Administrator and need to enroll, please click [here](#), or go to [www.ccbh.com](http://www.ccbh.com), click "For Providers" then click on "Secure Sites." If you are a Standard User, see your Account Administrators.

Claims are finalized when a check date is posted with the payment or denial.

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

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 claim denials can be obtained by calling the Community Care Provider Reimbursement Department at 1.888.251.2224, prompt 1, Monday through Friday from 8:00 a.m. to noon and 1:00 to 4:30 p.m. Community Care strongly recommends:

1. All claim corrections can be submitted electronically (837I, 837P), Prelog, or paper.
2. Community Care will accept a UB-04 with the appropriate bill type, or CMS-1500 Original Claim Form with corrected written on the claim. Copies of claim forms are not acceptable, only original red and white background claim forms must be submitted.
3. The form/claim number must be written in block 64 of the UB-04 and block 22 of the CMS-1500 form.
4. Corrected claims must mirror the original claim submission (e.g. two claim lines were billed, one claim line paid and one claim line denied). Both claim lines must be included on the corrected claim.
5. A date of service not previously considered cannot be added on a corrected claim.
6. Only one form/claim number is to be on a corrected claim.
7. The provider must indicate which components of the original claim form they are correcting by drawing a line through or circling the error or highlighting the correction.
8. Make sure the correction is clearly identified.
9. **Community care cannot process a claim correction without receiving an original red and white background (front and back) claim form. Claim copies are not acceptable. Do not submit any accounts receivable listing, Community Care Remittance Advice, Community Care Provider OnLine screen prints, or any spreadsheets.**
10. 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 of the claim form or the provider can submit the claim with separate lines on the same claim form indicating the place(s) of service.
11. 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) and a place of service 99.

12. 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.

13. 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.

14. To correct any error in billing, the provider must submit a “corrected claim” to update the original claim.

15. To reverse a denied claim, a “corrected claim” must be submitted with the additional information to update the original claim.

16. A request to void a claim should only occur if the service was never rendered to the member. The provider must submit a claim void electronically.

17. Once a claim is voided, the provider has no ability to complete another transaction on that claim.

18. 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. When writing “CORRECTED CLAIM” it should not be done in red ink within the body of the claim. Red ink interferes with the scanning process, black ink does not.

19. 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.

20. All claim corrections are subject to the timely filing guidelines specific to each county. Refer to Timely Filing Guidelines by Contract for initial claim submissions and Coordination of Benefits (COB) Timely File for COB claim submissions.

21. Community Care strongly recommends all claim corrections be completed electronically.

22. Corrections and/or voids cannot be completed until the original claim has finalized with a check number and a check date.

**Refund Requests**

A provider must complete all claim corrections electronically. Prior to mailing a refund check a provider is required to do the following:

1. Contact Provider Reimbursement at 1.888.251.2224, prompt 1, to speak with your Project Coordinator and

2. If determined a refund check is required, corrected claims with the form numbers must be included with the refund check.
### Community Care Billing Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adjudicate</strong></td>
<td>When a claim is processed and the result is ‘posted/paid,’ the claim has adjudicated.</td>
</tr>
<tr>
<td><strong>ALDA Member Identification</strong></td>
<td>Allegheny County Drug and Alcohol Services (ALDA) has a unique 7-digit member identification. The ALDA ID is to be used only for contracted providers and services found on their fee schedules.</td>
</tr>
<tr>
<td><strong>Alternative Payment Arrangements (APA)</strong></td>
<td>An APA is a universal payment for services that may be bundled, incentives, or other alternative payment arrangements.</td>
</tr>
<tr>
<td><strong>Alternative Payment Method (APM)</strong></td>
<td>Payments that include quality and total cost of care/services into reimbursement instead of a traditional fee-for-service payment.</td>
</tr>
<tr>
<td><strong>Ancillary Code</strong></td>
<td>Codes for services that are diagnostic, or therapeutic. These services would be laboratory tests, radiology, genetic testing, and/or diagnostic imaging.</td>
</tr>
<tr>
<td><strong>ANSI Codes</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Authorization Rules</strong></td>
<td>The definition and parameters of the service as listed on the Community Care Fee Schedule.</td>
</tr>
<tr>
<td><strong>Case Rate</strong></td>
<td>Reimbursement structure that is a flat rate to provider for every patient visit, regardless of the service provided.</td>
</tr>
<tr>
<td><strong>Chapter V ‘F’ Series</strong></td>
<td>Classification of mental and behavioral health disorders in the International Classification of Diseases 10th Revision.</td>
</tr>
<tr>
<td><strong>Clean Claim</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>CLIA</strong></td>
<td>Clinical Laboratory Improvement Amendments</td>
</tr>
<tr>
<td><strong>CMS-1500</strong></td>
<td>Also known as the Health Insurance Claim Form is the uniform claim form to submit outpatient/ancillary charges.</td>
</tr>
<tr>
<td><strong>Co-insurance</strong></td>
<td>The amount of an insurance payment the insured is responsible for, also known as health care cost sharing.</td>
</tr>
<tr>
<td><strong>Community Care Health-Choices Member</strong></td>
<td>Person receiving Medical Assistance through a county serviced by Community Care for behavioral health services.</td>
</tr>
<tr>
<td><strong>Community Care Member Number</strong></td>
<td>The Member’s 10-digit Recipient Number issued by Medical Assistance.</td>
</tr>
<tr>
<td><strong>Community Care Procedure Code</strong></td>
<td>The code assigned to a service and defined on the Community Care Service Code Fee Schedule.</td>
</tr>
<tr>
<td><strong>Community Care Modifier</strong></td>
<td>Two character code attached to procedure code to identify a different service, allow a unique rate, or facilitate reporting.</td>
</tr>
<tr>
<td><strong>Community Care Provider</strong></td>
<td>A contracted private practitioner, agency, facility, or hospital that provides care to a Community Care member.</td>
</tr>
<tr>
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<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Consecutive Billing Days</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>Coordination of Benefits (COB)</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>Contractual Obligation (CO)</strong></td>
<td>Amount for which the provider is financially liable.</td>
</tr>
<tr>
<td><strong>Date of Service (DOS)</strong></td>
<td>The date the service was rendered.</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>A specified amount of money that the insured must pay before an insurance company will pay a claim.</td>
</tr>
<tr>
<td><strong>EDI</strong></td>
<td>Electronic Data Interchange; the computer software system used to encode and transmit claims data electronically.</td>
</tr>
<tr>
<td><strong>EFT</strong></td>
<td>Electronic Fund Transfer</td>
</tr>
<tr>
<td><strong>EOP</strong></td>
<td>Explanation of Payment</td>
</tr>
<tr>
<td><strong>ERA</strong></td>
<td>Electronic Remittance Advice</td>
</tr>
<tr>
<td><strong>EVS</strong></td>
<td>Eligibility Verification System; used by providers to verify members' HealthChoices or Medicaid eligibility.</td>
</tr>
<tr>
<td><strong>Federal Tax ID Number</strong></td>
<td>The number used to identify your agency on your Federal Income Tax returns.</td>
</tr>
<tr>
<td><strong>Form Number/Claim Number</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>ICD-10</strong></td>
<td>The International Classification of Diseases 10th Revision. Effective 10/1/2015.</td>
</tr>
<tr>
<td><strong>Member Eligibility</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>MA Provider ID Number</strong></td>
<td>The 13-digit number assigned by the Commonwealth.</td>
</tr>
<tr>
<td><strong>MPI</strong></td>
<td>Master Provider Index Number</td>
</tr>
<tr>
<td><strong>NPI Number</strong></td>
<td>National Provider Identification Number (mandatory as of May 23, 2008).</td>
</tr>
<tr>
<td><strong>Non-Par</strong></td>
<td>Non-Participating provider or not a contracted provider for Community Care</td>
</tr>
<tr>
<td><strong>OIC</strong></td>
<td>Other insurance carrier.</td>
</tr>
<tr>
<td><strong>OPR</strong></td>
<td>Outpatient Registration; Community Care’s method for notification by providers of members receiving “outpatient” services.</td>
</tr>
<tr>
<td><strong>PAR</strong></td>
<td>Participating or contracted provider with Community Care</td>
</tr>
<tr>
<td><strong>Patient Responsibility</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Provider OnLine (POL)</strong></td>
<td>Community Care’s web-based application for submitting primary claims directly and for checking the status of claims.</td>
</tr>
<tr>
<td><strong>Procedure Code</strong></td>
<td>Current Procedural Terminology or a CPT. This is a medical code set that is used to report medical, surgical, and diagnostic procedures and/or services which are billed to insurance companies by physicians, or other licensed and/or other accreditation organizations.</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td><strong>Revenue Code</strong></td>
<td>Universal numbers of a 3 or 4 Digit Numbers that identify services rendered in a hospital. The revenue codes and description of the services are identified for inpatient services or services provided by an accredited hospital.</td>
</tr>
<tr>
<td><strong>Third Party Administrator (TPA)</strong></td>
<td>An organization that processes insurance claims for certain aspects of an employee benefit plan for a separate entity.</td>
</tr>
<tr>
<td><strong>Third Party Liability (TPL)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>UB-04</strong></td>
<td>Also known as the CMS-1450, the uniform claim form for submitting inpatient services/charges.</td>
</tr>
<tr>
<td><strong>Unclean Claim</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Unit of Service</strong></td>
<td>The “billing unit” defined on the Community Care Fee Schedule. Note: Your “charge collection units” may need to be converted to “billing units.”</td>
</tr>
<tr>
<td><strong>Usual Charge</strong></td>
<td>The amount charged by your agency, to all payers, for the service being rendered.</td>
</tr>
<tr>
<td><strong>Vendor</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>835 File</strong></td>
<td>Electronic remittance file</td>
</tr>
<tr>
<td><strong>837 File</strong></td>
<td>Electronic claims file.</td>
</tr>
</tbody>
</table>
## Community Care Glossary

(Billing-related terms can be found [here](#).)

<table>
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<th>Term</th>
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<tr>
<td>Abuse</td>
<td>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.</td>
</tr>
<tr>
<td>ASAM</td>
<td>American Society for Addiction Medicine.</td>
</tr>
<tr>
<td>Authorization</td>
<td>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).</td>
</tr>
<tr>
<td>BH-MCO</td>
<td>Behavioral Health Managed Care Organization, e.g., Community Care Behavioral Health Organization.</td>
</tr>
<tr>
<td>BHRSCA</td>
<td>Behavioral Health Rehabilitation Services for Children and Adolescents (formerly referred to as EPSDT or “wraparound”).</td>
</tr>
<tr>
<td>BPI</td>
<td>Bureau of Program Integrity (Commonwealth of Pennsylvania).</td>
</tr>
<tr>
<td>CASSP</td>
<td>Child and Adolescent Service System Programs.</td>
</tr>
<tr>
<td>CMS</td>
<td>Center for Medicare and Medicaid Services (previously HCFA/Health Care Financing Administration).</td>
</tr>
<tr>
<td>Community Care HealthChoices Member</td>
<td>A person receiving Medical Assistance through a county serviced by Community Care for behavioral health services.</td>
</tr>
<tr>
<td>Community Care Provider</td>
<td>A contracted private practitioner, agency, facility, or hospital that provides care to a Community Care member.</td>
</tr>
<tr>
<td>Complaint</td>
<td>An oral or written expression of dissatisfaction from a member or provider that initiates a formal investigation process.</td>
</tr>
<tr>
<td>Coordination of Benefits (COB)</td>
<td>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).</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services; the state agency that administers HealthChoices and other Medicaid programs.</td>
</tr>
<tr>
<td>DOH</td>
<td>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.</td>
</tr>
<tr>
<td>Emergency</td>
<td>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.</td>
</tr>
<tr>
<td>EOB</td>
<td>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).</td>
</tr>
<tr>
<td>EVS</td>
<td>Eligibility Verification System; used by providers to verify members’ HealthChoices or Medicaid eligibility.</td>
</tr>
<tr>
<td>Grievance</td>
<td>A request to have Community Care or a Certified Review Entity (CRE) reconsider a decision concerning the medical necessity and appropriateness of a health care service.</td>
</tr>
<tr>
<td><strong>MCO</strong></td>
<td>Managed Care Organization (see BH-MCO and PH-MCO).</td>
</tr>
<tr>
<td><strong>Member Eligibility</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>NCQA</strong></td>
<td>National Committee for Quality Assurance.</td>
</tr>
<tr>
<td><strong>OMHSAS</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>OPR</strong></td>
<td>Outpatient Registration; Community Care’s method for notification by providers of members receiving ‘outpatient’ services.</td>
</tr>
<tr>
<td><strong>PCP</strong></td>
<td>Primary Care Physician.</td>
</tr>
<tr>
<td><strong>PH-MCO</strong></td>
<td>Physical Health Managed Care Organization.</td>
</tr>
<tr>
<td><strong>PROMISe</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Provider OnLine</strong></td>
<td>Community Care’s web-based application for submitting primary claims directly and for checking the status of claims.</td>
</tr>
<tr>
<td><strong>Routine</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>RTF</strong></td>
<td>Residential Treatment Facility</td>
</tr>
<tr>
<td><strong>Supplemental Services</strong></td>
<td>These services may be paid for by Community Care but are not HealthChoices in-plan services.</td>
</tr>
<tr>
<td><strong>Urgent</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
Appendix A: Guidelines for Obtaining Approval for In-Plan & Supplemental Services

Coming Soon
Appendix B: Priority Populations

Mental Health—Adult
In order to be in the Adult Priority Group, a person must meet the federal definition of serious mental illness1; 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. Homelessness2; or
3. Release from Criminal Detention3

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.

---

1Adults 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)
2Homeless persons are those who are sleeping in shelters or in places not meant for human habitation, such as cars, parks, sidewalks or abandoned buildings.
3Applicable 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 C: 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 D: 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 ASAM; 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 is 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.
Appendix E: 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.