

Provider Guidelines

PBH – Provider Relationships

PBH believes that a strong alliance with our providers is the key to a successful managed care organization. Through ongoing evaluation and regular communication with our providers, we have been able to build effective relationships.

It is PBH's goal to continually evaluate the quality of the provider network through Quality Improvement initiatives, satisfaction surveys and regular interaction with providers. Providers are invited to give comments and suggestions regarding PBH's systems and communication mechanisms used for evaluation and provider interaction.

PBH seeks to establish long-term mutually respectful collegial relationships with providers and expects this standard to be reciprocated by our providers and their staff. Through mutually respectful interaction, PBH will provide feedback to network providers and give providers the opportunity to give feedback on PBH's systems and service. This approach has proven very successful in creating a network of knowledgeable, cooperative professionals who work in tandem with PBH to implement our clinical approach.

Our employees have made a commitment to clinical operational excellence on a company wide basis. This commitment to excellence encompasses not only how we deliver services to our clients but how we develop and strengthen our provider network.

In order to deliver consistent service to our mutual customers, it is important to apply consistent procedures. PBH expects network providers to adhere to the policies and procedures as outlined in this manual. To underscore this expectation, PBH has made this provider manual an attachment to its provider contracts.

Keys To A Successful Relationship With PBH

- ◆ *View relationship as collegial*
 - ◆ *Be willing to give and receive feedback*
 - ◆ *Build relationships with PBH staff with whom you have regular contact*
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Provider Standards of Practice

PBH realizes that its providers are the key to delivering service to members. In order to achieve consistent, high-quality treatment, PBH has developed provider standards of practice and provider evaluation criteria.

The following practices are required of all PBH providers:

- ◆ Submit all required PBH forms within specified time frames
- ◆ Inform the PBH Care Manager of any significant changes in the patient's condition
- ◆ Comply with the care management process
- ◆ Cooperate with PBH's Quality Improvement activities
- ◆ Demonstrate professional competence and adherence to community practice standards
- ◆ Begin discharge planning at time of admission for all levels of care
- ◆ Utilize community support groups and other community resources
- ◆ Provide 24-hour emergency availability to patients and PBH staff
- ◆ Provide availability within four hours of an emergency
- ◆ Utilize family involvement in treatment of children and adolescents
- ◆ Utilize Informed Consent forms when prescribing psychotropic medications
- ◆ Demonstrate adherence to time-limited therapy

- ◆ Coordinate care with other providers, including the Primary Care Physician (PCP)
- ◆ Complete the *Health Care Coordination Form* for all patients seen.
- ◆ Offer appointments for routine referrals within five working days and ensure the member is seen within 10 working days of the referral.

PBH Network Provider Responsibilities

Sentinel Event Reporting

PacifiCare Behavioral Health (PBH) maintains programs that reduce and prevent risk and assure the safety of the member through ongoing processes of risk identification, risk analysis, action implementation and action evaluation. Sentinel events are defined as an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Serious injury includes loss of limb or function. “Risk thereof” includes process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The sentinel event review process provides a mechanism to:

- ◆ identify unusual or untoward occurrences that could result in risk/liability; and,
- ◆ investigate whether standards of care were met.

Sentinel events are reviewed by Regional PBH Clinical Staff and are investigated by Regional Quality Improvement (QI) staff. Appropriate action/interventions are taken in consultation with the Regional Medical Director or his/her physician designee. These events need to be reported to PBH.

- ◆ **Death/Completed Suicide:** Any death that occurs during treatment provided under authorization from PBH, or within twelve (12) months of the individual receiving care authorized by PBH. For cases that appear to be medical in nature, review with a Regional Medical Director to ascertain potential relevancy of coexisting behavioral health issues (such as type of authorized care or lack of authorization/care).
- ◆ **Homicide:** Any act of a member currently in treatment authorized by PBH or of a member for whom treatment was authorized by PBH within the twelve (12) months prior to the incident, who kills another individual.

- ◆ **Suicide Attempt Requiring Medical Intervention:** An act of self-harm, which may result in a life-threatening situation. Consideration is given to lethality of suicide attempt, intent of member, and potential pattern of behavior. Suicide attempts should only be reported, however, if the member is currently in treatment authorized by PBH or within twelve (12) months of the individual receiving care authorized by PBH. It is not necessary to complete a report if the member has neither been previously assessed by PBH nor authorized for treatment by PBH.
- ◆ **Other:** An occurrence other than those defined by death, completed suicide, homicide or suicide attempt requiring medical attention, that is a process variation for which its occurrence or recurrence would carry a significant chance of a serious adverse outcome for the member.

Confidentiality and Release of Information

PacifiCare Behavioral Health has written policies and procedures that protect the confidentiality of member health information and that conform to federal and state confidentiality regulations and applicable standards of the National Committee for Quality Assurance (NCQA).

PBH's contracting practitioners are required by their provider contracts with PBH to maintain the confidentiality of all patient health information and other personal information about members. Contracting practitioners must implement procedures and safeguards to ensure that the confidentiality of all member records and information is maintained. Only the practitioners involved in the member's care and treatment, claims processing staff, UM and care management staff, QI staff and other authorized persons who must have access to confidential patient information in order to perform their functions for the contracting practitioner shall have access to such information.

Contracting practitioners should not disclose confidential patient information to any person or entity except upon the written authorization of the member to whom the information relates or as otherwise permitted or required by applicable state law. Legal exceptions to this are when a patient's mental condition becomes an issue in a lawsuit, when a patient presents as a physical danger to self or others or when child or elder abuse/neglect is suspected. Also see *Obligation to Report/Duty to Warn* below.

PBH providers should not release patient information pertaining to a member who is a minor or an incompetent adult to any person or entity without a valid authorization for the disclosure, unless disclosure without authorization is specifically permitted by law. PBH will apply state law to determine what constitutes a valid authorization to disclose patient medical information pertaining to minors and incompetent adults.

Whenever a PBH provider begins treating a PBH member, the provider must have the member or, if appropriate, the next-of-kin or legal guardian sign a consent form authorizing the release of treatment record information to PBH. Providers are responsible for ensuring they have all necessary member consents. If the member refuses to sign the consent form, this should be documented in the member's clinical record. Providers are required to comply with patient requests for their own medical record.

Alternative Provider Coverage

A PBH provider must contact PBH to discuss alternative provider coverage arrangements in any situation when s/he is unable to maintain a PBH member in active treatment. Prior notification to PBH is required regardless of the reasons for utilizing an alternative provider (e.g. coverage while on vacation). The alternative provider must be a PBH network provider and must receive prior authorization for all services rendered.

Compliance with State and Federal Laws

PBH expects its providers to comply with all provisions of the Americans With Disabilities Act (ADA), the Age Discrimination Act of 1975, Title VI of the Civil Rights Act of 1964 and all other laws applicable to recipients of Federal Funds as they are applicable to the provision of care for PBH members.

Obligation to Report/Duty to Warn

PBH providers must comply with all applicable state and federal child abuse and other reporting laws. It is the provider's responsibility to understand and comply with the professional and legal requirements in his/her state.

The duty to warn may override the usual right to confidentiality of which an individual is assured when speaking to a clinician. This applies to any PBH provider who receives information during assessment or treatment. In any life-threatening situation, relevant clinical data or history may be released.

If a PBH provider believes that a patient represents a threat to others, the provider must attempt to warn the potential victim(s) in a timely manner. It is preferable to contact the police, but the provider should warn the intended victim by telephone if that is the best way to ensure the potential victim's safety. PBH should also be made aware of any such situation.

Accessibility

PacifiCare Behavioral Health is concerned that members receive timely access to treatment. To this end, we have established performance standards regarding appointment times for routine, urgent and emergent referrals. For routine referrals, it is our expectation that practitioners will **offer** an appointment within 5 business days of referral and **ensure that the member will be seen** within 10 business days of referral. For urgent referrals, it is our expectation that practitioners will **see** a member within 24 hours of their referral. For emergent referrals, be it life threatening or non-life threatening, it is our expectation that practitioners will see the member immediately. PBH has implemented a process whereby we ask members for their permission to provide practitioners with a phone number to contact them for scheduling an appointment. While we still encourage members to contact the practitioner, we expect that if the practitioners have not heard from a member, they will use this number to call the member to schedule an appointment.

Communication of Treatment Options

Providers can freely communicate with patients regarding the treatment options available to them, including alternative medications, regardless of the benefit coverage limitations.

Member Communications

Providers must send any proposed member correspondence other than individual patient communication regarding test results, preventive health screens, or appointment reminders to PBH prior to distribution. Providers should be aware that in certain circumstances PBH will also need to obtain approval from the members' health plan(s) and/or HCFA prior to approving communications to be sent to members.

Information Updates

To ensure accurate and timely changes to our provider records, PBH must receive prompt written notification within thirty (30) days of any additions, deletions or changes (including the effective dates) related to any of the following:

- ◆ Changes in practice locations or mailing address, phone numbers or tax ID numbers

- ◆ Changes in services or levels of care offered
- ◆ Changes in appointment availability or ability to accept new referrals
- ◆ State licensure or certification renewal
- ◆ Facility accreditation status with JCAHO, CARF, COA, AOA or other national accrediting organizations
- ◆ PBH should be notified immediately of any accusation or allegation against you filed with a state licensing board or other regulatory agency and any actions taken including probation, reprimand, suspension, or revocation of your license
- ◆ Federal DEA certification for Physicians or DOs, RNs (if applicable)
- ◆ Registered nurse certification for prescriptive authority, if applicable
- ◆ ANA “clinical specialist” certification (advanced registered nurse practitioners)
- ◆ DEA license for Clinical Nurse Specialist (CNS) with prescriptive authority
- ◆ Individual malpractice liability insurance, with limits, dates of coverage and provider’s name

Remember

- ◆ *Notify PBH of changes in phone numbers, office location, licensure status and insurance*
 - ◆ *Notify PBH of vacation schedules or inability to accept new patients*
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Credentialing/Recredentialing for Independent Practitioners

PacifiCare Behavioral Health has developed and maintains a practitioner/provider network as an integral part of the delivery system for PBH members. Only independently licensed/certified practitioners who are professionally competent and continuously meet the credentials, qualifications, standards and requirements

established by PBH will be approved to provide behavioral health care services to PBH members.

Credentialing is the formal process through which PBH collects, verifies and evaluates the professional credentials and qualifications of licensed individual practitioners against the criteria, standards and requirements established by PBH for providing health care services to PBH members. PBH has written policies and procedures for credentialing and recredentialing behavioral health care practitioners, contracted group providers, and organizational providers who render treatment to PBH members across all levels of care.

In order for a practitioner to become fully credentialed they must submit a credentialing application to PBH with the required information and documents. PBH endeavors to complete credentialing of practitioners within five (5) months after the date PBH receives the practitioner's complete application. The time period for credentialing will not exceed 180 days. PBH will request all information necessary for proper evaluation of the practitioner's professional competence, character and other qualifications. PBH collects required Primary Source Verification from issuing sources or designated monitoring entities and needed explanations to any discrepancies identified. PBH's credentialing staff will maintain a complete and accurate credentials file for each applicant. PBH has an established Credentialing Committee which reviews and considers the professional credentials and qualifications of each practitioner who applies to PBH.

Practitioners credentialed by PBH are recredentialed at least every two (2) years. At that time the Credentialing Staff furnishes a recredentialing application to the practitioner. The practitioner must fill out, sign and return the complete recredentialing application to PBH within 30 days. By completing a recredentialing application, the provider signifies his or her continuing agreement to abide by all of PBH's policies and procedures.

Required Elements

PBH has set forth certain minimum criteria that must be met for a practitioner to become credentialed. Without this a practitioner will not be considered for credentialing or recredentialing. The minimum criteria are as follows:

- 1) Applicant's practice location meets PBH standards for individual practice sites:
 - ◆ Office is located in a business/professional/commercial zone.
 - ◆ Includes waiting room.
 - ◆ Adequate soundproofing.

- ◆ Accessible to the physically handicapped.
 - ◆ Medical records are maintained so as to guarantee patient confidentiality, and in a manner that meets PBH's treatment record standards.
 - ◆ Medications securely stored (double-locked).
 - ◆ Site visits will be conducted for all offices of potential high-volume behavioral health care practitioners prior to their acceptance to the PBH network. High volume practitioners will have subsequent site visits upon relocation or addition of a new office or if a deficiency or concern is identified through the Quality Improvement process. A high-volume practitioner is defined as any contracted group or any individual practitioner who is among, or is expected to be among the top five (5) percent of providers to whom PBH refers. These site visits will involve an audit of the physical practice location as well as the practitioner's record keeping practices (see Documentation Requirements).
- 2) Applicant is available for emergencies, by pager, or has established emergency coverage procedures.
 - 3) Applicant demonstrates experience in crisis intervention and brief, solution or goal focused therapy.
 - 4) Applicant practices a minimum of 20 hours per week.
 - 5) Applicant is licensed to practice independently in all states for which contract shall apply, and has been licensed in practicing specialty for at least two (2) full years; license is in good standing and free from restriction and/or without probationary status.
 - 6) Applicant has professional liability coverage at \$1,000,000/3,000,000 (or other level as required by law).
 - 7) Applicant (clinicians with prescriptive authority) submits a copy of a current and non-restricted DEA or CDS Certificate.
 - 8) Applicant graduated from an accredited professional school, and/or highest training program applicable to the academic degree, discipline, and licensure of the practitioner.
 - 9) If the applicant is a physician addictionologist they must be certified by ASAM or possess Added Qualifications in Addiction Psychiatry through ABPN.
 - 10) If the applicant is a physician they must have admitting privileges in at least one facility or they must provide a description of an adequate

- process for providing emergency care for patient's requiring inpatient treatment.
- 11) Resume or curriculum vitae must include at least 5 years work history (any gaps must be adequately explained).
 - 12) Application, as submitted, is complete with all required documentation, attestations and signatures. Attestations include:
 - ◆ The reason for any inability to perform the essential functions of the position with or without accommodation.
 - ◆ Lack of present illegal drug use.
 - ◆ History of loss of license and/or felony conviction.
 - ◆ History of loss or limitation of privileges or disciplinary activity.
 - ◆ An attestation as to the correctness and completeness of the application.

Preferred Elements

The following preferred elements are considered wherever the number of applicants exceeds PBH's need in a given geographic area:

- 1) Applicant works in a group setting, or shares an office with other practitioners.
- 2) Applicant has current experience with the delivery of managed care and EAP services as evidenced by membership on at least one managed care or EAP panel.
- 3) Physician applicants are board certified in a specialty relevant to the practice of psychiatry (as verified through ABMS or ASAM).
- 4) Physician applicants have admitting privileges at other than their primary admitting facility.
- 5) Applicant has oral and written competency in one or more languages that address the needs of the local PBH membership.
- 6) Applicant represents or has experience with different racial/cultural heritages.
- 7) Applicant has documented training/experience in specialty areas and/or specific patient populations (i.e. children/adolescents, chronically mentally ill, geriatrics, addictions).

In addition to the required elements listed above, a number of other elements are also reviewed at the time an application for recredentialing is submitted. Information such as quality of care complaints and member complaints are reviewed along with other data to determine whether a practitioner should be recredentialed and retained on the PBH panel. PBH also receives information from various monitoring organizations which include the State Board of Licensure or Certification, The National Practitioner Data Bank, State Board of Medical Examiners, Federation of State Medical Boards, and regional Medicare and Medicaid offices.

An on site assessment of high volume practitioners is conducted via practice and treatment record audits and the results are considered in the recredentialing review.

Provider Termination Process

PacifiCare Behavioral Health has established policies and procedures, as part of the Quality Improvement Program and in accordance with applicable legal requirements and accreditation standards, by which to deny credentialing/recredentialing, and/or limit, suspend or terminate a contracted practitioner from providing services to PacifiCare Behavioral Health members. Such actions are based upon reasons including, but not limited to, the following: (1) practitioner's or provider's failure to meet the minimum credentialing/recredentialing standards and qualifications established by PacifiCare Behavioral Health's Quality Improvement Committee or its subcommittees; (2) failure to provide care in a manner consistent with community standards and/or quality of clinical care and service standards established by PacifiCare Behavioral Health's Quality Improvement Committee or its subcommittees; or (3) violation of any of the terms of the provider agreement. All PBH practitioners and providers are subject to PacifiCare Behavioral Health's policies and procedures as specified in the provider agreement.

PacifiCare Behavioral Health's policies and procedures include, but are not limited to, procedures under which the Medical Director, and/or the Peer Review Committee, have the authority and discretion to immediately restrict, suspend or terminate a provider's ability to provide behavioral health services to PBH's members or take any action deemed necessary to protect the interests of members, including, but not limited to, ceasing all referrals to the provider. Such actions are based upon a determination of deficiencies in the practitioner's or provider's quality of care, professional competence or conduct and/or that the practitioner has failed to meet PacifiCare Behavioral Health's Quality Improvement or credentialing standards and/or has failed to provide treatment in a manner consistent with accepted community standards.

PacifiCare Behavioral Health’s termination process, and any appeals process that may be available to the practitioner or provider, are fully described in PacifiCare Behavioral Health’s policies and procedures.

Key Points

- ◆ Providers and practitioners must meet PBH minimum criteria to become credentialed.
- ◆ PBH will endeavor to complete the credentialing process within 5 months, and will not exceed 180 days from receipt of a completed application.
- ◆ Applications for credentialing and recredentialing must be filled out completely and accurately, with all requested attachments.
- ◆ Applications must be signed and returned to PBH within 30 days of signature.
- ◆ PBH has established policies and procedures for the denial of credentialing/recredentialing, and limiting, suspending or termination of practitioners and providers.

Documentation Requirements

PacifiCare Behavioral Health has established the following goals for submission of clinical information by individual practitioners:

- ◆ To give providers simplified forms to submit data
- ◆ To provide a minimum data set which will allow PBH to monitor the quality of services provided within the PBH system, while reducing the effort devoted to managing individual cases
- ◆ To give PBH the data necessary for routine provider profiling and to provide feedback to PBH providers on their performance.
- ◆ To ensure that behavioral health care and primary health care services are coordinated

The requirements outlined below are mandatory for all PBH providers. A provider's compliance with these documentation requirements will be routinely considered as one variable in profiling and recredentialing.

Requirements for Submission to PBH

Individual providers are required to submit the following basic forms to PBH (see Index of Forms for samples):

Provider Assessment Report (PAR): The revised PAR has been reduced in length from two pages to one and has a new feature that facilitates elimination of the PBH Provider Discharge Summary.

- 1) The PAR should continue to be used to request authorization for additional services.
- 2) In addition, the PAR should be used as a discharge summary for brief treatment episodes that are completed with the number of visits initially authorized. The new PAR has a field, “Treatment Terminated.” When this is checked and “00” additional sessions are requested, the PAR becomes a Discharge Summary. The PBH Utilization Management Committee determined that sufficient clinical data is already collected with longer episodes of care during the telephonic review process. Therefore, upon completing longer episodes of care, there is no need to submit any form.

The expectation is that PBH will receive one PAR for every episode of care. Prescribing practitioners who provide ongoing medication management (beyond the number of visits authorized by PAR review) have the choice to request authorization for additional sessions each year by submitting a PAR or by calling PBH for a brief telephonic review.

Life Status Questionnaire (LSQ) /Youth Life Status Questionnaire (YLSQ):

The Life Status Questionnaire (LSQ) and Youth Life Status Questionnaire (YLSQ) are 30-item assessment tools completed by the patient (or parent). These tools provide information on clinical risk, as well as the patient’s overall level of psychological distress. These are preferably faxed to the PBH toll free number – **(800) 992-2809**. Copies of these forms are sent to practitioners with every authorization.

- ◆ The LSQ/YLSQ should be administered at the time of the **first, third, and fifth** sessions -- they can be used prior to every session if the clinician desires.
- ◆ When a patient has multiple providers for medication monitoring and psychotherapy, each provider may utilize the LSQ/YLSQ. However, the expectation is that the psychotherapy provider will always use the LSQ/YLSQ.
- ◆ The LSQ/YLSQ should be periodically administered for longer, more complex episodes of care extending beyond the sessions authorized upon

PAR review – in other words, please submit an LSQ/YLSQ prior to calling PBH for telephonic review to request additional sessions.

- ◆ What about the resistant patient? We would never suggest that you force someone to complete a form when they are firmly opposed, but we usually find that there are two reasons people resist completing them. They often have mistaken ideas about how the form is used, and secondly, they refuse when they perceive that the clinician does not value the process. If you convey that these brief assessment tools can help you track progress together, most people are willing to complete the forms.

In summary, the protocol for submitting clinical information is as follows:

Situation	Information Needed by PBH
Treatment episode requires more visits than authorized initially at time of referral	Provider Assessment Report (PAR) is faxed to (800) 992-2809. Y/LSQ completed at first, third and fifth sessions.
Treatment episode requires more visits than authorized upon PAR review	Telephonic review with PBH Care Manager for psychotherapy services. Y/LSQ submitted at time of request for visits beyond those authorized upon PAR review. Prescribing practitioners have two choices—either submit the PAR each year for ongoing medication management, or if you prefer, call PBH to conduct a brief telephonic review.
Treatment has been completed with the number of visits initially authorized	Provider Assessment Report (PAR) is faxed to (800) 992-2809 with a request for “00” additional sessions and the “Treatment Terminated” field completed.
An extended treatment episode has been completed (PBH has already received clinical information via the PAR, Y/LSQ and telephonic review)	No information needed.

The forms and requirements for their submission are as follows:

The Routine Care Model

Provider Assessment Report (PAR). In most cases, four sessions are authorized at the time of referral. It is expected that the PAR will be completed and submitted after the second session, and as many as eight additional sessions will be authorized, at the provider's request, for cases of mild to moderate severity. More than eight additional sessions are authorized to complete a treatment episode for more severe and complex cases. (See The Routine Care Model).

Youth/Life Status Questionnaire. Patient reported data at the first, third and fifth visits is required. Should treatment need to be extended beyond the number of visits authorized upon PAR review, an additional Y/LSQ should be submitted at the time of telephonic review. Clinicians may administer the Y/LSQ as often as they find useful for treatment planning or risk management. The Y/LSQ may be requested of the treating clinician as frequently as every five visits beyond the number of sessions authorized upon PAR review.

Health Care Coordination Form Required for All Patients Seen

The *Health Care Coordination Form* (see Index of Forms) **must** be completed and mailed to the primary care physician (PCP) **for all patients seen**. At a minimum, each PCP should be informed when one of his/her patients accesses behavioral health services and be given the patient's diagnosis and basic treatment plan information. This release of information to the PCP requires member consent and the *Health Care Coordination Form* also serves as a release of information.

PBH and NCQA Requirements for Treatment Records and Clinical Documentation

PacifiCare Behavioral Health, Inc. (PBH) requires that all individual practitioners, group practices, facilities and chemical dependency programs must utilize the following standards for maintaining all treatment records and clinical documentation.

- ◆ Clinical records must be organized and available on-site to the practitioner or provider of services. They must be secured with a locking mechanism. Treatment records must include the patient's name or identification number on all pages; patient demographics, appropriate disclosure forms, and all pages must be legible to a reviewer and secured to the chart. All entries must include the responsible clinician's signature with, professional degree, and if applicable relevant identification number. All entries must be dated.

- ◆ Required disclosure forms include: Financial terms and copes; assignment of benefits; releases of information to PBH, the PCP, and any other appropriate providers or entities; limits of confidentiality; cancellation and other office policies; a statement on the philosophy of brief therapy; consent for treatment; appeals and grievance process; emergency procedures; and the Primary Care Physician's (PCP) name, address and phone or fax number. In addition, for Medicare +Choice members, the provider must document in a prominent place in the medical record whether or not the member has executed an Advance Directive.
- ◆ All clinical records must have the following four (4) essential elements:

1) Clinical Assessment

The clinical assessment must include all of the following:

- ◆ Special status situations including imminent risk assessment and conservatorship, if appropriate
- ◆ Mental status examination
- ◆ Presenting problem including relevant psychological and social conditions affecting medical and psychiatric status
- ◆ Allergies and adverse reactions clearly documented
- ◆ Lack of known allergies and sensitivities to pharmaceuticals and other substances prominently noted. (i.e., "NKA")
- ◆ Medical history including current medications and dosages, history of medication trials and results, and relevant medical conditions and their impact on emotional and behavioral functioning
- ◆ For children and adolescents, prenatal events and developmental history documented
- ◆ For patients twelve and older, documentation of past and present use of cigarettes, alcohol, illicit, prescribed and over the counter drugs
- ◆ Assessment of strengths/weaknesses that impact stabilization efforts
- ◆ Diagnostic impressions using current DSM diagnostic codes, terminology and multi-axial diagnosis

2) Treatment Plan

The treatment plan must include all of the following:

- ◆ Treatment plans consistent with diagnoses
- ◆ Problem statements concerning the primary treatment issues and the focus of the patient's treatment
- ◆ Treatment goals that are specific, objective, measurable and expressed in behavioral terms
- ◆ Estimated time frames for goal attainment or problem resolution
- ◆ Focus of treatment interventions consistent with the treatment plan goals and objectives
- ◆ Informed consent for medication is documented
- ◆ Plans for adjunctive treatment and referrals
- ◆ Signature of therapist
- ◆ Evidence of patient involvement in and understanding of the treatment planning process through either a patient signature or documentation by the treating clinician

3) Progress Notes

Progress notes must include all of the following:

- ◆ Name of the patient
- ◆ Date of the sessions
- ◆ Session number
- ◆ Treatment modality
- ◆ Problems as defined in the treatment plan are addressed in session
- ◆ Patient's strengths and limitations are clearly documented in terms of achieving treatment plan goals and objectives and maintaining stabilization over time
- ◆ Interventions used are consistent with the treatment plan

- ◆ Outcome of the interventions and/or progress in treatment are clearly documented
- ◆ For medication management cases, interventions should include documentation of the medications prescribed with doses and frequencies; and treatment outcomes should include responses to and compliance with those medications
- ◆ Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care through PBH care management
- ◆ The treatment record documents preventive services as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources
- ◆ Continued goals/plans for treatment (must be in objective and measurable form)
- ◆ Therapist's signature and degree/license
- ◆ As applicable, treatment should include the use of homework assignments and compliance with homework assignments should be documented
- ◆ Documentation reflects continuity of care between prescribing and non-prescribing clinicians, the clinician and the primary care physician, consultants, ancillary providers, and health care institutions; PBH's *Health Care Coordination Form* has been used to coordinate care with the Primary Care Physician (PCP)
- ◆ Documentation evidences that PBH access standards have been met

4) Provider Discharge Summary

The discharge summary must include all of the following:

- ◆ A narrative disposition of the discharge
- ◆ The dates of follow-up appointments or, as appropriate, a discharge plan which includes appropriate aftercare plans

Treatment Record Audits

PBH conducts random treatment records audits to assure compliance with the required documentation standards. These may be conducted either via onsite reviews or via mail-in audits. Treatment record keeping is reviewed for all high volume practitioners and group practices. In addition treatment record audits may be conducted when deficiencies or concerns are identified as part of the quality improvement process.

Key Points

- ◆ Treatment records must be kept in a secure area and they must be well organized.
- ◆ Required disclosure forms must be present and signed by the therapist and patient.
- ◆ Treatment records must contain a clinical assessment, treatment plan, progress notes and discharge summary that are consistent with PBH standards.
- ◆ Notes must reflect that treatment is brief, solution-focused therapy.
- ◆ Appropriate referrals and coordination of care must be clearly documented.
- ◆ Treatment record audits are conducted on a regular basis for Preferred Group Practices and individual practitioners.

Specialized Service Procedures

Psychological Testing Policy

Requests for psychological and/or neuro-psychological testing for patients, at any level of care, must meet PBH Medical Necessity criteria. PBH requires that testing be pre-authorized and provided by a licensed, doctoral-level clinical psychologist.

Psychological testing may be appropriate when:

- ◆ a specific clinical question cannot be answered through a comprehensive biopsychosocial evaluation, by a board-certified psychiatrist or through a specific medical work-up by a physician. It is appropriate that neuro-psychological testing take place as part of a comprehensive examination by a board-certified Neurologist. When neuro-psychological testing is ordered by a Neurologist, coverage would fall under the medical insurance plan.
- ◆ validated testing instruments exist that can be used to answer the clinical question; and
- ◆ the clinical question and the testing results will clearly affect the treatment plan; and
- ◆ the clinical question is not purely educational in nature. Testing of this sort is provided as part of a child's education under the Federal Education of Handicapped Children Act (PL 94-142).

Special note: Testing for ADD (with or without hyperactivity) would be appropriate if the proper use of observational checklists and a trial of medication have been inconclusive. Even then, only limited assessment of attention would typically be authorized. Neuropsychological test batteries are unnecessary unless there is a reason to believe that a genuine neurological disorder is present after a neurological evaluation has been performed.

Pre-authorization for Psychological Testing

Behavioral health assessment data is gathered through a variety of methods including observation, mental status examination and history taking. The provider's interpretation of that data can be supported by review of clinical literature and professional consultation. When these techniques do not resolve important clinical issues, psychological tests also can play a useful role.

To obtain referral for psychological testing, providers may call PBH to request that the member be referred to a licensed psychologist in the PBH provider network. A preliminary assessment interview can then be authorized. Before testing is initiated, the psychologist must complete the PBH Psychological Testing Authorization Request Form (see Index of Forms). To determine which testing measures will be requested, the psychologist may either consult with the referring therapist, or wait until completing the assessment interview with the member. Upon receiving the Testing Authorization Request, PBH will review the testing request according to the PBH Psychological Testing Protocol.

PBH authorizes psychological and neuropsychological testing in 15-minute increments. When testing is approved, an authorization letter will be sent informing the practitioner of the number of 15-minute units that have been authorized. Practitioners should bill using CPT codes 96100 (psychological testing) and 96117 (neuropsychological testing). Claims should include the specific names of all tests administered and the total number of units of service being billed. For example if testing took one hour, you should bill for 4 units.

Biofeedback

There is a scarcity of data regarding the usefulness and effectiveness of biofeedback with purely psychological conditions. PBH will not approve biofeedback as a treatment for ADHD/ADD. However, there is some data supporting its use with certain anxiety disorders. Biofeedback may also be appropriate for some conditions covered under the diagnosis of “Psychological Factors Affecting Physical Condition.” Authorizations for biofeedback under these conditions will be based on PBH Medical Necessity criteria and are dependent on the presence of biofeedback as an included benefit in the member’s benefit plan.