



# **Cenpatico Behavioral Health (CBH) Provider Manual For Peach State Health Plan**

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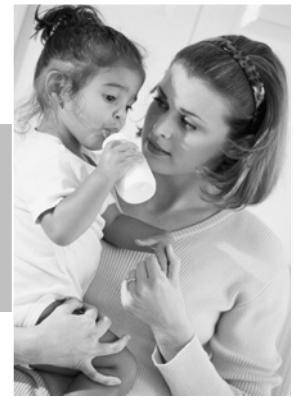
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# Georgia Healthy Families (GHF)



Georgia Healthy Families (GHF) is a program of the Georgia Department of Community Health (DCH). Scheduled for implementation over the course of the year, GHF will become a statewide, full-risk care management system for certain Medicaid adults, children, and PeachCare for Kids. The GHF program is designed to:

- Improve the Health Care status of the member population
- Establish a “Provider Home” for members through its use of assigned Primary Care Providers (PCP’s)
- Slow the rate of expenditure growth in the Medicaid Program
- Expand and strengthen a case of member responsibility that leads to more appropriate utilization of the health care system

## Purpose of the CBH Provider Manual

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The purpose of this manual is to provide specific and detailed information about Cenpatico Behavioral Health, LLC’s (CBH) service delivery system. The manual contains explicit statements regarding our mission, our managed care philosophy, and our commitment to total quality management. Our goal is to build a strategic partnership between CBH and the mental health/substance abuse providers who manage, provide, and coordinate behavioral treatment services for us. We will strive together to meet the objectives of our corporate mission.

We hope this manual provides you with a clear understanding of our treatment philosophy and of the policies and procedures that must be observed when providing treatment services to members on behalf of CBH. We are committed to providing support to help assure your success in the managed care environment.

We look forward to working with you and hope that you find your relationship with CBH a satisfying and rewarding one.

## CBH Mission Statement

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*“Cenpatico Behavioral Health will be the behavioral healthcare leader in the delivery of locally focused, innovative, compassionate and cost effective solutions for communities.”*

CBH provides quality, cost-effective behavioral health services and products to members, employers, schools, health plans and medical groups. We earn our customers’ trust by insuring satisfaction with the outcome of every contact with CBH: our products, services and people.



**Provider Services Department**  
**1-800-947-0633**

## CBH Values

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- **QUALITY** – We provide quality services, in all aspects of our business. We value doing the right thing at the right time, the first time
- **INTEGRITY** – We deal with our members, customers, vendors, providers and employees honestly, reliably and fairly

## CBH Objectives

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CBH is designed to achieve three main objectives. The objectives are:

- Improved access to care
- Improved quality of care
- Improved provider and member satisfaction

## CBH Summary

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CBH was established in 1994 and operates in Arizona, Indiana, Kansas, Missouri, Ohio, Texas, Georgia and Wisconsin.

CBH provides quality, cost-effective behavioral healthcare services for members of several health plans. CBH provides these services through a comprehensive network of qualified providers. CBH also contracts directly with hospitals and other behavioral health and substance abuse facilities and their attending physicians to see Peach State members.

An experienced network facility and provider panel is essential to providing consistent, superior services to our members. In order to achieve our goal, CBH builds strong, long-term relationships with network providers. This network manual was designed to assist our providers with the administrative and clinical activities required for participation in our system.

CBH prefers and encourages a partner relationship with its network providers and facilities. Member care is a collaborative effort that draws on the expertise and professionalism of all involved. We look forward to working with you to provide a system of care in this community in which we can all be proud to participate.

In addition to this manual, the Peach State Provider Training Manual (for providers and their staff) includes helpful and valuable information on serving members.



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**1-800-947-0633**

# Provider Responsibilities



## Provider Relations Department

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The Provider Relations Department at CBH is designed to make your experience with CBH a positive one by serving as your liaison within CBH and Peach State Health Plan. Provider Relations is responsible for providing the services listed below which include but are not limited to:

- Contracting
- Maintenance of existing CBH Provider Manual
- Development of alternative reimbursement strategies
- Researching of trends in claims inquiries to CBH
- Network performance profiling
- Individual provider performance profiling
- Provider and office staff orientation
- Hospital and Community Service Board (CSB) staff orientation
- Ongoing provider education, updates, and training

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Peach State enrolled membership. To contact the provider relations specialist for your area:

**Provider Services Toll Free Help Line  
1-800-947-0633**

The Provider Services toll free help line is available to you and your staff to answer questions, listen to your concerns, assist with patients, respond to your CBH and Peach State plan inquiries, connect you to the CBH provider relations specialist for your area, etc.

## Behavioral Health Provider Role & Responsibilities

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The behavioral health provider provides various modalities and comprehensive behavioral health and/or substance abuse services to Peach State members. In order to receive Peach State member referrals, providers must contract and credential with CBH.

To comply with the CBH contract agreement, CBH providers are responsible for meeting the following:

- Provider shall ensure that services are available on a basis of twenty-four (24) hours a day, seven (7) days a week
- Provide services within 14 business days of initial referral or as part of routine access to care
- Provide seven (7) day follow-up for members discharging from an inpatient level of care



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- Provide immediate service to members in crisis or an urgent situation
- Refer members with known or suspected physical health problems or disorders to their PCP for examination and treatment
- Ensure members who are pregnant or who have just delivered have access to primary care health care providers and will assist in coordinating care between CBH and Peach State Health Plan in the event they do not
- Screen all members receiving behavioral health services for co-occurring substance use.
- Ensure members know of and are able to avail themselves of their rights to execute Behavioral Health Advance Directives
- Contact members who have missed appointments within 24 hours to reschedule appointments
- Send initial and quarterly (or more frequently if clinically indicated) summary reports of member's behavioral health status to the PCP if a consent for release of information has been completed by members
- Abide by CBH Claims, QI, UM and Credentialing/Re-Credentialing policies and procedures as set forth in their CBH Agreement and the Provider Manual
- Provide services with all accepted clinical, legal and ethical standards governing such provider
- Provide services in a manner consistent with Provider's license, qualifications, training and experience and within the standards of practice for quality care
- Provider shall notify CBH within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Care to a Covered Person
- Provider shall not discriminate in the rendering of services on the basis of a member's race, color, national origin, sex, sexual orientation, age, religion, place of residence, health status, handicap, type of Plan, or source of payment, and agrees to observe, protect and promote the rights of and otherwise treat Covered Persons in the same manner as all other of Provider's patients who are in similar circumstances
- Provider agrees to carry out obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, and codes, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations
- Ensure patients receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language

## **Covered Behavioral Health Services**

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CBH covers a comprehensive range of treatment modalities. Please refer to the current Georgia State Medicaid Plan and Georgia Medicaid Policies and Procedures Manual and DCH Bulletins and Banner Pages for further information on limitations and exclusions. Covered services for Peach State members include services such as:

- Diagnostic Services
- Medication Management
- Traditional Outpatient Services
- Group Therapy
- Inpatient Hospitalization
- Detoxification



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- 23 hour observation
- Peach State Value Added Services:
  - Day Treatment/Partial Hospitalization Program (PHP)
  - Intensive Outpatient Program (IOP)

For more information on a member's covered services and their benefit package, please call CBH Customer Service at **1-800-947-0633**.

## Benefits Available Outside of CBH

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- Prescription medications are covered through Peach State Health Plan. Please see the Peach State formulary, or call Peach State Health Plan at 1-866-874-0633 to obtain more information.
- For non-emergent transportation, contact Logisticare at 1-800-224-7981 (Central) and Southeastrans at 1-770-693-8401 (Atlanta). In situations where urgent transportation is needed and cannot be coordinated with out transportation services, Peach State Member Services Representatives will coordinate transportation arrangements. To contact Peach State Member Services, call 1-800-704-1484.
- Emergency transportation is a covered benefit under Peach State, providers may directly contact emergency transport – no pre-authorization is required.
- Medical, Dental, and Vision services are also available to members through Peach State Health Plan. For more information, contact Peach State at 1-800-704-1484.

## Access, Availability and Coordination of Care

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Members may access behavioral health and/or substance abuse services through several mechanisms. This includes a referral from their primary care provider (PCP), a CBH referral, or a member self-referral for the first six standard outpatient sessions per member per year, using the online provider directory. All participating providers shall offer hours of operation that are no less than the hours of operation offered to commercial and fee-for-service members.

CBH adheres to DCH and URAC access standards for appointments. Providers must provide appointments within these timeframes. Current access standards are as follows:

- **Routine** appointments - within 14 business days
  - Routine Care:** Treatment of a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting.
- **Urgent** appointments - within 24 hours
  - Urgent care** is for an urgent behavioral health situation, that is not life threatening but should be treated within twenty-four hours. Urgent care services are not subject to prior authorization or pre-certification.
- **Emergent-life threatening** appointments are for immediate needs.
  - Emergency services** are inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize a behavioral health condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care to result in:
    - Injury to self or bodily harm to others



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- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious harm to self or others due to an alcohol or drug abuse emergency
- Injury to self or bodily harm to others, or
- With respect to a pregnant woman having contractions; (i) that there is not adequate time to affect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or unborn child.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms

- Emergent-non-life threatening appointments - within six (6) hours
- Discharge (from hospital) follow-up appointments - within seven (7) days of discharge
- Wait times in provider waiting rooms should not exceed one (1) hour

If you cannot offer an appointment within this time frame, please call or refer the member back to the CBH Service Center so the member may be re-scheduled with an alternative provider who can meet the access standards. Please call **1-800-947-0633** to access a CBH Customer Service Representative or Case Manager.

Network providers should call the CBH Provider Relations or Network Development Department, if unable to meet these access standards on a regular basis.

For emergency services:

- CBH shall provide payment for Emergency Services when furnished by a qualified Provider, regardless of whether that provider is in the CBH's network. These services shall not be subject to prior authorization requirements. CBH shall be required to pay for all Emergency Services that are Medically Necessary until the member is stabilized. CBH shall also pay for any screening examination services conducted to determine whether an Emergency Medical Condition exists.
- CBH shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson.
- The attending emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on CBH, who shall be responsible for coverage and payment. CBH, however, may establish arrangements with a hospital whereby CBH may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, provided that such arrangement does not delay the provision of Emergency Services.



**Provider Services Department**  
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- CBH shall not retroactively deny a claim for an emergency screening examination because the Condition, which appeared to be an Emergency Medical Condition under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining physician that an actual Emergency Medical Condition does not exist, then the determining factor for payment liability shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. In this case, CBH shall pay for all screening and care services provided. Payment shall be at either the rate negotiated under the provider contract, or the rate paid by DCH under the Fee for Service Medicaid program.
- The Member who has an Emergency Medical Condition shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- Once the member's condition is stabilized, CBH may require Pre-Certification for hospital admission or Prior Authorization for follow-up care.

**Post-stabilization services** are covered services, related to an Emergency Medical Condition, that are provided after a member is stabilized, in order to maintain the stabilized condition, or to improve or resolve the member's condition.

Covered services include post-stabilization services prior authorized or pre-certified by an in-network provider or CBH, regardless of whether they are provided within or outside the CBH's network of Providers.

Covered services also include post-stabilization services obtained from any contracted or out-of-network provider that are administered to maintain the member's stabilized condition for one (1) hour while awaiting a response from CBH to a Prior Authorization or Pre-Certification request.

CBH will review all requests for post-stabilization services and issue a determination within one (1) hour from the time the request is received.

Covered services include post-stabilization services obtained from any contracted or out-of-network provider not yet prior authorized by CBH network provider or CBH representative, but are administered to maintain, improve or resolve the member's stabilized condition if:

1. CBH does not respond to the provider's request for prior authorization or pre-certification within one (1) hour;
2. CBH cannot be contacted; or
3. CBH's authorization representative and the attending physician cannot reach an agreement concerning the Member's care and a CBH Medical Director or designee is not available for consultation. In such cases, CBH will give the treating physician the opportunity to consult with a CBH contracted physician and the treating physician may continue with care of the member until a CBH Medical Director or designee is reached or until one of the four (4) criteria in the next paragraph below is met.



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1-800-947-0633**

CBH's financial responsibility for post-stabilization services it has not approved ends when:

1. A CBH contracted provider with privileges at the treating hospital assumes responsibility for the member's care;
2. A CBH contracted provider assumes responsibility for the member's care through transfer;
3. CBH's authorization representative and the treating physician reach an agreement concerning the member's care; or
4. The member is discharged.

## Geographic Access Requirements

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CBH contracts with providers that are in the member service area. The State requires certain benchmarks are met in order to provide accessible service. CBH strives to meet and exceed prescribed Geo Access standards. Accessibility and availability are essential to quality, effective care. While there are exceptions outside these benchmarks, such as linguistic or cultural specialties, CBH adheres to the following requirements:

	Urban	Rural
<b>Hospitals</b>	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
<b>Mental Health Providers</b>	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles

## Coverage

CBH providers are expected to provide coverage when not available. Providers shall arrange for coverage with a provider who must be in the CBH network. If you would like to verify provider network participation, please call CBH Provider Relations or Network Development at **1-800-947-0633** or visit [www.pshpgeorgia.com](http://www.pshpgeorgia.com) to view an online directory of participating providers.

## Telephone Arrangements

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs

CBH will monitor appointment availability on an on-going basis through its Quality Improvement Program.



Provider Services Department  
1-800-947-0633

## **The Referral Process**

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CBH employs a team of customer service representatives to provide referrals and eligibility verification to our members and providers. Please call CBH Customer Service at **1-800-947-0633** to obtain a participating provider referral.

## **No New Referral Periods**

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Providers are required to notify CBH when they are not available for appointments. Providers may place themselves in a “no referral” hold status for a set period of time without jeopardizing their overall network status. “No referral” is set up for providers for the following reasons:

- Vacation
- Full Practice
- Personal Leave
- Other Personal Reasons

Providers must call the CBH Provider Relations or Network Development department to set up a “no referral” period. Providers must have a start date and an end date indicating when they will be available again for referrals. A “no referral” period will end automatically on the set end date.

DCH/CMS and Peach State prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

To further discuss or notify CBH of your “no referral” period, please call **1-800-947-0633**.

## **Coordination Between Behavioral Health and Primary Care Providers**

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CBH recognizes communication is the link that unites all the service components and is a key element in any program’s success. To further this objective, CBH providers are required to obtain consent for disclosure of information from the member permitting exchange of clinical information between the behavioral health provider and the member’s physical health provider.

If the member refuses to release their information, the network provider should document their refusal along with the reasons for declination in their medical record. CBH monitors Provider compliance to ensure that consent for release of information form has been signed by the member and for those agreeing to disclosure, that regular reports are being sent to the primary care provider.

## **Coordination Between Peach State Health Plan and CBH**

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Peach State and CBH work closely together to assure quality behavioral health and substance abuse services are provided to all members. This coordination includes participation in Quality Improvement (QI) committees for both organizations, and planned focus studies conducted conjointly for physical and behavioral health.



**Provider Services Department**  
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In addition, CBH works with health plans to educate and assist physical health and behavioral health providers in the appropriate exchange of medical information. Benchmarks for performance are measured, and non-compliance with the required performance standards prompts a corrective action plan to address and/or resolve any identified deficiency.

## **Provider Termination**

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Providers should refer to their Cenpatico Behavioral Health Provider or Group Provider Agreement for specific information regarding terminating from CBH. If you would like to further discuss provider termination, please call the **CBH Provider Relations or Network Development department at 1-800-947-0633**.

## **Advance Directives**

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CBH is committed to ensuring that its members know of, and are able to avail themselves of their rights to execute Advance Directives. CBH is equally committed to ensuring that its providers and staff are aware of, and comply with their responsibilities under federal and state law regarding Advance Directives.

Any provider delivering care to Peach State members must ensure **adult** members over the age of 18 years receive information on Advance Directives and are informed of their right to execute Advance Directives. Providers **must** document such information in the permanent medical record.

### **CBH recommends to its providers that:**

- The first point of contact in the provider office should ask if the member has executed an Advance Directive. The member's response should be documented in the medical record.
- If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Directive to the provider office and document this request.
- An Advance Directive should be included as a part of the member's medical record, including mental health directives.
- If a Behavioral Health Advance Directive exists, the provider should discuss potential emergencies with the member and/or family members (if named in the advance directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record
- If an Advance Directive has not been executed, the first point of contact within the office should ask the member if they desire more information about Advance Directives.
- If the member requests further information, Member Advance Directive education/information should be provided.

CBH Quality Improvement Department will monitor compliance with this provision during initial office site visits and as scheduled thereafter.

If you have any questions, regarding Advance Directives, please contact:

**Medical Management Department  
1-800-947-0633**



**Provider Services Department  
1-800-947-0633**

# Cultural Competency



Cultural Competency within the CBH Network is defined as “A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members”.

CBH is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate and quality care. When health care services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire health care process.

CBH as part of its credentialing and site visit process will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist provider’s in developing culturally competent and culturally proficient practices.

Network Providers must ensure the following:

- Members understand that they have access to medical interpreters, signers, and TTY services to facilitate communication without cost to them
- Care is provided with consideration of the members’ race/ethnicity and language and its impact/influence of the members’ health or illness
- Office staff that routinely come in contact with Members have access to and participate in cultural competency training and development
- Office staff responsible for data collection makes reasonable attempts to collect race and language specific patient information
- Treatment plans are developed and clinical guidelines are followed with consideration of the members race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process
- Office sites have posted and printed materials in the language spoken in English, Spanish, or other prevailing languages within the regions



**Provider Services Department**  
**1-800-947-0633**

## **Understanding the Need for Culturally Competent Services**

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The Institute of Medicine report entitled “Unequal Treatment” along with numerous research projects reveal that when accessing the healthcare system, people of color are treated differently. Research also indicates that a person has better health outcomes when they experience culturally appropriate interactions with medical providers. The path to developing cultural competency begins with self-awareness and ends with the realization and acceptance that the goal of cultural competency is an on going process. Providers should note that the experience of a member begins at the front door.

Failure to use culturally competent and linguistically competent practices could result in the following:

- Member’s feelings of being insulted or treated rudely
- Member’s reluctance and fear of making future contact with the office
- Member’s confusion and misunderstanding
- Non-compliance by the member
- Member’s feelings of being uncared for, looked down on and devalued
- Parents’ resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Provider’s misdiagnosis due to lack or information sharing
- Wasted time for the member and provider
- Increased grievances or complaints

## **Preparing Cultural Competency Development**

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The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Peach State and CBH are committed to helping you reach this goal.

Take into consideration the following as you provide care to the Peach State and CBH membership:

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patient’s culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?



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## **Facts about Health Disparities\***

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- Medicaid enrollees face many barriers to receiving timely care.
- Households headed by Hispanics are more likely to report difficulty in obtaining care.
- Many Medicaid enrollees are more likely to experience long wait times to see healthcare providers
- Medicaid enrollees experience longer waits in emergency departments and are more likely to leave without being seen.
- Many Medicaid enrollees are less likely to receive timely prenatal care, more likely to have low birth weight babies and have higher infant and maternal mortality.
- Medicaid enrollees that are children are less likely to receive childhood immunizations.
- Patient race, ethnicity, and socioeconomic status are important indicators of the effectiveness of healthcare.
- Health Disparities come at a personal and societal price.

*\* AHRQ "2003 National Healthcare Disparities Report"*

## **Cultural Competency Plan**

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The detailed Cultural Competency Plan is included in the CBH Provider Manual CD.



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# Clinical Practice Guidelines



## Clinical Practice Guidelines and Protocols

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CBH has adopted the Clinical Practice Guidelines from the American Psychiatric Association Guidelines. This summary is intended to help the provider select treatments with strong scientific support to assure treatment is efficient and effective.

CBH clinical practice guidelines are based on the health needs and opportunities for improvement identified as part of the QAPI program. The guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field. The guidelines consider the needs of the members, are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. CBH clinical practice guidelines are included in the CBH Provider Manual CD and are available on its website. The guidelines are available on request to members. CBH utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

In order to ensure consistent application of the guidelines, CBH will measure compliance with the guidelines until 90% or more of the providers are consistently in compliance.

These guidelines are intended to augment, not replace sound clinical judgment. Each provider should perform an accurate and careful assessment and develop an appropriate treatment plan based on this assessment. The provider must consider available treatment options and gain the member's informed consent to treatment. The process must take into consideration information about risks, benefits, efficiency and overall cost within the member's lifetime insurance benefit structure.

The choice of therapeutic approach ultimately belongs to the member.

CBH will be reviewing medical records and treatment plans submitted for authorization against the following guidelines. Providers will be given feedback about compliance.

### Depression

CBH has adopted the American Psychiatric Association's (APA) Practice Guideline for the Treatment of Patients With Major Depressive Disorder Second Edition April, 2000), which can also be obtained on [http://www.psych.org/psych\\_pract/treatg/pg/prac\\_guide.cfm](http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm). In addition, the APA website contains document entitled *Guideline Watch: Practice Guideline for the Treatment of Patients With Major Depressive Disorder, 2nd Edition and Quick Reference Guide*.

The Guideline Watch was designed to serve as an evidence-based framework for providers' clinical decision-making with adult members who have major depression. The guideline covers the psychiatric management of patients with this disorder, with content ranging from clinical features and epidemiology to all recognized aspects of treatment approach and planning. The "Quick Reference Guide" is a summary and synopsis of the American Psychiatric Association's Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Second Edition. The Quick Reference Guide is not designed to stand on its own and should be used in conjunction with the full text of the Practice Guideline. Graphical algorithms illustrating the treatment of major depressive disorder are included.



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## Schizophrenia

CBH has adopted The American Psychiatric Association's (APA) Practice Guideline for the Treatment of Patients With Schizophrenia (April 1997) (July 12, 2004), which can also be obtained on [http://www.psych.org/psych\\_pract/treatg/pg/prac\\_guide.cfm](http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm). The APA guideline covers psychiatric and medical management issues when treating patients with this disorder, ranging from clinical features, treatment formulary and implementation, treatment recommendations and epidemiology, as well as treatment approach and planning.

The APA website contains a document entitled *Quick Reference Guide*. The "Quick Reference Guide" is a summary and synopsis of the American Psychiatric Association's Practice Guideline for the Treatment of Patients With Schizophrenia, Second Edition. The Quick Reference Guide is not designed to stand on its own and should be used in conjunction with the full text of the Practice Guideline. Graphical algorithms illustrating the Treatment of Patients With Schizophrenia are included.

## Requirements for Referral to Psychiatry

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An accurate diagnostic assessment is integral to the development of an effective treatment plan. Frequently, members who access care are evaluated or treated by non-psychiatric providers. Once a diagnosis is established, members must be given access to the latest information concerning all of the treatment options available to them, in order to make informed treatment decisions. The requirements for referral of members to outpatient psychiatric services take into account current standards of practice in regard to the psychopharmacological treatment of certain diagnoses. Many conditions previously treated by psychotherapy alone are now known to be safely, effectively and reliably treated with medication, either alone or in combination with psychotherapy.

The referral process for psychiatric evaluation is intended to aid in collaborative treatment planning. Early referral to psychiatry may positively impact treatment, leading to significant amelioration of symptoms and a shorter course of treatment. At the same time, it is understood that in certain cases, psychotherapy alone may lead to amelioration of symptoms. The ability to monitor improvement requires time. Therefore, for some of the diagnoses, the requirements allow for a time span for referral to psychiatry. If a psychiatric referral is required, the mental health/substance abuse provider must coordinate a psychiatric appointment within the required time frame based on level of urgency.

### Diagnoses/conditions requiring immediate referral for psychiatric evaluation/ consultation:

- Presence of psychotic symptoms
- Major depression
- Bipolar Disorder
- Cyclothymic Disorder
- Obsessive Compulsive Disorder
- Attention Deficit Hyperactivity Disorder, unless another MD is handling medication management.
- Sudden or acute change in mental status marked by confusion or disorientation
- Discharge from a psychiatric/chemical dependency facility within the past ten days with medication for a psychiatric condition



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- Diagnoses requiring referral to psychiatry if there has been no demonstrable improvement within three-eight weeks of outpatient psychotherapy
- Generalized Anxiety Disorder
- Panic Disorder
- Post Traumatic Stress Disorder
- Anxiety Disorder NOS
- Bulimia Nervosa
- Anorexia Nervosa
- Dysthymic Disorder
- Mood Disorder due to General Medical Condition
- Mood Disorder NOS
- Presence of significant medical co-morbidity, psychophysiological impairment or psychosomatic overlay

## **Substance Use/Abuse/Dependency**

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CBH views assessment of substance use/abuse/dependency as an essential element of any thorough assessment that must be incorporated into routine history taking for all members. Substance use can mask, exacerbate, mimic and/or induce psychological disorders. The presence of significant untreated substance use can frustrate all psychotherapeutic efforts at addressing other psychological disorders/problems.

Some of the most difficult members to assess are those clients with substance abuse and additional mental health issues. Clearly psychological disorders and substance abuse disorders co-occur frequently and both issues must be addressed.

There are many screening assessment tools available in the public domain (for example, the MAST and the DAST) for providers to use as well as proprietary assessment tools (SASSI). All identified substance abuse must be addressed in the treatment plan with appropriate referrals made through the CBH Case Management Department.

## **Members with Chronic and Complex Conditions**

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Peach State and CBH provide individual case management services for members who have chronic, complex, high-risk, high-cost or other catastrophic conditions. Case managers work with all involved providers to coordinate care (including coordinating physical care with behavioral health care), provide referral assistance and other support as required, assist in identifying and obtaining supportive community resources, and arrange for long-term referral services as needed. CBH coordinates with Peach State on Peach State disease management programs and associated practice guidelines and protocols that relate to behavioral health care for members with chronic conditions, including conditions such as asthma and diabetes.

Members who qualify for chronic or complex case management services have an ongoing physical, behavioral or cognitive disorder, including chronic illnesses, impairments and disabilities. These limitations are expected to last at least twelve (12) months with a resulting functional limitation, reliance



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on compensatory mechanisms such as medications, special diet, or assistive device, and require service use or need beyond that which is normally considered routine.

Members determined to need a course of treatment or regular care monitoring may have direct access to a specialist as appropriate for the member's condition and identified needs, such as through a standing referral or an approved number of visits. Such a member's PCP will develop a treatment plan with member participation and in consultation with any behavioral health specialists caring for the member. The Peach State Medical Director oversees these processes in accordance with state standards. CBH encourages all providers to notify CBH Case Management when a member is identified who meets the criteria for a chronic or complex condition.



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# Medical Records



## Medical Records

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Medical records means the complete, comprehensive records of a member including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable rules and regulations, and signed by the medical professional rendering the services.

Providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable CBH to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. CBH requires providers to maintain all records in compliance with state and federal laws, as they pertain to mental health records.

## Required Information

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Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e. employer, home telephone number, spouse, etc.)
- All entries must be legible
- All entries must be dated and signed, or dictated by the provider rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If no known allergies, NKA or NKDA is documented
- Evidence that preventive screening and services are offered in accordance with CBH practice guidelines
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the record
- Past treatment history (for members seen three or more times) is easily identified and includes any psychiatric hospitalizations
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
- Unresolved problems from previous visits are addressed in subsequent visits
- Laboratory and other studies ordered as appropriate
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and an assessment of substance use
- Documentation of failure to keep an appointment



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- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of member information and records protected
- Evidence that an Advance Directive has been offered to adult members

## **Medical Records Release**

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All medical records of covered persons shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis. Each medical record release needs to be documented in compliance with HIPAA regulations.

Written authorization is required for the transmission of the medical record information of a current Peach State member or former Peach State member to any other provider.

## **Medical Records Transfer for New Patients**

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All providers are required to document, in the member's medical record, attempts to obtain records from prior treating providers for all new Peach State members. If the member or member's guardian is unable to remember where they obtained behavioral health care, or are unable to provide an appropriate address, then this should also be noted in the record.

## **Medical Records Audits**

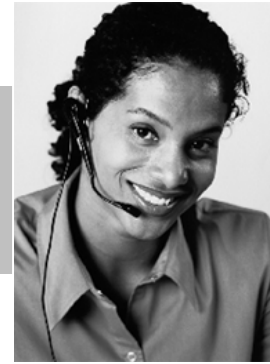
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Medical records may be audited to determine compliance with CBH standards for documentation and compliance with clinical practice guidelines. The coordination of care and services provided to members, including coordination with PCP may also be assessed during a medical record audit.



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# Utilization Management



## Utilization Management Overview

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The CBH Utilization Management Department hours of operation are Monday through Friday (excluding holidays) from 7:30 am to 4:30 pm CST.

For prior-authorizations during business hours, the provider should contact: **1-800-947-0633**. The purpose of CBH utilization management procedures and clinical practice guidelines is to assure treatment is specific to the member's condition, effective and provided at the least restrictive, most clinically appropriate level of care.

CBH Utilization review decisions are made in accordance with currently accepted behavioral healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. CBH Medical Necessity Criteria are used for the approval of medical necessity and plans of care that do not meet medical necessity guidelines are referred to a physician for review and peer to peer discussion. CBH Case Management staff are qualified behavioral health professionals whose education, training and experience are commensurate with the Case Management reviews they conduct.

Providers may obtain the criteria used to make a decision by contacting the Utilization Management Department at **1-800-947-0633**.

Appeals related to a medical necessity decision made during the authorization, pre-certification or concurrent review process can be made orally or in writing to:

**Appeals/Grievance Department**  
**5806 Mesa Drive, Suite 350**  
**Austin, TX 78731-3742**  
**512-406-7200 ext. 67226**

After-hours, holidays, and on weekends the provider can leave a message at the conclusion of the greeting or press Option 7 to be transferred to NurseWise to speak with a staff person.



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## Prior-Authorization

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Prior-authorization is required for all inpatient (non-emergent), partial hospitalization, day treatment, intensive outpatient, and home or community based treatment, except as provided below under Outpatient Authorization Process. The Provider must initiate prior-authorization of non-emergency services by contacting CBH at **1-800-947-0633**. Prior authorization is not required for emergency services, post-stabilization services or urgent care services.

**Standard Service Authorization** – Prior Authorization decisions for non-urgent services shall be made within fourteen (14) calendar days of receipt of the request for services. An extension may be granted for an additional fourteen (14) calendar days if the member or the provider requests an extension or if CBH justifies to DCH a need for additional information and the extension is in the member's best interest.

**Expedited Service Authorization** – In the event the provider indicates, or CBH determines, that following the standard timeframe could seriously jeopardize the member's life or health, CBH will make an expedited authorization determination and provide notice within twenty-four (24) hours. CBH may extend the twenty-four (24) hour time period for up to five (5) business days if the member or the provider requests an extension, or if CBH justifies to DCH a need for additional information and the extension is in the member's interest.

For access to out-of-network providers, the network provider must call CBH for a prior authorization for any service from an out of network or non-participating provider or facility.

The goal of CBH's care coordination program is to help all members to achieve the highest possible levels of wellness and quality of life. Case managers coordinate care and facilitate timely communication between providers, members and their families. This is especially important when new members transition care from a non-network provider, another CMO or traditional Medicaid. Subject to notification requirements, CBH will authorize and reimburse for all medically necessary Covered Services provided by non-network providers to new CBH members until clinical information and care can be transitioned to a CBH network provider.

Should a provider desire a standing referral, or access to a specialty care center for a life-threatening condition or certain prolonged conditions, the provider must contact CBH's Case Management Department.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.

## Observation Bed Guidelines

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If a member's clinical symptoms do not meet the criteria for an inpatient admission, but the treating physician believes that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period. Observation Bed Services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nurse or other staff. These services are reasonable and necessary to:

- Evaluate an acutely ill patient's condition
- Determine the need for a possible inpatient hospital admission
- Provide aggressive treatment for an acute condition

This observation may last for a period of up to 24 hours except when continued observation is clinically warranted, a maximum of 48 hours may be allowed.



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There may be instances that a member begins their hospitalization in an observation status and the member is upgraded to an inpatient admission. It is the responsibility of the physician and/or hospital to notify CBH of the acute admission.

*Providers should not substitute outpatient observation services for medically appropriate inpatient hospital admissions.*

## **Inpatient Notification Process**

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Inpatient facilities are required to notify CBH for emergent and urgent admissions the next business day following the admission. The authorization is required to track inpatient utilization, enable care coordination, discharge planning, and ensure timely claim payment. All non-emergent inpatient admissions require prior authorization.

## **Concurrent Review**

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The CBH Utilization Case Management Department will concurrently review the treatment and status of all members in inpatient, partial hospitalization, or residential treatment through contact with the member's attending physician or the facility Utilization and Discharge Planning Departments. The frequency of review for all higher levels of care will be determined by the member's clinical condition and response to treatment. The review will include evaluation of the member's current status, proposed plan of care and discharge plans. The number of initial days authorized is dependent on medical necessity and continued stay is approved or denied based on the findings in concurrent reviews. If the Care Manager disagrees with the hospital/physician's request for continued stay, the case will be referred to the CBH Medical Director or Medical Director designee.

## **Discharge Planning**

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Discharge planning activities should be initiated upon admission. The CBH Utilization Case Management Department will coordinate the discharge planning efforts with the facility to ensure that Peach State members receive appropriate post hospital discharge care.

## **Outpatient Authorization Process**

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For standard outpatient services, an authorization is not required for the first six sessions per member per year. An authorization is also not required for all routine appointments from a MD, DO, or APNP. It is the responsibility of the provider to monitor the member's ongoing insurance eligibility. CBH authorization of services is an indication of medical necessity, not a confirmation of eligibility and not a guarantee of payment.

## **Continuing Outpatient Treatment Authorization Process**

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Network Providers (excluding MDs, DOs, or APNPs) must obtain authorization for continued care beyond the initial six standard outpatient authorizations. All continued authorization is based upon medical necessity.

When requesting additional sessions, the network provider must complete an Outpatient Treatment Request (OTR) form. (Sample OTRs can be found in the Forms Section) and fax to CBH for clinical review. Network providers may call the Customer Service Department to check status of an OTR.



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- The OTR must be completed in its entirety. The five axis diagnoses, as well as all other clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delay and/or denials.
- CBH will not retroactively certify sessions. The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization. If the member's first appointment or last appointment falls outside the authorization date range, the network provider must contact CBH for an adjustment to the authorization date range.

Care management decisions are based on medical necessity and established Clinical Practice Guidelines. CBH does not pay for unauthorized services and the Participating Provider Agreement precludes network providers from balance billing (billing a member directly) for covered services.

Failure to submit a completed OTR can result in delayed authorization and may impact your ability to meet the timely filing deadlines, and result in payment denial.

## Second Opinion

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Members may receive a second opinion from a qualified professional within the CBH network. If there is not an appropriate provider to render the second opinion within the network, CBH will assist the member to obtain the second opinion from an out-of-network provider at no cost to the member.

## Continuity of Care

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CBH makes every effort to ensure continuity of care to avoid unnecessary disruption of medically necessary, effective treatment prior to the member's enrollment with CBH, or when affected by the termination of a provider or site of care.

### Prior to enrollment:

Prior to any authorization being issued, CBH must receive the signed Patient Transition Registration Form (PTRF) with fee schedule, licensure, malpractice and signed W-9 form. The provider will be activated as a Transition Provider. CBH may issue up to four transition visits within a thirty-day time limit. Visits beyond the initial transition visits may be authorized on a case by case basis determined by the Utilization Management Director or designee.

### Provider termination:

When a provider is being terminated without cause, CBH sends the members who are affected a letter informing him/her of the termination. The letter will offer to transition the member to another network provider and will also allow the member to continue access to the terminated provider for the currently authorized active course of treatment or ninety days, whichever is shorter. The exceptions include the following:

- The member requires routine monitoring for a chronic condition only
- CBH has discontinued the contract based on a professional review action as defined in the Health Care Quality Improvement Act of 1986 in which the provider's professional conduct or competence "affects or could affect adversely the health or welfare of a patient or patients"

If the member elects to remain with the terminated provider during the transition period, the provider must comply with all contractual provisions, including but not limited to:

- Accept the CBH fee schedule at the time of termination
- Continue the members' treatment for an appropriate amount of time, based on transition plan goals



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- Share information regarding the treatment plan with CBH
- Continue to follow CBH UM policies and procedures
- Not charge the patient an amount beyond any required co-payment

### **Facility Termination:**

When a member will be affected by the termination of a facility from the network, CBH arranges to have the member:

- Transferred to another facility
- Complete treatment at the terminated facility

## **Care Coordination Program**

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- Contact by telephone and letters to high- risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members are compliant with treatment
- Coordinate with the health plan, advocates or providers for members who may need behavioral health services
- Assist members with locating a provider
- Serve as a resource to hospital discharge planners needing services for members
- Coordinate requests for out-of-network providers by determining need/access issues involved
- Facilitate all requests for inpatient psychiatric consults for members in a medical bed

## **Medical Necessity Criteria**

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Medically Necessary services are generally accepted medical practices in light of conditions at the time of treatment. Medically Necessary services are those that follow:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition
- Compatible with the standards of acceptable medical practice in the community
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and severity of the symptoms
- Not provided solely for the convenience of the member or the convenience of the healthcare provider or hospital
- Not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage

There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

Pursuant to the Georgia State Medicaid Plan and the Georgia Medicaid Policies and Procedures Manual, in no instance shall CBH or Peach State cover experimental, investigational or cosmetic procedures.



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Consistent with 42 CFR 438.6(h) and 422.208, Peach State, CBH, and providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

### **Hospitalization, Eating Disorders**

CBH reviews mental health and substance abuse treatment for medical necessity. When applied to inpatient care, medical necessity means “the needed care can only be safely given on an inpatient basis.”

### **Quality of Care Standards**

*Criteria must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I Admission - Severity of Need**

*Criteria A and one of criteria B, C, D, or E must be met to satisfy the criteria for severity of need.*

- A. Members must have a *primary* diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder not otherwise specified. The illness can be expected to improve significantly through medically necessary and appropriate therapy by accepted medical standards. Members hospitalized because of another primary psychiatric disorder who have a coexisting eating disorder should be reviewed according to the criteria below *only* if the primary psychiatric disorder no longer requires hospitalization.
- B. Body weight less than 75% of Ideal Body Weight (IBW) or Body Mass Index (BMI) of 16 or below. If body weight is greater than 75% of IBW (or BMI > 16), this criterion can be met if there is evidence of weight loss of >15% in one month or weight loss associated with physiologic instability unexplained by any other medical condition. This criterion may be satisfied in children and adolescents who have a body weight between 75-85% of ideal, based upon height, during a period of rapid growth.
- C. Medical consequences of the eating disordered behavior that present the potential for imminent harm such that immediate medical and psychiatric stabilization is necessary before ambulatory or residential management can be considered safe or effective. Such medical consequences would include severe malnutrition, emaciation, significant electrolyte or fluid imbalance, cardiac arrhythmias, hypotension, impaired renal function, intestinal atony or obstruction, pancreatitis, gastric dilatation, esophagitis or esophageal tears and colitis.
- D. In Bulimia, immediate interruption of the binge/purge cycle is required to avoid imminent, serious harm due to the presence of a co-morbid medical or psychiatric condition (e.g., pregnancy, uncontrolled diabetes, severe depression with suicidal ideation, etc.), with the need to ensure adequate nutrition and absorption of pharmaceuticals.
- E. Failure to respond to an adequate therapeutic trial of treatment in a less restrictive setting (residential or partial hospital). An adequate therapeutic trial would at a minimum consist of treatment several times per week with twice weekly individual and/or family therapy, either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated.

To meet this criterion, the member must have significant weight loss (<85% IBW), significant impairment in social or occupational functioning, and be uncooperative with treatment (or cooperative only in a highly structured environment) despite having insight and motivation to recover. If member has failed to improve in an acute residential program, there must be evidence to suggest that necessary changes in the treatment plan cannot be implemented in a residential



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setting or that inpatient hospitalization is required due to medical co-morbidity or need for special feeding.

## **II. Admission - Intensity of Service**

*Criteria A, B and C must be met to satisfy the criteria for intensity of service.*

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the member performed by an Attending Physician prior to, or within 24 hours following the admission. For child and adolescents, parents/ guardians/other caretakers should be included in the evaluation process, unless there are specific clinical contraindications for their involvement.
- B. This care must require an individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs.

## **III. Continued Stay**

*Criteria A, B, C, D and E, and either one of F, G, H, I or J, must be met to satisfy the criteria for continued stay.*

- A. The admission criteria Severity of Need A and B, C, or D, and Intensity of Service A, B and C are continually met.
- B. The current treatment plan should include documentation of diagnosis (ICD-9, axes I-V), discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis.
- C. The member's progress confirms that the presenting or newly defined problem will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and member's response.
- E. There should be evidence of intensive family involvement occurring several times per week unless the treatment plan specifically indicates a clinical need for less frequent involvement.
- F. The member's weight remains <85% of IBW and he/she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.
- G. Continued inability to adhere to a meal plan and maintain control over urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required. In order to satisfy this criterion, there must be evidence that member is unable to participate in ambulatory or residential treatment, lacks significant insight into the symptoms of his/her illness, and has regressed in response to progressive increases in privilege level.
- H. The member continues to meet Admission Criteria, I-C with the need for ongoing medical monitoring of medical consequences of the eating disorder.



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- I. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. A physician should document this in daily progress notes.
- J. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

### **Hospitalization, Psychiatric, Child and Adolescent**

CBH reviews mental health and substance abuse treatment for medical necessity. When applied to inpatient care, the term means: “the needed care can only be safely given on an inpatient basis.”

#### Quality of Care Standards

*Criteria must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*Criteria A and either B, C or D must be met to satisfy the criteria for severity of need.*

- A. Member must have a diagnosed or suspected mental illness that can be expected to improve significantly. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate ICD-9 codes on all applicable axes (I-V).
- B. The member demonstrates a clear and reasonable inference of imminent serious harm to self by (any one of the following):
  - 1. Current plan or intent to harm self with an available and highly lethal means.
  - 2. A highly lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  - 3. An imminently dangerous inability to care adequately for own physical needs through disordered, disorganized or bizarre behavior.
  - 4. Other similarly clear and reasonable evidence of imminent serious harm to self.
- C. The member demonstrates a clear and reasonable inference of imminent serious harm to others by (any one of the following):
  - 1. Current plan or intent to harm others with an available and highly lethal means.
  - 2. A highly lethal action to harm others with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  - 3. Violent, unpredictable, or uncontrolled behaviors that represents an imminently serious harm to the body or property of others.
  - 4. Other similarly clear and reasonable evidence of imminent serious harm to others.
- D. As a result of potential reasonable complications from an acute psychiatric assessment technique or intervention, there is a high probability of serious, imminent and dangerous deterioration of the member’s general medical or mental health.



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## II. Admission - Intensity of Service

*Criteria A, B and C must be met to satisfy the criteria for intensity of service.*

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the member performed by an attending physician prior to, or within 24 hours following the admission. Parents/ guardians/other caretakers should be included in the evaluation process, unless there are specific clinical contraindications for their involvement.
- B. This care must require an individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs.

## III. Continued Stay

*Criteria A, B, C, D and E, and either F, G or H must be met to satisfy the criteria for continued stay.*

- A. Admission criteria must be met.
- B. The current treatment plan should include documentation of diagnosis (ICD-9 axes I-V), discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis.
- C. The member's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received, and member's response.
- E. There should be evidence of intensive family involvement occurring several times per week unless the treatment plan specifically indicates a clinical need for less frequent involvement.
- F. Despite therapeutic efforts, clinical evidence indicates the persistence of problems that caused the admission to the degree that would necessitate continued hospitalization, or the emergence of additional problems consistent with the admission criteria and to the degree that would necessitate continued hospitalization.
- G. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. A physician should document this in daily progress notes.
- H. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.



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## **Hospitalization, Substance Related Disorders**

CBH reviews mental health and substance abuse treatment for medical necessity.

When applied to inpatient care the term means: “the needed care can only be safely given on an inpatient basis.”

### Quality of Care Standards

*Criteria must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*Criteria A and either B, C or D must be met to satisfy the criteria for severity of need.*

- A. Member must have a disorder related to substance use/dependency that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(s) must be documented through the assignment of appropriate ICD-9 codes on all applicable axes (I-V).
- B. The member demonstrates a clear and reasonable inference of imminent serious harm to self by (any one of the following):
  - 1. Current plan or intent to harm self with an available and highly lethal means.
  - 2. A highly lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  - 3. An imminently dangerous inability to care adequately for own physical needs through disordered, disorganized or bizarre behavior.
  - 4. Other similarly clear and reasonable evidence of imminent serious harm to self.
- C. The member demonstrates a clear and reasonable inference of imminent serious harm to others by (any one of the following):
  - 1. Current plan or intent to harm others with an available and highly lethal means.
  - 2. A highly lethal action to harm others with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  - 3. Violent, unpredictable, or uncontrolled behavior that represents an imminently serious harm to the body or property of others.
  - 4. Other similarly clear and reasonable evidence of imminent serious harm to others.
- D. As a result of potential reasonable complications from an acute psychiatric assessment technique or intervention, there is a high probability of serious, imminent and dangerous deterioration of the member's general medical or mental health.

#### **II. Admission - Intensity of Service**

*Criteria A, B and C must be met to satisfy the criteria for intensity of service.*

- A. The evaluation and assignment of the behavioral illness diagnoses must take place in a face-to-face evaluation of the member performed by an attending physician prior to, or within 24 hours following the admission.



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- B. This care must require an individual plan of active psychiatric and substance abuse/dependency treatment that includes 24-hour need for and access to the full spectrum of behavioral health staffing (physicians, nurses, counselors, social worker, and other therapists). This staffing must provide 24-hour services, including quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes as appropriate, timely evaluation of post-hospitalization needs.

### **III. Continued Stay**

*Criteria A, B, C, D and E, and either F, G or H must be met to satisfy the criteria for continued stay.*

- A. Admission criteria must be met.
- B. The current treatment plan should include documentation of diagnosis (ICD-9 axes I-V), discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis.
- C. The member's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and member's response.
- E. There should be evidence of intensive family involvement occurring several times per week unless the treatment plan specifically indicates a clinical need for less frequent involvement (for child or adolescent members).
- F. Despite therapeutic efforts, clinical evidence indicates the persistence of problems that caused the admission to the degree that would necessitate continued hospitalization, or the emergence of additional problems consistent with the admission criteria and to the degree that would necessitate continued hospitalization.
- G. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. A physician should document this in daily progress notes.
- H. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the behavioral illness(es) to the degree that would necessitate continued hospitalization.

### **Intensive Outpatient Treatment, Psychiatric, Child and Adolescent**

CBH reviews mental health and substance abuse treatment for medical necessity.

When applied to inpatient care, the term means: "the needed care can only be safely given on an inpatient basis."

#### Quality of Care Standards

*Criteria must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.



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**I. Admission - Severity of Need**

*Criteria A, B and C must be met to satisfy the criteria for severity of need.*

- A. The clinical evaluation indicates that the individual has a primary ICD-9 diagnosis or severe emotional disturbance that is the cause of significant psychological, personal care, vocational, educational and/or social impairment. The individual's disorder can be expected to improve significantly through medically necessary and appropriate therapy. The individual is sufficiently competent, and behaviorally and cognitively stable to benefit from admission to an intensive outpatient program.
- B. The impairment results in at least one of the following:
  - 1. A clear, current threat to the individual's ability to live in his/her customary setting for an individual who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care.
  - 2. A clear, current threat to the individual's ability to be employed or attend school.
  - 3. An emerging/impending risk to the safety or property of the individual or of others.
- C. Either:
  - 1. For individuals with persistent or recurrent disorders, the individual's past history indicates that when the member has experienced similar clinical circumstances, less intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the member or others; or
  - 2. For individuals with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the member or others.

**II. Admission - Intensity of Service**

*Criteria A, B and C must be met to satisfy the criteria for intensity of service.*

- A. In order for intensive outpatient services to be safe and therapeutic for an individual, professional and/or social supports must be identified and available to the individual outside of program hours, and the individual must be capable of seeking them as needed when not attending the program.
- B. The individual's condition must require an integrated program of rehabilitation counseling, education, therapeutic, and/or family services at least two hours/day or for six hours in a week.



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- C. The individual treatment plan for intensive outpatient requires that a multidisciplinary team of professional and supervised support staff provide the services. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the member to outpatient treatment follow-up and/or self-help support groups.

### **III. Continued Stay**

*Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.*

- A. Admission criteria must be met.
- B. Despite treatment efforts, clinical evidence indicates the persistence of the problems that necessitated the admission to the intensive outpatient program, or the emergence of additional problems consistent with the admission criteria.
- C. There are progress notes for each day that member is in intensive outpatient services documenting the provider's treatment, and the member's response to treatment.
- D. The member's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.

Clinical evidence indicates that attempts at therapeutic re-entry into a less intensive level of care have or would result in exacerbation of the psychiatric illness to the degree that would warrant the continued need for intensive outpatient services.

An expectation that the member will be evaluated on a once per week basis.

### **Intensive Outpatient Treatment, Substance Related Disorder, Child and Adolescent**

CBH reviews mental health and substance abuse treatment for medical necessity.

When applied to inpatient care, the term means: "the needed care can only be safely given on an inpatient basis."

#### Quality of Care Standards

*Criteria must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*Criteria A, B and C must be met to satisfy the criteria for severity of need.*

- A. The clinical evaluation indicates that the individual has a primary ICD-9 diagnosis(es) of substance abuse/dependence meeting ICD-9 criteria, and is sufficiently mentally competent and cognitively stable to benefit from admission to an intensive outpatient program.
- B. Individual requires more intensive treatment and support than can be provided in a traditional outpatient visit setting; i.e., needs to be involved in treatment three or more times per week for two or more hours per session. The member's condition reflects a pattern of severe alcohol and/or drug use as evidenced by periods of inability to maintain abstinence over a consistent period of time.



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- C. For individuals with a history of repeated relapses and a treatment history involving multiple treatment attempts in intensive outpatient or partial hospital programs, there must be documentation of the restorative potential for the proposed program admission.

## **II. Intensity of Service**

*Criteria A, B and C must be met to satisfy the criteria for intensity of service.*

- A. In order for intensive outpatient services to be safe and therapeutic for an individual, professional and/or social supports must be identified and available to the individual outside of program hours, and the individual must be capable of seeking them as needed when not attending the program.
- B. The individual's condition must require an integrated program of rehabilitation counseling, education, therapeutic, and/or family services at least two hours/day or for six hours in a week.
- C. The individual treatment plan for intensive outpatient requires that a multidisciplinary team of professional and supervised support staff provide the services. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the member to outpatient treatment follow-up and/or self-help support groups.

## **III. Continued Stay**

*Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.*

- A. Admission criteria must be met.
- B. Despite treatment efforts, clinical evidence indicates the persistence of the problems that necessitated the admission to the intensive outpatient program, or the emergence of additional problems consistent with the admission criteria.
- C. There are progress notes for each day that member is in intensive outpatient services documenting the provider's treatment, and the member's response to treatment.
- D. The member's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.
- E. Clinical evidence indicates that attempts at therapeutic re-entry into a less intensive level of care have or would result in exacerbation of the psychiatric illness to the degree that would warrant the continued need for intensive outpatient services.
- F. Members must receive family therapy a minimum of once per week, unless a specific clinical reason is given as to why this is not needed and is documented in the medical record.

The most appropriate supply or level of service. When applied to inpatient care, the term means: "the needed care can only be safely given on an inpatient basis."

### Quality of Care Standards

*Criteria must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.



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## **Partial Hospitalization, Psychiatric, Child and Adolescent**

CBH reviews mental health and substance abuse treatment for medical necessity. When applied to inpatient care, the term means: "the needed care can only be safely given on an inpatient basis."

### Quality of Care Standards

*Criteria must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*Criteria A, B, C and D must be met to satisfy the criteria for severity of need.*

- A. Member must have a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate ICD-9 codes on all applicable axes (I-V).
- B. There is clinical evidence that a less intensive outpatient setting is not appropriate at this time and/or a partial hospital program can safely substitute for, or shorten, a hospital stay.
- C. Either:
  - 1. There is clinical evidence that the member would be at risk to self or others if he were not in a partial hospitalization program; or
  - 2. As a result of the member's mental disorder there is an inability to adequately care for one's physical needs, representing potential serious harm to self.
- D. Additionally, either:
  - 1. The member can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time; or
  - 2. The member is believed to be capable of controlling this behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

#### **II. Admission - Intensity of Service**

*Criteria A, B, C and D must be met to satisfy the criteria for intensity of service.*

- A. In order for a partial hospital program to be safe and therapeutic for an individual member, professional and/or social supports must be identified and available to the member outside of program hours, and the member must be capable of seeking them as needed.
- B. The member's condition must require a structured program with nursing and medical supervision, intervention and/or treatment for at least four hours per day.
- C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the member to a lesser level of care.



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- D. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-partial hospitalization needs.

### **III. Continued Stay**

*Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.*

- A. Admission criteria must be met.
- B. Despite treatment efforts, clinical evidence indicates the persistence of problems that necessitated the admission to the partial hospitalization program, or the emergence of additional problems consistent with the admission criteria.
- C. There are progress notes for each day that member is in a partial hospital/day treatment program documenting the provider's treatment, and the member's response to treatment.
- D. The member's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.
- E. Clinical evidence indicates that attempts at therapeutic re-entry into a less intensive level of care have or would result in exacerbation of the psychiatric illness to the degree that would warrant the continued need for partial hospitalization services.
- F. Members must receive family therapy a minimum of once per week, unless a specific clinical reason is given as to why this is not needed and is documented in the medical record.

### **Partial Hospitalization, Substance Related Disorder, Child and Adolescent**

CBH reviews mental health and substance abuse treatment for medical necessity.

When applied to inpatient care, the term means: "the needed care can only be safely given on an inpatient basis."

#### Quality of Care Standards

*Criteria must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*Criteria A, B and C must be met to satisfy the criteria for severity of need.*

- A. The provider must be able to document that the individual has a history of alcohol/substance related disorder meeting ICD-9 criteria but is mentally competent and cognitively stable enough to benefit from admission to a partial hospitalization/ day treatment program.
- B. The individual requires more intensive multidisciplinary evaluation, treatment and support than can be provided in a traditional outpatient visit setting or an intensive outpatient program.
- C. For individuals with a history of repeated relapses and a treatment history involving multiple treatment attempts, there must be documentation of the restorative potential for the proposed admission.



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## **II. Admission - Intensity of Service**

*Criteria A, B, C and D must be met to satisfy the criteria for intensity of service.*

- A. In order for a partial hospital/day treatment program to be safe and therapeutic for an individual member, professional and/or social supports must be identified and available to the member outside of program hours, and the member must be capable of seeking them as needed.
- B. The member's condition must require a structured program with nursing and medical supervision, intervention and/or treatment for part of each program day.
- C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the member to a less intensive level of care.
- D. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes as appropriate, timely evaluation of post-partial hospitalization needs.

## **III. Continued Stay**

*Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.*

- A. Admission criteria must be met.
- B. Despite therapeutic efforts, clinical evidence of the persistence of the problems that caused the admission to partial hospitalization/day treatment, or the emergence of additional problems consistent with the partial hospital admission criteria that would necessitate continued treatment at this level of care.
- C. There are progress notes written for each treatment day by the provider documenting the provider's treatment and the member's response to treatment.
- D. The member's progress confirms that the presenting or newly defined problem(s) will respond to the current treatment plan.
- E. Clinical evidence indicates that attempts at therapeutic re-entry into a less intensive level of care have or would result in relapse or exacerbation of the illness to the degree that would warrant the continued need for intensive treatment services.
- F. Members must receive intensive family involvement a minimum of once per week, unless a specific clinical reason is given as to why this is not needed and is documented in the medical record.



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## **Outpatient Treatment, Psychiatric and Substance Related Disorder**

CBH reviews mental health and substance abuse treatment for medical necessity.

When applied to inpatient care, the term means: “the needed care can only be safely given on an inpatient basis.”

### Quality of Care Standards

*Criteria must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Initial Review - Severity of Need**

*Criteria A, B, C, and D must be met to satisfy the criteria for severity of need.*

- A. ICD-9 diagnosis on Axis I and/or Axis II.
- B. Completed assessments on Axes III, IV and V.
- C. A description of DSM IV/IV<sup>®</sup> psychiatric symptoms, intrapsychic conflict, behavioral and/or cognitive dysfunction consistent with the diagnoses on Axes I and II.
- D. Either 1, 2, or 3 below must be met to satisfy criteria D.
  1. At least mild symptomatic distress and/or impairment in functioning due to psychiatric symptoms and/or behavior in at least one of the three spheres of functioning (occupational, scholastic, or social), that are the direct result of an Axis I or Axis II disorder. This is evidenced by specific clinical description of the symptom(s) and/or impairment(s) consistent with a GAF (ICD-9, Axis V) score of less than 71.
  2. The individual has a persistent ICD-9 illness for which maintenance treatment is required to maintain optimal symptom relief and/or functioning.
  3. There is clinical evidence that further therapy is required to support termination of therapy, although the individual no longer has at least mild symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued medical necessity of treatment in this termination phase are the frequency and severity of previous relapse, level of current stressors, and other relevant clinical indicators. The therapist should be able to explain whether the treatment being utilized will change (and if not, why) when there has been sustained improvement as measured in part by a GAF score over 70.

#### **II. Initial review - Intensity of Service**

*Criteria A and B must be met to satisfy the criteria for intensity of service.*

- A. A medically necessary and appropriate treatment plan, or its update, specific to the member's impairment in functioning and ICD-9 psychiatric symptoms, behavior, cognitive dysfunctions, and/or psychodynamic conflicts. The treatment plan is expected to be effective in either:
  1. Alleviating the member's distress and/or dysfunction, or
  2. Achieving appropriate maintenance goals for a persistent illness, or
  3. Supporting termination
- B. The treatment plan must identify (1-6) to satisfy criteria B:



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1. The status of target-specific DSM IV/IV® psychiatric symptoms, behavior, and cognitive dysfunction being treated.
2. The current, or anticipated modifications in, biologic, behavioral, psychodynamic or psychosocial framework(s) of treatment for each psychiatric symptom/cluster and/or behavior.
3. The status of specific and measurable goals for treatment specified in terms of symptom alleviation, behavioral change, cognitive alteration, psychodynamic change, or improvement in social, occupational, or scholastic functioning;
4. The current, or anticipated modifications in, treatment methods in terms of:
  - a. Treatment framework or orientation
  - b. Treatment modality
  - c. Treatment frequency
  - d. Estimate of treatment duration
5. Status of measurable, target criteria used to identify both interim treatment goals and end of treatment goals (unless this is a maintenance treatment) to substantiate that: a) treatment is progressing, and/or b) goals have been met and treatment is no longer needed.
6. An alternative plan to be implemented if the member does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are a second opinion or introduction of adjunctive or alternative therapies.

### **III. Continued Stay**

*Criteria A, B, C and D must be met to satisfy the criteria for continued outpatient treatment.*

- A. Intensity of Service Criteria for the Initial Treatment Review must be met.
- B. A ICD-9 diagnosis on Axis I and/or a personality disorder diagnosis on Axis II.
- C. A description of ICD-9 psychiatric symptoms, intrapsychic conflict, cognitive dysfunction, or behavior consistent with the diagnoses given.
- D. 1, 2 or 3 must be met to satisfy criteria D.
  1. There is the persistence of, or recurrence of at least mild symptomatic distress and/or impairment in functioning due to these psychiatric symptoms and/or behavior.
  2. The individual has a persistent ICD-9 illness for which maintenance treatment is required to maintain optimal symptom relief and/or functioning.
  3. There is clinical evidence that further therapy is required to support termination of therapy, although the individual no longer has at least mild symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued medical necessity of treatment in this termination phase are the frequency and severity of previous relapse, level of current stressors, and other relevant clinical indicators. The therapist should be able to explain whether the treatment being utilized will change (and if not, why) when there has been sustained improvement as measured in part by a GAF score over 70.



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# Eligibility and Enrollment



## Eligibility for the Peach State Program

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CBH manages the Behavioral Health benefits for the Peach State Health Plan. You may have patients who request information about their benefits or eligibility with this plan. The local office of the Georgia Department of Community Health (DCH) is responsible for determining eligibility of persons applying for the Peach State Program. Persons interested in applying for the Peach State Program should be referred to the local county office of the DCH in the county in which the individual lives.

Applicants enroll in Peach State by contacting the Enrollment Broker during the application process. The member has an opportunity to select a primary care provider (PCP) with the assistance of a Selection Counselor. Individuals who do not make a voluntary PCP selection are assigned to a PCP via an automated assignment process that links the member with an appropriate PCP.

Member eligibility in Peach State is effective on the first calendar day of a month, and may be confirmed by any of the Eligibility Verification systems described below.

## Verifying Enrollment

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Providers are responsible for verifying eligibility every time a member schedules an appointment and when they arrive for services. CBH Customer Service will assist you with determining member eligibility. Customer Service Representatives, available during regular business hours at 1-800-947-0633, have access to current member eligibility information. When you call them, please have available as much of the following information as possible:

- Member's full name (including correct spelling)
- Any other names such as maiden names, aliases, etc
- Medicaid Number
- Social Security Number
- Address
- Telephone

Providers also may verify member enrollment through Peach State's website at [www.pshpgeorgia.com](http://www.pshpgeorgia.com).



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## **Enrollment Guidelines for Providers**

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CBH and Peach State providers must adhere to enrollment/marketing guidelines as outlined by DCH. Those guidelines include the following:

### **Providers may:**

- Stock and distribute only state approved Peach State Member Educational Materials to Peach State members
- Inform members of particular hospital services, specialists, or specialty care available in the Peach State Plan
- Assist a member in contacting Peach State to determine if a particular specialist or service is available
- Directly contact only Peach State members with whom they have an established relationship
- Encourage pregnant Peach State members to select a PCP for their baby before the baby is born

### **Providers cannot:**

- Influence a patient to choose one health plan over another
- Influence patients based upon reimbursement rates or methodology used by a particular plan
- Enroll patients in a plan unless the physician office, clinic or site has been designated by the state as an enrollment center
- Distribute any marketing materials to a Peach State member without prior approval from Peach State and DCH



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# General Billing



## Payment of Covered Services

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Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with CBH for payment of covered services.

It is important that providers ensure CBH has accurate billing information on file.

**Please confirm with your Provider Relations Department that the following information is current in our files:**

- Provider Name (as noted on his/her current W-9 form)
- Medicaid Number
- Physical location address
- Billing name and address (if different)
- Tax Identification Number

CBH will return claims when billing information does not match the information that is currently in our files. Such claims are not considered “clean” and therefore cannot be entered into the system. The claims are then returned to the provider, creating payment delays.

We recommend that providers notify CBH in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider’s Tax Identification Number and/or address are NOT acceptable when conveyed via a claim form.

**Claims eligible for payment must meet the following requirements:**

- The member is effective on the date of service,
- The service provided is a covered benefit under the Member’s contract on the date of service, and
- Referral and prior authorization processes were approved

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.



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## Imaging Requirements

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CBH uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

### Do

- Do use the correct PO Box number
- Do submit all claims in a 9" x 12", or larger envelope whenever possible
- Do type all fields completely and correctly
- Do use black or blue ink only
- Do submit on a proper form CMS 1500 or CMS 1450

### Don't

- Do not use red ink on claim forms
- Do not circle any data on claim forms
- Do not add extraneous information to any claim form field
- Do not use highlighter on any claim form field
- Do not submit photocopied claim forms
- Do not submit carbon copied claim forms
- Do not submit claim forms via fax

## Clean Claim Definition

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A clean claim means a claim received by CBH for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by CBH. The following exceptions apply to this definition: (a) a claim for payment of expenses incurred during a period of time for which premiums are delinquent; (b) a claim for which fraud is suspected; and (c) a claim for which a Third Party Resource should be responsible.

## Non-Clean Claim Definition

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Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. The errors or omissions in claims result in CBH requesting additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or to the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

- A claim is a request for reimbursement either electronically or by paper for any medical service
- A claim must be filed on the proper form, such as CMS 1500 or CMS-1450
- A claim will be paid or denied with an explanation for the denial. For each claim processed, an Explanation of Payment (EOP) will be mailed to the provider who submitted the original claim



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## Procedures for Filing a Claim

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CBH encourages all providers to file claims/encounters electronically. See “Electronic Filing” in this section for more information on how to initiate electronic claims/encounters.

### **Please remember the following when filing your claim/encounter:**

- All documentation must be legible
- All claims and encounter data must be submitted on either form CMS 1500 or CMS 1450, or by electronic media in an approved format
- For contracted providers, all claims and encounters must be submitted within 120 days, of the date of service.
- All requests for reconsideration or adjustment to paid claims must be received within 45 days from the date the notification of payment or denial is received
- When submitting claims where other insurance is involved, a copy of the EOB or rejection letter from the other insurance carrier must be attached to the claim
- Peach State members must never be billed by any provider for covered services unless the criteria listed under “Billing the Patient” is met

## Claims Submission

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All behavioral health claims and encounters, should be submitted to:

**Cenpatico Behavioral Health  
P.O. BOX 6700  
Farmington, MO 63640-3816  
ATTN: CLAIMS DEPARTMENT**

## Electronic Filing

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Network providers are encouraged to participate in CBH Electronic Claims/Encounter Filing Program through Centene Corporation. Centene Corporation has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, Centene Corporation has the capability to generate an ANSI X12N 835 electronic explanation of payment (EOP). For more information on electronic filing, contact:

**Centene EDI Department  
1-800-225-2573, extension 25525  
or by e-mail at: EDI@centene.com**

### **NOTE:**

- Providers who bill electronically are responsible for filing claims within the same filing deadlines as stated above
- Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the claims and encounters



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## Third Party Liability (TPL)

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Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the member.

Provider shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CBH members. If the Provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources after sixty (60) calendar days of such efforts, the provider shall inform CBH, that efforts have been unsuccessful. CBH will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, CBH will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability; and pay the provider only the amount, if any, by which the provider's allowable claim exceeds the amount of third party liability coverage.

## Common Billing Errors

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In order to avoid rejected claims or encounters always remember to:

Use SPECIFIC CPT-4 or HCPCS codes. Avoid the use of non-specific or "catch-all" codes (i.e. 99070).

- Use the most current CPT-4 and HCPCS codes. Out-of-date codes will be denied
- Use the 4th or 5th digit when required for all ICD-9 codes
- Submit all claims/encounters with the proper provider number
- Submit all claims/encounters with the member's complete Medicaid number or the member's ID number
- Report other insurance information entered on claim

## Billing Codes

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It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment.

Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-9 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-9 codes and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a patient's diagnosis. We require the use of valid ICD-9 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-9 codes must be carried out to the fifth digit when indicated by the coding requirements in the ICD-9 manual (Note: not all codes require a fifth digit). The highest degree of specificity, or detail, can be determined by using the Tabular List (Volume One) of the ICD-9 coding manual in addition to the Alphabetic List (Volume Two) when locating and designating diagnosis codes.

The Tabular List gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to the fifth digit if appropriate. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.



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In addition, written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of CBH.

## Claim Payment

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Clean claims will be adjudicated (finalized as paid or denied) within fifteen (15) business days of the receipt of the claim. Non-clean claims will be adjudicated (finalized as paid or denied) within forty-five (45) days of receipt of the claim.

No later than the fifteenth (15th) business day after the receipt of a Provider claim that does not meet Clean Claim requirements, CBH will pend the claim and request additional information through the CBH Website or Explanation of Benefits for all outstanding information such that the claim can be deemed clean. Upon receipt of all the requested information from the Provider, CBH will complete processing of the Claim within fifteen (15) Business Days.

Claims pended for additional information must be closed (paid or denied) by the thirtieth (30<sup>th</sup>) Calendar Day following the date the claim is pended if all requested information is not received prior to the expiration of the 30-day period. CBH will send Providers written notification via the Website or an Explanation of Benefits for each Claim that is denied, including the reason(s) for the denial, the date Contractor received the Claim, and a reiteration of the outstanding information required from the Provider to adjudicate the Claim.

CBH shall process, and finalize, all appealed Claims to a paid or denied status within (30) Business Days of receipt of the Appealed Claim. CBH shall finalize all Claims, including appealed Claims, within twenty-four (24) months of the date of service. Appealed claims means claims regarding which a provider files a request for informal claims payment adjustment or a claim complaint with CBH.

Note: It is the provider's responsibility to check their audit report to verify that CBH has accepted their electronically submitted claim.

## Unsatisfactory Claim Payment

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If a provider has a question or is not satisfied with the information they have received related to a claim, they should contact:

**Claims Support Customer Services**  
**1-866-324-3632**

- When submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as "**RE-SUBMISSION and include the original claim number.**" Failure to mark the claim as a resubmission and include the claim number or EOP may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline
- Providers may discuss questions with CBH Provider Services Representatives regarding amount reimbursed or denial of a particular service; Providers may also submit in writing, with all necessary documentation, including the Explanation of Payment (EOP) for consideration of additional reimbursement
- Any response to approved adjustments will be provided by way of check with accompanying explanation of payment

All disputed claims will be processed in compliance with the claims payment resolution procedure as described herein.



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For an explanation regarding how to request an informal claim payment adjustment or file a complaint refer to the process described herein.

## Billing Forms

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Providers submit claims using standardized claim forms whether filing on paper or electronically.

Submit claims for professional services on a CMS 1500. The following areas of information on CMS 1500 claim forms are common submission requirements of a clean claim accepted for processing:

- Full patient name
- Patient’s date of birth
- A valid member identification number
- Complete service level information:
  - Date of service
  - Diagnosis
  - Place of service
  - Procedural coding (appropriate CPT-4, ICD-9 codes)
  - Charge information and units
- Servicing provider’s name, address and Medicaid Number
- Provider’s federal tax identification number
- All mandatory fields must be complete and accurate

Submit claims for hospital based inpatient and outpatient services as well as swing bed services on a UB 92.

## Completing a CMS 1500 Form

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All medical claims are to be submitted on the CMS 1500.

The CMS 1500 claim form is required for:

- All professional services “including specialists”
- Individual providers
- Non-hospital outpatient clinics
- Professional and/or technical components of hospital based physicians and Certified Registered Nurse Anesthetists (CRNAs)

The CMS 1500 **must** provide all requested information to receive payment for services rendered. Failure to do so may result in delayed or denied reimbursement.

CBH requires all **CAPITALIZED, BOLD TYPE FIELDS** to be completed. Failure to complete these fields may cause the claim or encounter to be rejected. An asterisk next to a capitalized, bold type (required) field indicates required if applicable. Listed below are the field numbers and names, along with explanations of the fields. CBH accepts Georgia Department of Community Health (DCH) approved and recognized coding as defined in the DCH Billing Instruction Manual (BIN.1001.2)

FIELD#	FIELD NAME	DESCRIPTION
1	PROGRAM BLOCK	Check the appropriate plan block.



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FIELD#	FIELD NAME	DESCRIPTION
1a	MEMBER'S ID	Enter the patient's 12-digit billing number as it appears on the patient's ID card.  <b>REQUIRED</b>
2	Member's Name	Member's last name, first name, and, middle initial <b>REQUIRED</b>
3	Member's Birth Date	Month, day, and, year of the member's birth. <b>REQUIRED</b>
	Member's Sex	M (male) or F (female).
4	Member's Name	"Same" indicates that the insured and the patient name in Field 2 are the same.
5	Member's Address	Street, city, state, ZIP code, area code and phone number.
6	Member's Relation to Insured	Not Required.
7	Insured's Address	Not Required.
8	Member's Status	Marital status (single, married, other), employment status, and student status (full-time, part-time).
9	*OTHER INSURED'S NAME	If the member has no coverage other than CBH, field should be blank. If other coverage exists, the name of the insured should be entered. "Same" indicates that the other insured's name is the same as the Peach State member. <b>REQUIRED, if applicable</b>
9a	*OTHER INSURED'S GROUP NUMBER	Group number of the other insurance <b>REQUIRED, if applicable</b>
9b	Other Insured's DOB/Sex	Not Required
9c	*OTHER INSURED'S EMPLOYER/SCHOOL	Name of organization, such as the employer of the insured or the school, that makes insurance available. <b>REQUIRED, if applicable</b>
9d	*INSURANCE PLAN OR PROGRAM NAME	Name of insurance company or program that provides the insurance coverage. <b>REQUIRED, if applicable</b>
10a - 10c	*RELATION OF MEMBER CONDITION	Indicates whether member's condition is the result of employment, auto accident, or other type of accident. <b>REQUIRED, if applicable</b>
11	INSURED'S GROUP POLICY HFCA#	Not Required
11a	*INSURED'S DOB/SEX	<b>REQUIRED, if applicable</b>



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FIELD#	FIELD NAME	DESCRIPTION
11b	*EMPLOYER'S NAME OR SCHOOL NAME	<b>REQUIRED, if applicable</b>
11c	*INSURANCE PLAN NAME OR PROGRAM NAME	<b>REQUIRED, if applicable</b>
11d	*OTHER HEALTH BENEFIT PLAN	If "Yes" is checked, Fields 9a-9d should be completed. <b>REQUIRED, if applicable</b>
12	Member or Authorized Person's Signature	Patient's signature authorizes release of medical or treatment data.
13	Member's or Authorized Person's Signature	Not Required.
14	DATE OF ILLNESS OR INJURY	Date of onset of symptoms or date of injury, if available. <b>Not Required</b>
15	Date of Same or Similar Illness	Not Required.
16	DATES MEMBER UNABLE TO WORK IN CURRENT OCCUPATION	Not Required
	*NAME OF REFERRING PHYSICIAN	Name of referring physician if patient was referred or another physician ordered service. A "0" indicates the service billed was not a referral. Not REQUIRED,
17a	ID NUMBER OF REFERRING PHYSICIAN	Not Required.
	*HOSPITALIZATION DATES	From and To dates of hospitalization related to service billed on claim. <b>REQUIRED, if applicable</b>
19	EPSDT/Referral Code(s)	Required for EPSDT services.
20	Outside Lab	Indicates whether outside lab work was performed as part of service. If outside lab work was performed, charges for these services are entered.
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Primary Diagnosis Code (ICD-9 code) along with Secondary Diagnosis Code billed to the appropriate 4 <sup>th</sup> and 5 <sup>th</sup> digit where indicated. <b>REQUIRED</b>
22	Resubmission code	Not Required
23	PRIOR AUTHORIZATION NUMBER	Not required



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FIELD#	FIELD NAME	DESCRIPTION
24A	DATE(S) OF SERVICE	Month, day, and year on which the service began and ended in MM/DD/YY format. If the service was completed in one day, the FROM and TO dates will be the same. A separate line is needed for each date of service. <b>REQUIRED</b>
24B	CMS STANDARD PLACE OF SERVICE CODE	Must use 2 digit numeric CMS 1500 standard location codes as defined in the DCH Billing Instruction Manual (BIN.1001.2) <b>REQUIRED</b>
24C	Type of Service	Not Required
24D	PROCEDURE	The CPT/HCPC/ASA procedure code that identifies the service provided to the member. <b>REQUIRED</b>
	*PROCEDURE MODIFIER	Enter the appropriate two-digit modifier. The appropriate Medicaid Handbook should be referenced for further details regarding the use of modifiers.  <b>Required if applicable</b>
24E	DIAGNOSIS	Enter the appropriate diagnosis pointer, as stated in Field 21, as it relates to the particular service line by indicating the line number of the diagnosis. More than one diagnosis referenced may be entered for each procedure. If more than one is entered, they should be in descending order of importance. The diagnosis code itself is NOT entered in field 24E, only the reference to Field 21. <b>REQUIRED</b>
24F	CHARGES	Total charges for each service line reported. If more than 1 unit of the service is provided, the charges for all units should be entered. <b>REQUIRED</b>
24G	DAYS OR UNITS	Enter the number of units of service in whole numbers. Services that can be submitted with units greater than one include but are not limited to allergy tests, injectibles, certain diagnostic and medical supply codes. <b>REQUIRED</b>



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FIELD#	FIELD NAME	DESCRIPTION
24I	EMERGENCY/ Co-Pay	A "Y" indicates that the service was an emergency service. Medicare requires a check only if provided in an emergency room. Emergency should be indicated on each line applicable. If the member is eligible for emergency services only or if no PA has been obtained as required, the claim will be denied if the service is/was not an emergency. Documentation to substantiate the emergent nature of the service will not be reviewed if the service is not indicated as an emergency.  Co-pay exclusion indicator (P,S,H or E)
24J	COB	Not Required
24K	<i>RESERVED FOR LOCAL USE</i>	Six-digit, CBH assigned provider ID number required. Not REQUIRED
25	FEDERAL TAX ID	<b>REQUIRED</b>
26	Patient's Account Number	Enter your internal patient tracking number. Optional
27	Accept Assignment	Not Required.
28	TOTAL CHARGES	Total for all charges for all lines on the claim. <b>REQUIRED</b>
29	*AMOUNT PAID	Total amount that the provider has been paid for the claim by all sources other than CBH. Payments expected from CBH should NOT be entered. <b>REQUIRED, if applicable</b>
30	BALANCE DUE	The difference between total charges in Field 28 and the sum of payments in Field 29. <b>REQUIRED</b>
31	SIGNATURE	Claim must be signed by the provider submitting the claim or by an authorized representative. Rubber stamp signatures are acceptable but must be initialed by a provider representative. <b>REQUIRED</b>
	DATE	Date on which the claim was signed. <b>REQUIRED</b>



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FIELD#	FIELD NAME	DESCRIPTION
32	Name and address of facility where services were provided	List facility where services were rendered. This field should be completed to assist CBH with contacting you should the need arise.
33	PROVIDER NAME, ADDRESS, AND PHONE	Name, address, and phone number of the provider rendering service. If the group is billing, the group biller's name, address, and, phone should be entered. Your CBH 6-digit provider identification number is required. <b>REQUIRED</b>
	GROUP ID	Not applicable



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## CMS 1500 Standard Codes

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*Not all of these are appropriate for Behavioral Health*

### **Place of Service Codes**

00 -10	Not in Use
11	Office
12	Home
13 - 20	Not in Use
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27 - 30	Not in Use
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35 – 40	Not in Use
41	Not Valid
42	Not Valid
43 – 50	Not in Use
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Immediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57 - 60	Not in Use
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63, 64	Not in Use
65	End Stage Renal Disease Treatment Facility
66 – 70	Not in Use
71	State or Local Public Health Clinic
72	Rural Health Clinic
73 – 80	Not in Use
81	Independent Laboratory
82 - 98	Not in Use
99	Other Unlisted Facility



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## Completing a CMS 1450 Claim Form

A CMS 1450 is the only acceptable claim form for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by CBH. CMS 1450 Incomplete or inaccurate information will result in the claim/encounter being rejected or denied for corrections.

### CMS 1450 Hospital Outpatient Claims

The following information applies to outpatient claims:

- Professional fees must be billed on a CMS 1500 claim form
- Include the appropriate CPT-4 code next to each revenue code

### CMS 1450 Claim Instructions

CBH requires all **CAPITALIZED, BOLD TYPE FIELDS** to be completed. Failure to complete these fields may cause the claim/encounter to be rejected. An asterisk next to a capitalized, bold type (required) field indicates required if applicable. Listed below are the field numbers and names, along with explanations of the fields. CBH accepts approved and recognized coding as defined in the Georgia Medicaid Hospital Handbook.

FORM LOCATOR	CONTENTS	REQUIRED/ NOT REQUIRED
1	REMIT PAYMENT TO	<b>REQUIRED</b>
2	Unassigned	Not Required
3	Patient Control Number	NOTE: Number assigned by provider. CBH will use number as cross-reference on Claims Correction Letters for claim. <b>REQUIRED</b>
4	TYPE OF BILL	NOTE: Describes type of facility (1st digit), classification (2nd digit), and frequency (3rd digit). <b>REQUIRED</b>
5	FEDERAL TAX NUMBER	Maintained in CBH provider records. <b>REQUIRED</b>
6	STATEMENT COVERS PERIOD, FROM/THROUGH	Enter the beginning and ending service dates included on this bill. For all service rendered on a single day, use both the FROM and THROUGH dates. <b>REQUIRED</b>
7	COVERED DAYS	Enter the number of days for the statement covers period. <b>REQUIRED</b> for Inpatient and RTC.
8	Non-covered Days	Not Required
9	Coinsurance Days	Not applicable
10	Lifetime Reserve Days	Not applicable
11	Unlabeled	Not applicable



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FORM LOCATOR	CONTENTS	REQUIRED/ NOT REQUIRED
12	Member NAME	Last name, first name and middle initial of the member. <b>REQUIRED</b>
13	Member Address	
14	BIRTHDATE	Enter member's date of birth in a MMDDYY format. <b>REQUIRED</b>
15	SEX	Enter the member's sex. Not <b>REQUIRED</b>
16	MS	Enter the member's marital status. Not Required
17	ADMISSION DATE	Enter the date the patient was admitted for inpatient care. <b>REQUIRED</b> for inpatient
18	ADMISSION HOUR	Enter the appropriate two-digit code as defined in the Georgia Medicaid Hospital Handbook <b>REQUIRED</b> for inpatient
19	TYPE OF ADMISSION	Enter the appropriate one-digit code as defined in the Georgia Medicaid Handbook. <b>REQUIRED</b> for Inpatient and RTC
20	Source of Admission	Enter the appropriate one-digit code as defined in the Georgia Medicaid Hospital Handbook. <b>REQUIRED</b> for Inpatient and LTC
21	Discharge Hour	Enter the appropriate two-digit code as defined in the Georgia Medicaid Hospital Handbook <b>REQUIRED</b> for Inpatient and LTC
22	PATIENT STATUS	Enter the appropriate two-digit code as defined in the Georgia Medicaid Hospital Handbook <b>REQUIRED</b> for Inpatient and LTC
23	*MEDICAL RECORD NUMBER	NOTE: The provider assigns The Medical Record Number to the member's medical/health record. It is not the same as the Patient Control Number (Form Locator 3). <b>REQUIRED</b> , if applicable
24 - 30	*CONDITION CODES	
31	Unassigned	Not Required
32 - 35 a-b	*OCCURRENCE CODES/DATE	
36 a-b	OCCURRENCE SPAN CODE, FROM/THROUGH DATE	Not Required
37	Unlabeled Field	Not Required
38	Unlabeled Field	Not Required



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FORM LOCATOR	CONTENTS	REQUIRED/ NOT REQUIRED
39 - 41	*VALUE CODES AND AMOUNTS	Enter the appropriate two-digit
42	REVENUE CODE	Enter the applicable revenue code that identifies the specific accommodation, ancillary service, or billing calculation. The appropriate three-digit, numeric revenue code must be entered to explain each charge entered in form locator 47. <b>REQUIRED</b>
43	*REVENUE DESCRIPTION	Enter a narrative description of the related revenue categories on this bill.  <b>REQUIRED</b> , if applicable
44	*HCPCS/RATES	Enter the CPT/HCPC's code applicable to the service provided. Only one service code per line is permitted. <b>REQUIRED</b> , if applicable
45	*SERVICE DATES	The date the indicated service was provided. <b>REQUIRED</b> for Outpatient, if applicable.
46	UNITS OF SERVICE	Enter the number of units corresponding to the revenue code (or HCPCS code) billed. <b>REQUIRED</b>
47	TOTAL CHARGES	Enter the total charges pertaining to the related revenue code for the statement covers period. Enter revenue code 001 to indicate totals, with the sum of all charges billed reflected in the form locator 47. <b>REQUIRED</b>
48	Non-covered charges.	Not Required
49	Unassigned	Not Required
50 a-c	*PAYER IDENTIFICATION	Enter the appropriate payer name <b>REQUIRED</b> , if applicable
51 a-c	PROVIDER NUMBER	Your CBH 6-digit provider identification number is requested. Not Required
52 a-c	Release of information	Not Required
53 a-c	Assignment of Benefits	Not Required
54 a-c, p	PRIOR PAYMENTS	Not Required
55 a-b	ESTIMATED AMOUNT DUE	Not applicable
55c	ENTER AMOUNT BILLED	Not Required
56	Unassigned	Not Required
57	DUE FROM MEMBER	Not Required
58	*INSURED'S NAME	Enter member's Last Name, First Name and Middle Initial. <b>REQUIRED</b> , if applicable



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FORM LOCATOR	CONTENTS	REQUIRED/ NOT REQUIRED
59	Relationship to Insured	Not Required
60	CERTIFICATE, SSN, HIC NUMBER	Enter the patient's 12-digit billing number as it appears on the patient's Peach State member ID card <b>REQUIRED</b>
61	*INSURED'S GROUP NAME	Enter the name of the group or plan through which the insurance is provided, to the member, by the respective payers entered in form locators 50a-c. <b>REQUIRED</b> , if applicable
62	*INSURANCE GROUP NUMBER	Enter the identification number(s), control number(s), or code (s) assigned by the carrier of administrator to identify the group(s) under which the individual is covered (see form locators 50a-b). Include the policy number. <b>REQUIRED</b> , if applicable
63 a-c	TREATMENT AUTHORIZATION	Not Required
64 a-c	EMPLOYMENT STATUS	Not Required
65 a-c	EMPLOYER NAME	Not Required
66 a-c	EMPLOYER LOCATION	Not Required
67	PRINCIPLE DIAGNOSIS CODE	Enter the ICD-9 diagnosis code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.) <b>REQUIRED</b> for Inpatient, Outpatient, LTC, Hospice, ASC and Home Health.
68 - 75	*OTHER DIAGNOSIS CODES	Required, if applicable
76	*ADMITTING DIAGNOSIS CODE	Enter the ICD-9-CM diagnoses codes provided at the time of admission as stated by the physician. <b>REQUIRED</b> for Inpatient.
77	E-Code	Not Required
78	DRG	<b>REQUIRED</b> for inpatient only
79	Procedure Coding Method	Not required



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FORM LOCATOR	CONTENTS	REQUIRED/ NOT REQUIRED
80	*PRINCIPLE PROCEDURES CODE/DATE	Enter the ICD-9 diagnosis procedure code(s) that identify the principle procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed.
81	*OTHER PROCEDURES & DATES	Enter the ICD-9-CM procedure codes identifying all significant procedures other than the principal procedure, and the dates (identified by code) on which the procedures were performed.
82	ATTENDING PHYSICIAN	Enter the Georgia license number of the physician who would normally be expected to certify and re-certify the medical necessity of the services rendered and/or who is primarily responsible for the patient's medical care and treatment Not Required
83	OTHER PHYSICIANS ID	Enter the Georgia license number of the physician performing the principal procedure or the admitting physician. Not required
83b	Other Physicians ID	Not applicable
84	Remarks	Not applicable
85	PROVIDER REPRESENTATIVE	An authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. A stamped signature is acceptable; however, a typed signature is not. <b>REQUIRED</b>
86	DATE	Enter the date the bill is submitted. <b>REQUIRED</b>



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## Billing the Member

CBH reimburses only services that are medically necessary and covered through Medicaid. Providers can bill a member only if they provide proof that they attempted to obtain member insurance identification information within 180 days of service. See the Georgia DCH Provider Manual for additional explanation and instruction regarding member co-payment services.

### APPLICABLE CO-PAYMENTS

Children under age 21, pregnant women, nursing facility residents and Hospice care members are exempted from co-payments.

There are no co-payments for family planning services and for emergency services except as defined below.

Services cannot be denied to anyone based on the inability to pay these co-payments.

Service	Additional Exceptions	Co-Pay Amount	
FQHC/RHCs		A \$2 co-payment on all FQHC and RHC.	
Outpatient		A \$3 member co-payment is required on all non-emergency outpatient hospital visits	
Inpatient	Members who are admitted from an emergency department or following the receipt of urgent care or are transferred from a different hospital, from a skilled nursing facility, or from another health facility is exempted from the inpatient co-payment.	A co-payment of \$12.50 will be imposed on hospital inpatient services	
Emergency Department		A \$6 co-payment will be imposed if the Condition is not an Emergency Medical Condition	
Prescription Drugs		Drug Cost:	Co-pay Amount
		<\$10.01	\$0.00
		\$10.01 - \$25.00	\$0.50
		\$25.01 - \$50.00	\$1.00
		\$50.01 - \$100.00	\$2.00
		>\$100.01	\$3.00



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## Member Acknowledgement Statement

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A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the Member has exceeded the program limitations for a particular service only if the following condition is met:

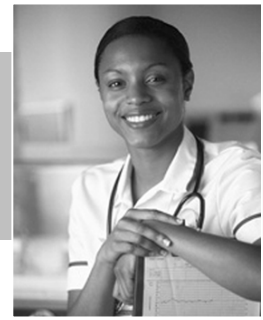
Prior to the service being rendered, the provider has obtained and kept a written **Member Acknowledgement Statement** signed by the client that states:

*"I understand that, in the opinion of (**provider's name**), the services or items that I have requested to be provided to me on (**dates of service**) may not be covered under the Georgia Department of Community Health Services as being reasonable and medically necessary for my care. I understand that Peach State through its contract with the Department of Community Health determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."*



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# Provider Complaints and Administrative Reviews



## Inquiry, Claims Adjustment, Administrative Review and Provider Complaints

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### Claims-Specific Processes

*Providers should exhaust each level of the claims inquiry and resolution process before initiating the next level.*

#### 1. Status inquiries

To check the status of previously submitted claim(s), providers should contact the CBH Provider Services Department at 1-800-947-0633, Monday through Friday 7:00 a.m. to 7:00 p.m. Providers should have the servicing provider's name, member name, member ID number, date of birth, date of service and claim number, if applicable.

#### 2. Resubmitted claims

Providers may resubmit claims, clearly marking them with the word "resubmission" and the claim number, usually to correct simple or basic errors in the original submission and to qualify the claim as a clean claim. Resubmissions usually are received by CBH within the first 45 days following initial filing of a non-clean claim.

#### 3. Informal claim payment adjustment

An informal claim payment adjustment typically corrects an error in processing, for example, typographical errors, contractual payment errors, or supported timely filing reconsiderations. Informal adjustment requests normally are filed after the (maximum) 45-day period that follows initial filing of a claim (in other words, after the claim is either paid in part or denied within 45 days following initial filing of the claim).

#### 4. Claim complaint

Providers may file a claim complaint to seek a reconsideration or exception to a plan policy or contract requirement such as benefit limitations, eligibility, failure to obtain authorization or reconsideration related to CBH code auditing process or unsupported timely filing. Claim complaints also are filed after the 45 day (maximum) period that follows initial filing of the claim.

#### 5. Claims audits

CBH uses claims audits to ensure accuracy of the claims payment process.

### Administrative review

A request for administrative review is a request for review of a Proposed Action, which includes certain adverse decisions made by the plan Medical Management Department. Providers may request an administrative review on behalf of a member so long as they submit to CBH within 30 days of the date of the Proposed Action written member consent for the provider to act on the member's behalf.



Provider Services Department  
1-800-947-0633

## Provider complaints

CBH's provider complaint system permits providers to dispute CBH's policies, procedures, or any aspect of CBH administrative functions (including the process by which CBH handles Proposed Actions and EOPs), other than the specific claims and administrative review matters described above.

Provider complaints must be submitted in writing (or via the CBH website) to the CBH Provider Complaint Coordinator.

## Second level review by Peach State Health Plan following administrative review or provider complaint review by CBH

Providers who:

- File a request for administrative review on behalf of a member, or a provider complaint on their own behalf, and
- Are not satisfied with CBH's disposition of the administrative review or provider complaint may request a second level review by Peach State Health Plan of CBH's disposition of the administrative review or provider complaint. Peach State's second level review of an administrative review determination by CBH has no impact on the member's concurrent right to request a fair hearing from the state.

## Status Inquiries

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To check the status of previously submitted claim(s), providers may use the CBH website or contact the CBH Provider Services Department at 1-800-947-0633, Monday through Friday 7:00 a.m. to 7:00 p.m. Providers should have the servicing provider's name, member name, member ID number, date of birth, date of service and claim number, if applicable.

## Resubmitted Claims

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Resubmitted claims should be sent to:

**Cenpatico Behavioral Health**  
**PO Box 6700**  
**Farmington, MO 63640-3816**  
**ATTN: CLAIMS DEPARTMENT**

Resubmitted claims should be clearly marked at the top with the word **RESUBMISSION** and the claim number.

*Providers resubmitting claims must attach a statement along with documentation, including the EOP explaining the reason for resubmission.*

Reasons for resubmission include but are not limited to:

- Provider has corrected the claim (for example, previously submitted wrong diagnosis, etc.)
- Denial for other insurance
- Problem with electronic filing, now sending paper claim
- No payment received within 45 days of initial filing of claim. **Providers must make sure the resubmitted claim is at least forty-five (45) days old before resubmission, and clearly mark and identify the claim as a resubmission and the claim number. This will help to ensure that the claim is not denied as a duplicate or for exceeding the filing limit deadline.**



**Provider Services Department**  
**1-800-947-0633**

## **Informal Claim Payment/Adjustment Dispute Resolution**

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If a provider believes that an improper payment of a claim for covered Medicaid services has occurred through either the omission of information, submission of incorrect claims data, and/or systems error, an adjustment may be requested by submitting a copy of the Explanation of Payment (EOP) along, with a completed adjustment form. Adjustments should be submitted within 45 calendar days from the date of the EOP to the following address:

**Cenpatico Behavioral Health  
PO Box 6700  
Farmington, MO 63640-3816  
ATTN: CLAIMS DEPARTMENT**

## **Claim Complaint**

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A provider may request that a specific issue be re-evaluated by CBH. A claim complaint should be submitted in writing, within 45 calendar days of the adverse finding (usually the date of the EOP) and clearly marked "Claim Complaint" on the letter. Included in the letter should be why the claim or issue merits reconsideration, and a copy of both the claim in question and the EOP. If applicable, the provider should also include medical records, chart notes and/or other pertinent information to support the request for reconsideration.

An acknowledgement letter will be sent within five business days of receipt of the complaint. If the initial claim determination is upheld, the provider will be notified in writing within 30 business days of CBH's receipt of the claim complaint. If the initial claim determination is overturned, the provider will be notified through a newly issued EOP.

## **Claim Payment Audits**

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CBH audit review nurses will perform retrospective review of claims paid to providers to ensure accuracy of the payment process. If a claim is found to be overpaid, the amount will be recouped against future claim payments. A letter will be sent to the provider notifying them of the reason for the recoupment and the amount.

## **Medical Management Administrative Review**

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Providers may request on behalf of a member an Administrative Review of a Proposed Action, in particular, when a decision is made by Medical Management to deny a service, in whole or in part (including type or level), or to reduce, suspend or terminate a service previously authorized for a member. The provider must obtain and provide to CBH the written consent of the member to file an Administrative Review on behalf of the member. Requests for Administrative Review should be clearly marked as requests for "Administrative Review." Provider requests labeled as requests for administrative review, but which are not accompanied by written member consent or for which such consent is not provided within 30 days of receipt of the Notice of Proposed Action, will be processed as provider complaints.



**Provider Services Department  
1-800-947-0633**

Standard requests for administrative review (including written member consent) must be received by CBH within 30 days of the date of the Proposed Action that they concern. Written requests for administrative review should be submitted to:

**Cenpatico Behavioral Health  
ATTN: Appeals Coordinator  
5806 Mesa Drive, Suite 350  
Austin, Texas 78731**

During the administrative review process, CBH will continue the member's benefits if the member or the members authorized representative files the request for administrative review timely (as specified in this subsection); the administrative review involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of the benefits. As used in this paragraph, timely filing means filing on or before the later of the following: (1) Within ten (10) Calendar Days of CBH mailing the Notice of Adverse Action, (2) The intended effective date of CBH's Proposed Action.

The timeframe for determinations on standard requests for administrative review is within no more than 45 days from CBH receipt of the request for the review, subject to an authorized extension of up to 14 days.

If a decision on an administrative review request is needed immediately due to the Member's health condition, providers may request an expedited administrative review. A decision for this review will be made within no more than 72 hours from CBH receipt of the request for the review, subject to an authorized extension of up to 14 days. Requests for expedited administrative review should be submitted electronically through the CBH website or by calling 1-800-947-0633.

All Medical Management Administrative Reviews will follow the guidelines of the Administrative Review process located in the Member Services section of this Provider Manual.

Providers who:

- File a request for administrative review on behalf of a member, and
- Are not satisfied with CBH's disposition of the administrative review

may request a second level review by Peach State Health Plan of CBH's disposition of the administrative review. Peach State's second level review of an administrative review determination by CBH has no impact on the member's concurrent right to request a fair hearing from the state. Providers must file second level review requests with Peach State in writing within 30 days of the date of CBH's Notice of Adverse Action, by mailing the request to:

**Peach State Health Plan  
Administrative Review  
P.O. BOX 6000  
Farmington, MO  
63640-3816**

Peach State completes second level reviews of CBH administrative review determinations within 45 days of receipt of the request for second level review.



**Provider Services Department  
1-800-947-0633**

## **Provider Complaints**

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CBH's provider complaint system permits providers to dispute CBH's policies, procedures, or any aspect of CBH administrative functions (including the process by which CBH handles Proposed Actions and EOPs), other than the specific claims and administrative review matters described above. Provider complaints must be submitted in writing (or via the CBH website) to the CBH Provider Complaint Coordinator at:

**Cenpatico Behavioral Health  
ATTN: Complaint Coordinator  
5806 Mesa Drive, Suite 350  
Austin, TX 78731**

Provider complaints must be filed within 45 days of the date of the event or occurrence addressed in the complaint. Within 30 business days of receipt of each timely filed provider complaint, the Provider Complaint Coordinator mails or electronically transmits to the provider written notice of CBH's resolution of the complaint. Providers with questions regarding provider complaints should call the Provider Services Department at 1-800-947-0633.

Providers who:

- File a provider complaint, and
- Are not satisfied with CBH's disposition of the provider complaint

may request a second level review by Peach State Health Plan of CBH's disposition of the provider complaint. Providers must file second level review requests with Peach State in writing within 30 days of the date of CBH's written notice of determination regarding the provider complaint, by mailing the request to:

**Peach State Health Plan  
Provider Complaint Coordinator  
3200 Highlands Parkway SE  
Suite 300  
Smyrna, GA 30082**

Peach State completes second level reviews of CBH administrative review determinations within 45 days of receipt of the request for second level review.



**Provider Services Department  
1-800-947-0633**

# Credentialing



## **CBH Credentialing Requirements**

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The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by CBH, as well as government regulations and standards of accrediting bodies such as URAC.

**Notice:** In order to maintain a current provider profile, providers are required to notify CBH of any relevant changes to their credentialing and re-credentialing file in a timely manner.

**Physicians and other providers must submit at a minimum the following information when applying for participation in the CBH network:**

- Complete signed and dated Georgia Department of Insurance Standardized Credentialing Form
- Signed and dated release of information form
- Attestation of history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance and/or alcohol abuse; and mental and physical competence
- CBH Provider Specialty Profile
- Core Competencies Profile
- Signed Cenpatico Behavioral Health Provider or Group Provider Agreement (CBH will complete the execution date)
- W-9
- Current unrestricted Georgia Medical License
- Current Department of Public Safety (DPS) registration certificate (if applicable)
- Current Drug Enforcement Administration (DEA) registration certificate
- Current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage of \$1,000,000/\$3,000,000 and provider's name. (An explanation of any liability lawsuits).
- Copy of ECFMG certificate, if applicable
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history (mm/yy format). An explanation of any gaps of (six) 6 months or longer in your work history
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training

Once the application is completed, the CBH Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting.

Providers must be credentialed prior to accepting or treating members.



**Provider Services Department**  
**1-800-947-0633**

## CBH Credentialing Committee

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The CBH Credentialing Committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination and direction of the credentialing procedures, including provider participation, denial and termination.

The CBH Credentialing Committee meets monthly, at a minimum 10 times per year.

## Criteria for Provider Participation

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**A set of minimum level criteria established by CBH will be used to determine physicians' and other professional providers' participation. The minimum criteria include:**

- A current unrestricted Georgia license to practice medicine
- An individual DCH provider number
- A valid, unrestricted DPS Certificate
- A valid, unrestricted DEA Certificate
- Satisfactory review of a five year work history (MM/YY format) via the Provider Application or curriculum vitae with no unexplained gaps of employment over six (6) months
- Evidence of current malpractice/professional liability insurance in the amounts of \$1,000,000/\$3,000,000 or as otherwise required by Georgia state law and DCH
- Professional liability claims history for a five (5) year period, which is reviewed by and found acceptable to the Credentialing Committee. When reviewing this history, the Committee will consider the frequency of the cases(s) and their outcome.
- A National Practitioner Data Bank (NPDB) query and Healthcare Integrity and Protection Data Bank (HIPDB) query which is reviewed by and found acceptable to the Credentialing Committee.
- Completed facility site review with a passing score set by CBH when applicable (Pending further notice on State of Georgia requirements)
- Signed Cenpatico Behavioral Health Provider or Group Provider Agreement (CBH will complete the execution date)

**An applicant applying for participation must include a signed application and in doing so:**

- Signifies willingness to appear for interviews with regard to his/her application
- Agrees to adequately respond to a request for assistance during the application process. (Failure to respond may result in termination of the application process.)
- Authorizes CBH representatives to consult with others who have been associated with him/her and/or who have information bearing on his/her competence and qualifications
- Releases from any liability all CBH representatives for their acts performed in good faith and without malice in connection with evaluation of his/her credential



Provider Services Department  
1-800-947-0633

## CBH Re-Credentialing

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To comply with URAC standards, CBH conducts the recredentialing process for providers at least every three years from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the provider's licensure, sanctions, certification, competence or health status, which may affect the ability to perform services the provider is under contract to provide. This process includes all ancillary providers and/or facilities previously credentialed to practice within the CBH network.

A CBH Provider or group Provider Agreement may be terminated if it is determined by CBH Board of Directors or the Credentialing Committee that participation requirements are no longer being met.

## Credentialing of Health Delivery Organizations

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Prior to contracting with Health Delivery Organizations (HDOs), CBH verifies that the following organizations have been approved by a recognized accrediting body or meet CBH standards for participation, and are in good standing with state and federal agencies:

Hospital or Facility
Community Service Board
CMHC
FQHC
RHC
Significant Traditional Provider

CBH recognizes the following accrediting bodies:\*

- CARF -Commission on Accreditation of Rehabilitation Facilities
- CLIA - Clinical Laboratory Improvement Amendment certification  
(Please note: Certification required not just CLIA license)
- JCAHO -Joint Commission on Accreditation of Healthcare Organizations.
- NCQA - National Committee for Quality Assurance
- URAC - Utilization Review Accreditation Commission

\* This list may not be inclusive of all accrediting organizations

For those organizations that are not accredited and licensed, an on-site evaluation will be scheduled to review the scope of services available at the facility, physical plant safety, and the quality improvement program. A current Centers for Medicare and Medicaid Services (CMS) certificate will be accepted in lieu of a formal site visit, and can be utilized to augment the information required to assess compliance with CBH standards.

HDOs are re-credentialed at least every three (3) years to assure that the organization is in good standing with state and federal regulatory bodies, has been reviewed and approved by an accrediting body (as applicable), and continues to meet CBH participation and QI requirements.



Provider Services Department  
1-800-947-0633

## **Right to Review and Correct Information**

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All providers participating with CBH have the right to review information obtained by the Plan to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the Georgia Composite State Board of Medical Examiners.

This does not allow a provider to review references, personal recommendations or other information that is peer review protected.

Should you believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a provider, you have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the provider will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to CBH. The CBH Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.



**Provider Services Department**  
**1-800-947-0633**

# Quality Improvement Program



## CBH Quality Improvement Program

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CBH Quality Improvement (QI) Program provides a structure and process by which quality of care and service is defined, continually monitored, and improvements implemented and refined across time. The scope of CBH's Quality Improvement Plan (QIP) is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service. The scope of the QIP ensures that all demographic groups, care settings, and services are included in QI activities. The scope may include, but is not limited to, monitoring of the following:

- Compliance with clinical practice guidelines
- Adherence to treatment record standards
- Adverse incidents and quality of care concerns
- Continuity and coordination of care
- Under and over utilization
- Appointment availability
- After hours telephone accessibility
- Member satisfaction
- Provider satisfaction
- Complaints and appeals
- Geographic access
- Departmental performance and service

## Network Provider Participation in the QI Process

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All providers are expected to monitor and evaluate their own compliance with performance requirements to assure the quality of care and service provided.

Providers are expected to meet CBH performance requirements, to assure that treatment is efficient and effective by:

- Cooperating with medical record reviews and reviews of telephone and appointment accessibility
- Cooperating with the CBH complaint review process, including timely review and response to member complaints
- Cooperating with reviews of quality of care issues and adverse outcomes

In addition, network providers are invited to participate in CBH Physician Advisory, Quality Improvement and Credentialing Committees.



Provider Services Department  
1-800-947-0633

## Continuous Performance

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The CBH Quality Improvement Program (QIP) allows for continuous performance of quality improvement activities, and has established mechanisms to track issues over time.

The QI Work Plan is utilized by the QI Department to manage projects and by the QI Committees and Subcommittees, and CBH Board of Directors to monitor progress. The Work Plan is modified throughout the year with approval from the state. Modifications are reported to the Board of Directors and appropriate QI committees.

## Provider Review

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The CBH QIP provides for review of the process followed in the provision of behavioral health services through the QI Committee and subcommittees. The responsibilities of the QIP include monitoring and evaluating aspects of care and services by CBH providers to their members. The Provider Advisory Committee, a subcommittee of the QIC, is a multidisciplinary committee composed of behavioral health providers and representatives from other departments of CBH.

## Feedback on Physician Specific Performance

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As part of the re-credentialing process, performance data on each provider is reviewed and evaluated by the Credentialing Committee. This review of provider specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, after hours access, and in office waiting time
- Compliance with clinical practice guidelines
- Sentinel events and/or adverse outcomes
- Complaint and appeal data

## Feedback after Focused Studies

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Results from focused studies and audits are shared with providers either at the time of the audit or by follow-up letter.

## Feedback of Aggregate Results

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Aggregate results of studies and guideline compliance audits are presented to the QI committee and the Provider Advisory Committee where participating providers give vital input into action plans and serve as a liaison with providers within the community. Aggregate results may be published in a special provider mailing.

When a guideline, indicator, or standard is developed in response to a documented quality of care deficiency, CBH disseminates the materials through an in-service training program to upgrade providers' knowledge and skills.



Provider Services Department  
1-800-947-0633

## **Confidentiality**

Confidentiality is an extremely high priority for CBH. CBH complies with all federal and state legal codes pertaining to mental health and substance abuse procedures for storing, maintaining, and releasing member information in order to guarantee member confidentiality.

## **Release of Member Information**

Mental health/substance abuse providers must protect and facilitate member information disclosure requests when appropriate consent is given by the member/guardian.

For disclosure of member specific information, individuals or organizations requesting mental health treatment information must submit to the network provider a written request describing:

- The information that is requested
- Intended use or uses of the information
- Length of time the information will be kept before it is destroyed
- A statement that the information will not be used for other purposes and will be destroyed within the designated time frame

This request for information must be signed by the person requesting the information or an authorized agent of the entity requesting the information. Network providers should then document in treatment records that the request letter was, on a specific date, delivered to the member.

In connection with obtaining consent, the member or representative must be informed in writing within 30 days of a request, in a manner that assures his/her understanding of the specific type of information that has been requested, and if known, the benefits and disadvantages of releasing the information. Aside from certain limited disclosures allowed or mandated by law, the member's written consent is required if the data requested contains alcohol/drug abuse, psychiatric treatment, Human Immunodeficiency Virus (HIV), or HIV-related information.

Absent a statutory or contractual implied consent, any member 18 years of age or older must consent in writing to any release of information prior to the release. For any member who does not have the legal right to sign the authorization form (i.e., member is deemed incompetent or is a minor under the age of 18), the responsible guardian, parent, or other family member must consent in writing to any release of information. When one of the required signatures cannot be obtained, the provider should obtain a legal counsel consultation prior to the release of any information.

Confidential documents are defined as those that identify an individual as a member and/or contain identifying information. All providers must ensure that all member information is kept secure and confidential.

## **Waste, Abuse and Fraud (WAF) System**

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CBH takes the detection, investigation, and prosecution of fraud and abuse very seriously, and uses the Peach State WAF program which complies with state and federal laws. Peach State, in conjunction with its management company, Centene Corporation, successfully operates a billing errors/waste, abuse and fraud unit. If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at **1-866-685-8664**. Peach State and/or Centene take all reports of potential waste, abuse or fraud very seriously and investigates all reported issues.



**Provider Services Department**  
**1-800-947-0633**

## **Authority and Responsibility**

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The President and CEO of CBH have overall responsibility and authority for carrying out the provisions of the compliance program.

CBH in conjunction with Peach State is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The CBH provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations, at Peach State or the subcontractor's own expense.

These are the primary agencies to which incidents or practices of abuse and/or fraud are to be reported:

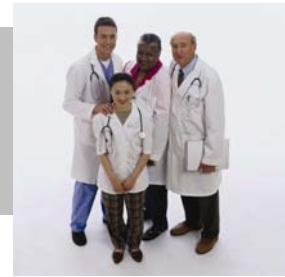
**Peach State Provider Services Department  
3200 Highlands Parkway SE, Ste. 300  
Smyrna, Georgia 30082  
1-866-874-0633**

**Department of Community Health  
Two Peachtree Street, NW-40th Floor  
Atlanta, Georgia 30303-3159  
1-800-533-0686**



**Provider Services Department  
1-800-947-0633**

# Member Services



## Member Materials

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Members may receive various pieces of information from CBH through mailings and informative web-based presentations. These materials are printed in English and Spanish and can be requested in other languages as needed. These materials include:

- Care Coordination Brochure
- Peach State Health Plan Member Handbook which includes:
  - Benefit information, including pharmacy network information, transportation information and so on
  - Member rights and responsibilities

Providers interested in receiving any of these materials may contact **CBH Member Services** at 1-800-947-0633

## Member Rights & Responsibilities

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Following are the members' rights and responsibilities.

### **A CBH member has the following rights and responsibilities:**

- All personal information including the information in a member's medical record will be confidential
- A member will be given choices about the care that they receive; we will make sure that the member understands every options that is available to them and their situation
- A member will never have to be concerned with any form of restraint or seclusion for someone else's convenience or as a means to force them to do something they don't want to do or to punish them.
- A member has the right to request and receive a copy of their Medical Record
- A member has the right to request that their medical record be changed or corrected
- A member has the right to healthcare services in accordance with Quality Assessment and Performance Improvement Access Standards as outlined in 42 CFR 438.206 through 438.210
- A member has the right to file a complaint against a doctor, hospital or CMO. In doing so, no one will stop them from receiving the services that they are entitled to
- A member will never have to pay if Peach State runs out of money to pay their bills
- A member will never have to pay for covered services for which DCH does not pay Peach State



**Provider Services Department**  
**1-800-947-0633**

- A member will never have to pay for health insurance even if DCH or the Peach State does not pay the doctor that treated them
- A member will never have to pay for treatment under a contract, referral, or other arrangement to the extent that those payments are in excess of amount the member would owe if Peach State provided the services directly
- A member will only have to pay a small co-payment and/or deductible, as allowed by state laws and DCH regulations
- A member will receive courteous, respectful and considerate treatment from Peach State staff, providers, physicians and their office staff
- A member has a right to choose a Peach State doctor (PCP) and be told which hospitals they are to use
- A member has a right to change their doctor without a reason
- A member has a right to know about other doctors who can help them with treatment
- A member has the to know about information about rights and responsibilities, as well as the Peach State's providers and services
- A member has the right to get a second opinion from a qualified healthcare professional
- A member has the right to know all about all of the services that they will receive; including the hours of operation, how to get emergency care after hours, how to get services if they are out of town and what exclusions and limits are present on covered services
- If any of the services get change, we must tell the member. If your doctor is not available we must tell the member. If we cancel a service, we must tell the member.
- A member has a right to tell their doctor and us if they need an interpreter. We will get one at no charge if they are hearing impaired or have limited English-speaking abilities
- A member has a right to all information about their doctor(s) in order for them to properly care for the member

**A Peach State member is responsible for learning and understanding each right they have under the Medicaid program. This includes the responsibility to:**

- Ask questions if they don't understand their rights
- Keep their scheduled appointments
- Cancel appointments in advance when they can't keep them
- Only go to the emergency room when they think it is an emergency



**Provider Services Department  
1-800-947-0633**

**A member is responsible to share information relating to their behavioral health status with their PCP and become fully informed about service and treatment options. That includes the responsibility to:**

- Tell their PCP about their health
- Talk to their providers about their healthcare needs and ask questions about the different ways their healthcare problems can be treated
- Help their providers get their medical records

**A member should actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:**

- Work as a team with their provider in deciding what healthcare is best
- Do the best they can to stay healthy
- Treat providers and staff with respect

## **Member Grievances, Administrative Review and Appeals**

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A **grievance** is an expression of dissatisfaction with any aspect of CBH's or a provider's operation, provision of healthcare services, activities, or behaviors, other than a Proposed Action. A member or member's authorized representative may file a grievance either orally or in writing. CBH will notify the member or authorized representative that the grievance has been received in writing within 10 business days of receipt of the grievance. **A provider cannot file a grievance on behalf of a member.** Members or their authorized representative may file a grievance by contacting Member Services at: 1-800-704-1484 or by submitting written notification to:

**Cenpatico Behavioral Health  
Appeals/Grievance Coordinator  
5806 Mesa Drive  
Suite 350  
Austin, Texas 78731**

CBH will respond to all issues raised by members within 90 calendar days of receipt of the grievance. Should CBH (with approval of DCH) or the member request additional time to resolve the grievance, CBH will extend the resolution timeframe to 14 additional calendar days for resolution of the grievance.

## **Administrative Review**

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An Administrative Review is the request for review of a Proposed Action. An Action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner, as defined by the State of Georgia; or the failure of CBH to act within the time frames provided in 42 CFR 438.408(b). The review may be requested by telephone or in writing, however oral requests for administrative review within the standard timeframe must be confirmed in writing within 30 days of the date of the Proposed Action. Members may request that CBH review the Proposed Action to verify if the right decision has been made.



**Provider Services Department  
1-800-947-0633**

Who may file an Administrative Review?

- Peach State member
- Authorized representative of Peach State member
- Provider acting on behalf of member (with written member consent)

Requests for an Administrative Review must be made within **thirty (30)** calendar days from the date of the Notice of Proposed Action. Under certain circumstances, members have the right to request, within 10 days of the date of the Notice of Proposed Action, that benefits be continued while an administrative review is pending. CBH will send a written decision within **forty-five (45) calendar days** after the request for an Administrative Review is received by CBH, subject to an authorized extension of up to 14 days.

## **Expedited Administrative Review**

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If a decision on an Administrative Review is required immediately due to the Member's health needs, an expedited Administrative Review may be requested. CBH's decision will be provided within **72 hours** of CBH's receipt of the request for the review, subject to an authorized extension of up to 14 days.

## **Assistance**

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CBH works in coordination with Peach State Health Plan to resolve member grievances. Peach State's Appeals and Grievance Coordinator is available to assist members who need help in filing a grievance or request for Administrative Review or in completing any element in the grievance or Administrative Review process. Members may seek assistance or initiate a grievance or request for Administrative Review by calling 1-800-704-1484 (or TDD/TTY 1-800-659-7487).

## **Members Right to an Administrative Law Hearing and Peach State Review**

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### **Administrative Law Hearing at the Department of Community Health**

The State will maintain an independent Administrative Law Hearing process as defined in the Georgia Administrative Procedure Act (O.C.G.A Title 50, Chapter 13) and as required by federal law, 42 CFR 431.200 et seq. The Administrative Law Hearing process shall provide Medicaid Members an opportunity for a hearing before an Administrative Law Judge.

A member or member's authorized representative may request in writing an Administrative Law Hearing within thirty (30) Calendar Days of the date the Notice of Adverse Action is mailed by CBH. The parties to the Administrative Law Hearing shall include CBH as well as the Member, Member's Authorized Representative, or representative of a deceased Member's estate. A Provider cannot request an Administrative Law Hearing on behalf of a Member. The request for the Administrative Law Hearing should be mailed to:

**Department of Community Health  
Legal Services Section  
Division of Medical Assistance  
Two Peachtree Street, NW-40<sup>th</sup> Floor  
Atlanta, Georgia 30303-3159**



**Provider Services Department  
1-800-947-0633**

PeachCare members do not have access to the Medicaid Administrative Law Hearing process. If a PeachCare member is dissatisfied with a Notice of Adverse Action issued through a CBH Administrative Review, the member can request a review of the decision by the State Management Review Committee (level two) in writing to:

**Department of Community Health  
PeachCare for Kids  
2 Peachtree Street, NW  
Atlanta, GA 30303-3159**

**Second level review by Peach State Health Plan following grievance disposition or administrative review by CBH**

Members who:

- Submit a grievance or a request for administrative review to CBH, and
- Are not satisfied with CBH's disposition of the grievance or administrative review

may request a second level review by Peach State Health Plan of CBH's disposition of the grievance or administrative review. Peach State's second level review of an administrative review determination by CBH has no impact on the member's concurrent right to request a fair hearing from the state. Members may file second level review requests in writing with Peach State within 30 days of the date of CBH's determination on a grievance or Notice of Adverse Action, by mailing the request to:

**Peach State Health Plan  
Appeals/Grievance Coordinator  
3200 Highlands Parkway SE  
Suite 300  
Smyrna, GA 30082**

Peach State completes second level reviews of CBH grievance and administrative review determinations within 45 days of receipt of the request for second level review.

## **Special Services to Assist with Members**

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CBH has designed its programs and trained its staff to ensure that each member's cultural needs are considered in carrying out CBH operations. Providers should remain cognizant of the diverse CBH population. Member needs may vary depending on gender, ethnicity, age, beliefs, etc. We ask that you recognize these needs in serving your patients. CBH is always available to assist your office in providing the best care possible to your patients.

There are several services that are also available to members to assist with their everyday needs. Please see the descriptions below.



**Provider Services Department  
1-800-947-0633**

## Transportation Services

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For non-emergent transportation, contact Logisticare at 1-800-224-7981 (Central) and Southeastrans at 1-770-693-8401 (Atlanta). In situations where urgent transportation is needed and cannot be coordinated with out transportation services, Peach State Member Services Representatives will coordinate transportation arrangements. To contact Peach State Member Services, call 1-800-704-1484.

**Peach State Member Service Department  
1-800-704-1484**

## Interpreter/Translation Services

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As a provider for CBH, please remember that it is your obligation to identify any member who requires translation, interpretation, or sign language services. CBH will pay for these services whenever you need them to effectively communicate with a member. Peach State members are not to be held liable for these services. To arrange for any of the above services, please call the CBH Customer Service Department at **1-800-947-0633**.

CBH is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its members. In order to meet this need, CBH is committed to the following:

- Having individuals available who are trained professional interpreters for Spanish and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical, or treatment information with members as needed
- Providing Language Line services that will be available 24 hours a day, seven (7) days a week in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language
- In-person interpreter services are made available when CBH is notified in advance of the members scheduled appointment in order to allow for a more positive encounter between the member and provider. Telephonic services are available for those encounters involving urgent/emergent situations, as well as non-urgent/emergent appointments as requested
- Providing TTY access for members who are hearing impaired through the Georgia Relay service at **1-800-255-0056 (TDD only) or 1-800-255-0135 (Voice)**
- Peach State's medical advice line, NurseWise, provides 24 hour access, seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line
- Providing or making available Peach State Member Services and Health Education materials in alternative formats as needed to meet the needs of the members, such as audio tapes or language translation; all alternative methods must be requested by the member or designee

**To access interpreter services, contact CBH Customer Service at 1-800-947-0633.**



**Provider Services Department  
1-800-947-0633**

## NurseWise

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NurseWise is our 24-hour nurse line available for members. The Registered Nurses provide basic health education, nurse triage and answer questions about urgent or emergency access.

Members may use NurseWise to request information about providers and services available in your community after CBH is closed. Providers can use it to verify eligibility any time of the day. The NurseWise staff is conversant in both English and Spanish and can offer the Language Line for additional translation services. The nurses document their calls using Barton Schmitt, M.D. and David A. Thompson, M.D. protocols in a web-based data system. These protocols are widely used in nurse call centers and have been reviewed and approved by physicians from around the country.

When CBH or Peach State is closed you can always reach a live voice by calling **1-800-704-1484** and choosing the option for NurseWise. The NurseWise call center is open 24 hours a day and seven days a week and all holidays.



**Provider Services Department**  
**1-800-947-0633**

# Pharmacy



## Preferred Drug List (PDL)

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Peach State is responsible for maintaining a Preferred Drug List (PDL) of medications that provides a comprehensive range of psychotropic medications that are reviewed for efficacy, safety, evidence-based support for therapeutic benefit, and cost-effectiveness.

The Peach State PDL is not intended to be a substitute for sound clinical knowledge and judgment. Each Physician, Nurse Practitioner, and Physician's Assistant is expected to select appropriate drug therapy individualized for each member and that provides the highest quality of care.

The updated Peach State PDL can be found on the Peach State website at: [www.pshpgeorgia.com](http://www.pshpgeorgia.com).

## Pharmacy Lock-In Program

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The purpose of the Pharmacy Lock-In Program is to detect and prevent continued abuse of the pharmacy benefit by restricting the members to only one pharmacy for a defined period. Peach State will monitor and control alleged abuse of the prescription benefit, by Peach State members, as determined through analysis and audit, when one or more of the following criteria are met:

- Prescriptions written on stolen, forged or altered prescription blank;
- Two or more episodes of over-utilization, which involve the Member receiving prescriptions in excess of what the prescriber intended;
- Medication prescribed is inappropriate for age or gender of patient;
- Prescribed medications do not correlate with the Member's medical condition, as identified by his/her PCP, or ICD-9 code from encounter data;
- Prescription written by Out-of-Network Providers;
- Member tends to have prescriptions filled at multiple pharmacies, and/or pharmacies out of the Member or Provider's local area; or
- Member receives more than five therapeutic agents per month;
- Members receives more than three Controlled Substances per month;
- Member receives duplicative therapy from different prescribers.

Providers who suspect a member is meeting the above criteria should contact the department below to report such cases.

**Peach State Health Plan Pharmacy Department**  
**Pharmacy Director**  
**3200 Highlands Parkway, Suite 300**  
**Smyrna, GA 30082**  
**800-704-1463**



**Provider Services Department**  
**1-800-947-0633**

# Forms



**Provider Services Department**  
**1-800-947-0633**



**OUTPATIENT TREATMENT REPORT (OTR)**

Please print clearly – incomplete or illegible forms will delay processing.

<p><b>I. Demographics</b></p> <p>Patient Name: _____</p> <p>Subscriber Name: _____</p> <p>Health Plan: _____</p> <p>DOB: _____</p> <p>SS#: _____</p> <p>Patient ID#: _____</p> <p>Last Auth. # _____</p>	<p><b>II. Provider Information</b> (Please indicate by checking below, whether requested services should be authorized to the provider or agency.)</p> <p>___ Provider Name (print): _____</p> <p>Professional Credential: ___ MD ___ PhD ___ Other _____</p> <p>___ Group/Agency Name: _____</p> <p>Physical Address: _____ (street address, city, state, zip)</p> <p>Phone Number: _____</p> <p>FAX Number: _____</p> <p>Medicaid/TPI #: _____ Tax ID#: _____</p>																		
<p><b>III. Diagnosis</b> (All axes must be completed using DSM multi-axial format; use disorder names and complete codes with modifiers where applicable.)</p> <p>AXIS I _____</p> <p>AXIS II _____</p> <p>AXIS III _____</p> <p>AXIS IV _____</p> <p>AXIS V _____</p>	<p><b>IV. Risk Assessment</b> (check all that apply)</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;"></th> <th style="width:20%; text-align: center;">Suicidality</th> <th style="width:20%; text-align: center;">Homicidality</th> </tr> </thead> <tbody> <tr> <td>Not Present</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>Ideation</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>Plan</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>Means</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> <tr> <td>Prior Attempt (give dates)</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> </tr> </tbody> </table>		Suicidality	Homicidality	Not Present	___	___	Ideation	___	___	Plan	___	___	Means	___	___	Prior Attempt (give dates)	___	___
	Suicidality	Homicidality																	
Not Present	___	___																	
Ideation	___	___																	
Plan	___	___																	
Means	___	___																	
Prior Attempt (give dates)	___	___																	
<p><b>V. Medical Conditions</b></p> <p>___ Asthma ___ Diabetes ___ CHF ___ COPD</p> <p>Has communication been established with PCP? _____</p>	<p><b>VI. Substance Use</b></p> <p>___ yes what substance(s) _____</p> <p>date/amount of last use _____</p> <p>___ no</p> <p>Does treatment focus primarily or equally on substance-related disorder?</p> <p style="text-align: center;">___ yes ___ no</p>																		
<p><b>VII. Requested Authorization</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Modality</th> <th style="width:30%;">How often?</th> <th style="width:40%;">How many sessions/units?</th> </tr> </thead> <tbody> <tr> <td>Individual therapy</td> <td></td> <td></td> </tr> <tr> <td>Family therapy</td> <td></td> <td></td> </tr> <tr> <td>Group therapy</td> <td></td> <td></td> </tr> <tr> <td>Rehab Skills Training</td> <td></td> <td></td> </tr> </tbody> </table> <p>Date first seen: _____ Date last seen: _____</p> <p>Total # of visits used to date: _____</p> <p>Est. # of session to complete treatment episode: _____</p> <p>Projected start date for requested authorization: _____</p>	Modality	How often?	How many sessions/units?	Individual therapy			Family therapy			Group therapy			Rehab Skills Training			<p><b>VIII. Treatment History and Concurrent Services</b></p> <p>Inpatient or residential treatment in past 12 months? ___ yes ___ no</p> <p>What other treatment or community services is the patient currently receiving?</p> <p>___ individual therapy _____ AA/NA</p> <p>___ family therapy _____ other (please specify below)</p> <p>___ group therapy _____</p> <p>___ EAP _____</p> <p>___ medication management _____</p>			
Modality	How often?	How many sessions/units?																	
Individual therapy																			
Family therapy																			
Group therapy																			
Rehab Skills Training																			

**IX. Treatment Plan**

**Presenting Problem:** (Why did the patient present for treatment at this time? Please briefly and specifically describe the current situation/symptoms.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Treatment Goals / Progress:**

Describe measurable goals and treatment objectives and note progress. Please be specific in the documentation of progress made.

Measurable Goal / Date Initiated

Current Progress / Date Completed

Measurable Goal / Date Initiated	Current Progress / Date Completed

**Discharge Criteria:**

Objectively describe how you will know that the patient is ready to discontinue treatment.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**X. Medication**

Has patient been evaluated for medication? \_\_\_ yes \_\_\_ no

Current medication? \_\_\_ None \_\_\_ Psychotropic \_\_\_ Medical

Medication	Dose / frequency	Prescribed by	Is patient compliant with prescription?

Provider Name (please print) \_\_\_\_\_

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

**SUBMIT TO:**

Utilization Management Department  
 5806 Mesa Drive, Suite 350  
 Austin, TX 78731  
 800.589.3186  
**FAX: 512-406-7215**



**INTENSIVE OUTPATIENT TREATMENT FORM  
CHEMICAL DEPENDENCY**

Please print clearly--incomplete or illegible forms will delay processing.

Member's Name: _____	Insurance Plan: _____
Members SSN: _____ - _____ - _____	Members ID#: _____
DOB: _____	TODAYS' DATE: _____
DATE OF ADMISSION: _____	NUMBER OF SESSIONS COMPLETED: _____
EXPECTED DISCHARGE DATE: _____	NUMBER OF SESSIONS REQUESTED: _____

IOP FACILITY: _____	THERAPIST: _____
TAX ID#: _____	
Address: _____	City, State, Zip: _____
Phone: (____) _____ - _____	Fax: (____) _____ - _____

**Diagnosis:**

DSM-IV CODES	
Axis I (primary):	
Axis I (secondary):	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	Current: Past Year:

Medication (Psychotropic)	Amount	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

<b>SUBSTANCE ABUSE HISTORY:</b>
DATE OF LAST USE:

<b>SUBSTANCE ABUSE TREATMENT HISTORY:</b>

Please return completed form to: CBH Utilization Management  
5806 Mesa Drive, Suite 350 ♦ Austin, Texas 78731  
800.589.3186 ♦ 512.406.7215 (fax)

**TREATMENT PLAN: Chemical Dependency**

1. Indicate what STEP patient is currently on: \_\_\_\_\_

2. Indicate the *goals* for treatment, *progress toward each goal*, and the *clinical interventions* for each goal:

Goals	Progress Toward Goal	Clinical Interventions
1.		
2.		
3.		

**Date of Family Therapy Session:** \_\_\_\_\_

4. Indicate the *date* of the family therapy session, and progress made (if appropriate):  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Was a SPONSOR identified? \_\_\_\_\_

6. Attendance at AA/NA meetings? \_\_\_\_\_

7. What modifications to previous treatment plan have been made to facilitate progress?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 PROVIDER SIGNATURE

\_\_\_\_\_  
 DATE

( ) - \_\_\_\_\_  
 PHONE NUMBER

\_\_\_\_\_  
 PROVIDER PRINTED NAME

This authorization is only for the services and number of visits indicated. This authorization is not a guarantee that claims will be paid. Reimbursement will be in accordance with the plan provisions, including all limitations and exclusions, and providing that the patient is covered under the plan when the charges are incurred.

Please return completed form to: CBH Utilization Management  
 5806 Mesa Drive, Suite 350 ♦ Austin, Texas 78731  
 800.589.3186 ♦ 512.406.7215 (fax)



**INTENSIVE OUTPATIENT TREATMENT FORM**  
***MENTAL HEALTH***

Please print clearly--incomplete or illegible forms will delay processing.

Member's Name: _____	Insurance Plan: _____
Members SSN: ____ - ____ - ____	Members ID#: _____
DOB: _____	TODAYS' DATE: _____
DATE OF ADMISSION: _____	NUMBER OF SESSIONS COMPLETED: _____
EXPECTED DISCHARGE DATE: _____	NUMBER OF SESSIONS REQUESTED: _____

IOP FACILITY: _____	THERAPIST: _____
TAX ID#: _____	
Address: _____	City, State, Zip: _____
Phone: (____) _____ - _____	Fax: (____) _____ - _____

**Diagnosis:**

DSM-IV CODES	
Axis I (primary):	
Axis I (secondary):	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	Current: Past Year:

Medication (Psychotropic)	Amount	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

<b>PREVIOUS MENTAL HEALTH HISTORY:</b>

<b>CURRENT SYMPTOMS:</b>

Please return completed form to: CBH Utilization Management  
5806 Mesa Drive, Suite 350 ♦ Austin, Texas 78731  
800.589.3186 ♦ 512.406.7215 (fax)

1. Indicate the *goals* for treatment, *progress toward each goal*, and the *clinical interventions* for each goal:

Goals	Progress Toward Goal	Clinical Interventions
A.		
B.		
C.		

Date of Family Therapy Session: \_\_\_\_\_

4. Indicate the *date* of the family therapy session, and progress made (if appropriate):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Progress toward discharge? \_\_\_\_\_

6. What modifications to previous treatment plan have been made to facilitate progress?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
PROVIDER SIGNATURE

\_\_\_\_\_  
DATE

( ) \_\_\_\_\_  
PHONE NUMBER

\_\_\_\_\_  
PROVIDER PRINTED NAME

This authorization is only for the services and number of visits indicated. This authorization is not a guarantee that claims will be paid. Reimbursement will be in accordance with the plan provisions, including all limitations and exclusions, and providing that the patient is covered under the plan when the charges are incurred.



**CENPATIO™**  
behavioral health  
A CenCorp Health Solution

**IN HOME TREATMENT FORM**

***Mental Health***

Please print clearly--incomplete or illegible forms will delay processing.

Member's Name: _____	Insurance Plan: _____
Members SSN: ____ - ____ - ____	Members ID#: _____
DOB: _____	TODAYS' DATE: _____
DATE OF ADMISSION: _____	NUMBER OF SESSIONS COMPLETED: _____
EXPECTED DISCHARGE DATE: _____	NUMBER OF SESSIONS REQUESTED: _____

IN-HOME FACILITY: _____	THERAPIST: _____
TAX ID#: _____	
Address: _____	City, State, Zip: _____
Phone: (____) _____ - _____	Fax: (____) _____ - _____

**Diagnosis:**

DSM-IV CODES	
Axis I (primary):	
Axis I (secondary):	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	Current: Past Year:

Medication (Psychotropic)	Amount	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

<b>PREVIOUS MENTAL HEALTH HISTORY:</b>
_____
_____
_____

<b>CURRENT SYMPTOMS:</b>
_____
_____

Please return completed form to: CBH Utilization Management  
5806 Mesa Drive, Suite 350 ♦ Austin, Texas 78731  
800.589.3186 ♦ 512.406.7215 (fax)

1. Indicate the *goals* for treatment, *progress toward each goal*, and the *clinical interventions* for each goal:

Goals	Progress Toward Goal	Clinical Interventions
A.		
B.		
C.		

Date of Family Therapy Session: \_\_\_\_\_

4. Indicate the *date* of the family therapy session, and progress made (if appropriate):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Progress toward discharge? \_\_\_\_\_

6. What modifications to previous treatment plan have been made to facilitate progress?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
PROVIDER SIGNATURE

\_\_\_\_\_  
DATE

( ) \_\_\_\_\_  
PHONE NUMBER

\_\_\_\_\_  
PROVIDER PRINTED NAME

This authorization is only for the services and number of visits indicated. This authorization is not a guarantee that claims will be paid. Reimbursement will be in accordance with the plan provisions, including all limitations and exclusions, and providing that the patient is covered under the plan when the charges are incurred.



**CENPATICO™**  
behavioral health  
*A CenCorp Health Solution*

To:

Date:

Member Name:

Member ID:

Fax Number:

CBH, LLC. provides utilization management services for *Peach State Health Plan* and confirms the precertification of benefits for the requested services outlined below.

<u>Qty</u>	<u>Approved Codes</u>	<u>Description</u>	<u>Date Span</u>	<u>Authorization</u>
------------	-----------------------	--------------------	------------------	----------------------

The authorization number(s) provided is for reference only. To expedite the processing of your claim, please do not enter this number on the claim form

If you have any questions about this review, please call the number listed below to discuss the decision with a care manager.

To obtain a copy of our Medical Necessity Criteria, please call (800) xxx-xxxx

*Certification is based upon medical information provided. This authorization is not a guarantee of benefits or payment. CBH, LLC. will not pay claims for patients who are not eligible for benefits at the time of service. It is the patient's responsibility to notify the provider of any changes in their benefit plan. Payment of benefits is subject to any subsequent review of medical information or records, the patient's eligibility on the date the service is rendered, and any other contractual provisions of the plan.*

**Claims should be submitted promptly to:**

CBH, LLC.  
P.O. Box XXXX  
Farmington, MO 63640

**CBH Psychological Testing Authorization Request Form**  
(Please type or print neatly)

**I. Identifying Information**

Patient's Name: _____	PT. ID#: _____	DOB: _____
Provider's Name: _____	Group Name: _____	
Provider's Phone Number: _____	Fax: _____	

**II. Differential Diagnosis**

Axis I _____	Axis III _____
Axis II _____	Axis IV _____
	Axis V _____
Danger to Self or Other(If yes, please explain)? YES NO _____	
MSE Within Normal Limits (If no, please explain)? YES NO _____	

**III. Current symptoms that testing will address:** \_\_\_\_\_

**IV. Is testing needed for differential diagnosis?** YES NO

**V. Has the patient had previous treatment for the symptoms currently described?** YES NO

**VI. Has the patient responded to this treatment (please circle below)?**

NOT AT ALL      MINIMALLY      SOMEWHAT      SIGNIFICANTLY

**VII. What information will testing acquire that cannot be obtained from interview data, collateral information and information obtained from the therapeutic process?**

**VIII. Please List the Tests Planned to Answer the Clinical Question(s)**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

\*\*\*If IQ testing is requested and the patient is a child, what collateral information have you obtained from the school regarding cognitive/academic functioning (i.e., teacher feedback, school testing)? \_\_\_\_\_

_____ Clinician's Signature/Title	_____ Date
--------------------------------------	---------------

