Carelon Behavioral Health of California, Inc.

Provider Handbook

www.carelonbehavioralhealthca.com

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Overview

Welcome to the Carelon Behavioral Health of California, Inc. (Carelon Behavioral Health of California) network of participating providers. This handbook is an extension of the provider agreement and includes requirements for doing business with Carelon Behavioral Health of California, including policies and procedures for individual providers, affiliates, group practices, programs and facilities. It provides important information regarding the managed care features incorporated in the Carelon Behavioral Health of California provider agreements and reflects the policies and procedures that are applicable to our Knox-Keene product lines.

Carelon Behavioral Health of California is a wholly owned subsidiary of Carelon Behavioral Health, Inc. (Carelon Behavioral Health) and a health care service plan licensed under the Knox-Keene Act to provide Mental Health or Substance Use Disorder or Mental Disorder (MHSUD) and Employee Assistance Program (EAP) services. As a KnoxKeene Plan, Carelon Behavioral Health of California is regulated by the California Department of Managed Health Care (DMHC).

Together, the Carelon Behavioral Health of California provider agreement, addenda, and the handbook outline the requirements and procedures applicable to providers in the Carelon Behavioral Health of California networks. Information specific to participating providers in the EAP network can be found in the EAP Affiliate Handbook. Carelon Behavioral Health of California also maintains a web site at www.carelonbehavioralhealthca.com.

Carelon Behavioral Health of California may, by notice, amend or change any or all provisions of the handbook by providing 45 business days prior written notice to providers unless the amendment is material and not made in order to comply with a change in state or federal law or accreditation standards. Refer to your Carelon Behavioral Health of California participation agreement for information related to handbook or agreement amendments. To the extent that there is an inconsistency between the handbook and the provider agreement, Carelon Behavioral Health of California reserves the right to interpret such inconsistency. Carelon Behavioral Health of California's interpretation shall be final and binding.

Contact Information

Administrative Appeal	To request an administrative appeal, call the toll-free number included in the administrative denial letter received.
Changing and/or Confirming Your Provider Directory Demographic Profile (e.g. Name, address)	If you are a Council for Affordable Quality Healthcare (CAQH) participating provider, demographic profile updates must be made via CAQH, including reviewing and attesting to your information's accuracy. **Practitioners:** Visit CAQH at https://proview.caqh.org, update your information, and attest that it is accurate. If you are not already participating with CAQH, you can get started by visiting the CAQH website and selecting "Register Now" to register. **Provider Groups, Facilities, and Practitioners not Participating in CAQH:** If you do not participate with CAQH, you may change or update your demographic profile through the "Update Demographic Information" option within the Provider Portal or call the National Provider Service Line at 800397-1630 Monday through Friday 8 a.m. – 8 p.m. Eastern Time. NOTE: Updating a Tax ID requires an accompanying W-9 form, which can be uploaded as an attachment in the Provider Portal. A copy of the W-9 Form is available at www.carelonbehavioralhealth.com.
Claims	For general claim inquiries, please call 800-888-3944. For technical questions related to a direct claim submission or batch submission via the Provider Portal, please contact the EDI Help Desk at: **Telephone:** 888-247-9311 from 8 a.m. – 6 p.m. Eastern Time **E-mail:** e-supportservices@carelon.com For providers who are unable to submit a claim electronically, paper claims should be sent to: Carelon Behavioral Health , Inc. P.O. Box 1852 Hicksville, NY 11802 Carelon Behavioral Health of California's Payer ID is CARELON BEHAVIORAL HEALTH 963116116

Clinical Appeals	To request a clinical appeal on a member's behalf, call the toll-free number included in the adverse determination letter received.
Complaints/Grievances	To file a complaint/grievance, call the toll-free number on the back of the member's identification card to speak to Member Services.
Credentialing	To obtain information pertaining to network participation status, contact the National Provider Service Line at 800-397-1630 from 8 a.m. – 8 p.m. Eastern Time Monday through Friday. To send supporting documentation such as malpractice or insurance cover sheets, please fax to 866-612-7795.
Fraud and Abuse	Report questionable billing practices or suspected fraud to: https://www.fighthealthcarefraud.com/report-fraud-form/ From the drop down menu "Who is the insurance company?" select **Carelon Behavioral Health**. siu@carelon.com National Provider Services Line at 800-397-1630 from 8 a.m. – 8 p.m. Eastern Time Monday through Friday.
Member Benefits, Eligibility, and Authorizations	For questions about member eligibility or benefits, providers can submit an inquiry via the Provider Portal by selecting the "Eligibility and Benefits" option. For questions about authorization status, providers can select the "Review an Authorization" option via the Provider Portal. For additional questions about authorizations or benefits, call the toll-free number on the back of the member's identification card.
Member Services	To reach Member Services, call the toll-free number on the back of the member's identification card.
Potential Quality of Care Concerns	Report all potential quality of care concerns to the Clinical Care Manager with whom the provider conducts reviews.
Provider Coverage During Absences	To update Carelon Behavioral Health of California about a lack of provider coverage due to absences (e.g. coverage while on vacation), contact the National Provider Service Line or the Clinical Care Manager with whom the provider conducts reviews or call the number on the member's identification card.

Provider Dispute	For any claims and other types of billing and contract disputes contact: providerdisputeresolution@carelon.com Carelon Behavioral Health Provider Dispute Resolution P.O. Box 1864 Hicksville, NY 11802-1864 National Provider Service Line at 800-397-1630 from 8 a.m. – 8 p.m. Eastern Time Monday through Friday.
All Other Questions	Please contact the Carelon Behavioral Health of California Provider Relations office listed below for general questions via email. Please do not include member information in the email: provider.inquiry@carelon.com

Electronic Resources

Providers in the Carelon Behavioral Health of California network are encouraged to conduct all routine transactions electronically, including:

- Submission of claims
- Submission of authorization requests
- Verification of eligibility inquiries
- Submission of recredentialing applications
- Updating provider information
- Electronic fund transfer/direct deposit through PaySpan
- Provider claims and authorization status checks
- Reviewing claims remittance information

The following electronic resources are available to assist providers:

Council for Affordable Quality Healthcare (CAQH)

All participating providers are encouraged to register and participate with CAQH, including attesting on a regular basis, to reduce the credentialing timeline and improve directory accuracy. CAQH is an industry standard solution to capture and share health care self-reported information that 1.4 million health care providers use today – 97 percent of Carelon Behavioral Health of California's individual providers are already registered. Carelon Behavioral Health of California accesses information from CAQH as updates are made to provider data. Be sure to give "Carelon Behavioral Health" permission to access CAQH content.

Provider Portal

Carelon Behavioral Health of California's Provider Portal, is a secure, password protected site where participating providers conduct certain on-line activities with Carelon Behavioral Health of California

directly 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues). Currently, participating providers are provided access to the following on-line activities:

- Authorization or certification requests for all levels of care
- Concurrent review requests and discharge reporting
- Single and multiple electronic claims submission
- Claim status review for both paper and electronic claims submitted to Carelon Behavioral Health of California
- Verification of eligibility status
- Submission of inquiries to Carelon Behavioral Health of California's Provider Customer Service
- Updates to demographic profiles/records, if not participating with CAQH
- Electronic access to authorization/certification letters from Carelon Behavioral Health of California
- Provider summary vouchers (PSVs)

Links to information and documents important to providers are located within the Provider Portal.

Electronic Claims Submission and Clearinghouses

Electronic claim submission is also accepted through clearinghouses or batch submissions directly to Carelon Behavioral Health of California. Submissions must reference Payer ID, CARELON BEHAVIORAL HEALTH **963116116**, to ensure Carelon Behavioral Health of California receives those claims. The provider must register for online services and submit the appropriate EDI form to be linked with the clearinghouse.

For information about testing and setup for EDI, review the 837 Companion Guide available within the Provider Portal. Carelon Behavioral Health of California accepts standard HIPAA 837 professional and institutional health care claim transactions and provides 835 remittance advice response transactions.

PaySpan

Carelon Behavioral Health of California participating providers must use PaySpan for electronic fund transfer. PaySpan enables providers to receive payments automatically in their bank account of choice, receive email notifications immediately upon payment, view remittance advices online, and download an 835 file to use for auto-posting purposes.

Carelon Behavioral Health of California Website

Carelon Behavioral Health of California's website, www.carelonbehavioralhealthca.com contains information about Carelon Behavioral Health of California and its business. Links to information and documents important to providers are located in the Carelon Behavioral Health of California Providers' section. Important documents specific to Carelon Behavioral Health of California include, but are not limited to:

- Provider Dispute Resolution (PDR) Request form
- Member Grievance form
- Member Rights and Responsibilities
- Medical Necessity Criteria and Resources

Participating Providers

Carelon Behavioral Health of California does not refuse to contract or terminate existing contractual relationships with providers because a provider: (a) advocates on behalf of a member, (b) files a complaint with or against Carelon Behavioral Health of California, or (c) appeals a decision or determination made by Carelon Behavioral Health of California.

Participating providers are independent contractors of Carelon Behavioral Health of California. This means that participating providers practice and operate independently, are not employees of Carelon Behavioral Health of California, and are not partners with or involved in a joint venture or similar arrangement with Carelon Behavioral Health of California. Carelon Behavioral Health of California does not direct, control or endorse health care or treatment rendered or to be rendered by participating providers.

Carelon Behavioral Health of California encourages participating providers to communicate with members to discuss available treatment options, including medications and available options, regardless of coverage determinations made or to be made by Carelon Behavioral Health of California or a designee of Carelon Behavioral Health of California. Treating providers, in conjunction with the member (or the member's legal representative), make decisions regarding what services and treatment are rendered. Any preauthorization, certification or medical necessity determinations by Carelon Behavioral Health of California relate solely to payment. Participating providers should direct members to Carelon Behavioral Health of California or their respective benefit plan representatives for questions regarding coverage or limitations of coverage under their benefit plan prior to rendering nonemergency services.

Carelon Behavioral Health of California's Provider Identification Numbers

The Carelon Behavioral Health of California provider number is a participating provider's unique number (often six digits) assigned by Carelon Behavioral Health. The provider number identifies a provider in the Carelon Behavioral Health of California system and is used for giving access to the Provider Portal. The provider number is on file with Carelon Behavioral Health of California. Participating providers should contact the National Provider Service Line at 800-397-1630 Monday through Friday, 8 a.m. to 8 p.m. ET for questions regarding Provider Identification Numbers and/or for assistance in obtaining a Provider Identification Number.

The provider's service location vendor number is a number that identifies where services are or were rendered. A participating provider may have multiple vendor locations and each vendor location is given a vendor location number preceded by a letter (e.g. A23456, D45678).

The pay-to vendor number is a vendor number issued by Carelon Behavioral Health and indicates the mailing address for all payments and when using our electronic payments service through PaySpan. A provider can have more than one pay-to vendor number and each number needs to be registered with PaySpan.

The National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI is different from a Carelon Behavioral Health of California assigned provider number. The NPI is a single provider identifier that replaces the different identifiers used in standard electronic transactions. HHS adopted the NPI as a provision of HIPAA. This number is also contained in the Carelon Behavioral Health of California system and can be used to locate a provider record for claims, referrals and authorization purposes.

Provider Satisfaction Survey

Carelon Behavioral Health of California conducts an annual provider satisfaction survey to measure participating providers' opinions regarding Carelon Behavioral Health of California clinical and administrative processes. Data is aggregated, trended and used to identify improvement opportunities. Results are reviewed with the Quality Management/Utilization Management/Case Management (QMUMCM) Committee. A formal written improvement plan is developed by Carelon Behavioral Health of California to identify and act on improvement opportunities.

Changes to Provider Directory Information

Participating provider information is used in credentialing and recredentialing activities as well as in provider directories and listings made available to clients and members. California Health & Safety Code §1367.27(l) requires the verification of the accuracy of information concerning each provider listed in the Carelon Behavioral Health of California provider directory. It is important that provider directory information is accurate and current so that members are able to easily select and make appointments with providers that match their needs. As a Knox-Keene licensed health plan, Carelon Behavioral Health of California, must take certain measures to assure the accuracy of its provider directory.

To be compliant, participating providers must notify Carelon Behavioral Health of California or its designee in advance of any changes or updates to the following information:

- Name
- Service physical addresses and locations
- Email address
- Phone number
- Hours of operation
- Discipline
- NPI
- Board certification(s)
- Accreditation
- License
- Clinical specialties
- Services provided
- Whether accepting new patients
- Hospital admitting privileges, where applicable
- Language(s) spoken
- Gender identity
- Compliance with Americans with Disabilities Act accessibility guidelines

Each element of information must be accurate for the individual provider; it should not be based on the profile of a group practice or facility. If you are a Council for Affordable Quality Healthcare (CAQH) participating provider, demographic profile updates must be made via CAQH, including reviewing, and attesting to your information's accuracy. Participating providers are contacted by CAQH at least quarterly to notify them to update or verify their directory information and then attest to the accuracy

of that information. Failure to attest to the accuracy of the information for a period of 12 months within CAQH will result in removal from the directory. *Note*: the obligation to respond to CAQH is in addition to, and not in lieu of, the obligation to provide notice of changes in information in advance of the change occurring.

If you do not participate with CAQH, are a provider group, or facility you may change or update your demographic profile through the "Update Demographic Information" option within the Provider Portal or by calling the National Provider Service Line at 800-397-1630 Monday through Friday 8 a.m. – 8 p.m. Eastern Time.

Participating facilities are to provide the following additional information:

- Facility Name
- Type
- Location(s) – physical addresses of primary and affiliated locations
- Accreditation Status
- Telephone contact information

If availability changes, all participating providers are required to notify Carelon Behavioral Health of California and update CAQH within five business days of the date they are no longer accepting new patients as well as when availability has resumed.

A participating provider, who may have received a referral from a member seeking to become a new patient after the provider notified Carelon Behavioral Health of California that they are no longer accepting new patients, is required to direct the member to Carelon Behavioral Health of California for assistance in finding a new provider. The participating provider is also required to direct the member to the Department of Managed Health Care (DMHC) to report any potential inaccuracies with the Carelon Behavioral Health of California Provider Directory.

If changes to a Tax ID are necessary, there is a W-9 form accessible through the Carelon Behavioral Health of California website.

Policies and Procedures

Pursuant to the terms of the provider agreement, providers must comply with Carelon Behavioral Health of California policies and procedures, as outlined in this handbook. Certain policies and procedures may apply only to a designated line of business or type of government sponsored health benefit program, such as Medicare or Medi-Cal. Information specific to regulatory requirements and guidelines about participation in networks available to Medicare and Medi-Cal plans are described in more detail in other sections of this handbook.

Carelon Behavioral Health of California maintains continuous quality improvement and utilization management programs that include policies and procedures and measures designed to provide for ongoing monitoring and evaluation of services rendered to members (e.g., clinical review criteria, member and participating provider surveys, evaluations, and audits). Provider involvement is an integral part of these programs. Participating providers must cooperate with and participate in Carelon Behavioral Health of California quality improvement and utilization management programs and activities. Refusal to cooperate with Carelon Behavioral Health of California quality improvement and/or utilization management activities may adversely affect continued network participation status or result in sanctions up to and including termination of network participation.

Detailed information about a specific member's benefit plan requirements can be obtained by viewing a member's benefits on the 'Benefit' tab in the Provider Portal.

Credentialing and Recredentialing

Carelon Behavioral Health of California's credentialing processes for new providers seeking to contract with Carelon Behavioral Health of California and recredentialing processes for providers currently contracted with Carelon Behavioral Health of California are designed to comply with national accreditation standards, as well as applicable state and/or federal laws, rules, and regulations. Credentialing and recredentialing is required for all providers and participating providers, respectively, including without limitation individual practitioners and organizations (clinics, facilities, or programs). All provider office or facility locations where services are rendered and that share the same federal tax identification number and that are identified in credentialing/recredentialing applications are considered for participation status under that application.

Providers are credentialed and recredentialed, respectively, for participation status for designated services, level(s) of services, or practice sites. Should providers have other or additional services, levels of services, or practice sites available, additional credentialing and/or recredentialing may be necessary prior to a designation as a 'participating provider' for such additional services, levels of services or practice sites. Services, levels of services, or practice sites for which a participating provider is not credentialed are subject to all applicable out-of-network authorization, certification and any benefit or coverage limitations under the member's benefit plan.

As provided for in Carelon Behavioral Health of California policies and procedures, decisions to approve or deny initial credentialing applications, to approve recredentialing applications and/or to submit a given credentialing or recredentialing application for further review are made by the Carelon Behavioral Health of California Credentialing Committee.

Providers have the right to:

- Request review of information submitted in support of credentialing or recredentialing applications
- Correct erroneous information collected during the credentialing or recredentialing processes
- Request information about the status of credentialing or recredentialing applications

All requests to review information must be submitted in writing. Verbal requests for the status of a credentialing or recredentialing application can be made by calling the National Provider Service Line at 800-397-1630, Monday through Friday, 8 a.m. to 8 p.m. Eastern Time. Regardless of the above, Carelon Behavioral Health of California will not release information obtained through the primary source verification process where prohibited by applicable state and/or federal laws, rules and/or regulations.

Credentialing

Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation using one of the following methods:

- After completing the online universal credentialing process offered by the Council for Affordable Quality Healthcare (CAQH), give **Carelon Behavioral Health** access to your credentialing information and ensure it has a current attestation confirming the accuracy of the information.

Call the CAQH Help Desk at 888-599-1771 for answers to your questions related to the CAQH application or website;

- Request an online application by completing the Online Form found in the provider section under "Join our network" at **www.carelonbehavioralhealth.com.** Once the online form has been completed, you will be sent a secured link to access the application to join the network; or
- Call the National Provider Service Line at 800-397-1630 Monday through Friday, 8 a.m. to 8 p.m. Eastern Time to request a paper application be sent to you via USPS.

Required documentation includes without limitation an attestation as to:

- Any limits on the provider's ability to perform essential functions of their position or operational status
- With respect to individual practitioner providers, the absence of any current illegal substance or drug use
- Any loss of required state licensure and/or certification
- Absence of felony convictions
- With respect to individual practitioner providers, any loss or limitation of privileges or disciplinary action
- The correctness and completeness of the application

Failure of a provider to submit a complete and signed credentialing application, and all required supporting documentation timely and as provided for in the credentialing application and/or requests from Carelon Behavioral Health and/or Carelon Behavioral Health of California, may result in a denial of the request to participate in the Carelon Behavioral Health of California provider networks.

Once the provider has been approved for credentialing and contracted with Carelon Behavioral Health of California as an individual practitioner, group member, or facility, Carelon Behavioral Health of California will advise of the effective date for specified lines of business. Once the facility has been approved for credentialing and contracted with Carelon Behavioral Health of California, all licensed or certified behavioral health professionals listed may treat members for applicable services and lines of business. The credentialed facility is responsible for overseeing its clinical staff, as Carelon Behavioral Health of California does not individually credential facility-based staff.

Recredentialing

Recredentialing for participating providers is required every three years. The process for recredentialing begins approximately three months prior to the end of the initial credentialing cycle or the preceding recredentialing cycle, as applicable, and can be accomplished using one of the following methods:

- After completing the online universal credentialing process offered by the Council for Affordable Quality Healthcare (CAQH), give **Carelon Behavioral Health** access to your credentialing information and ensure it has a current attestation confirming the accuracy of the information. Call the CAQH Help Desk at 1-888-599-1771 for answers to your questions related to the CAQH application or website; or
- Carelon Behavioral Health will notify the participating provider via email, voicemail or fax that their online recredentialing application is available within the Provider Portal.

- Call the National Provider Service Line at 800-397-1630 Monday through Friday, 8 a.m. to 8 p.m. Eastern Time to request a paper application be sent to you via USPS.

Required documentation includes without limitation an attestation as to:

- Any limits on the provider's ability to perform essential functions of their position or operational status
- With respect to individual practitioner providers, the absence of any current illegal substance or drug use
- The correctness and completeness of the application (including without limitation identification of any changes in or updates to information submitted during initial credentialing)

Failure of a provider to submit a complete and signed recredentialing application, including all required supporting documentation timely and as provided for in the recredentialing application, and/or failing to respond to requests from Carelon Behavioral Health and/or Carelon Behavioral Health of California, may result in termination of their participation status with Carelon Behavioral Health of California. Participating providers that are terminated because they failed to comply with the recredentialing requirements may be required to wait a period of six months before they are reconsidered for network participation, at which time they must comply with the requirements of initial applicants.

Standards

Standards applicable to providers in the initial credentialing process and to providers in the recredentialing process include, but are not limited to the following:

- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements) and valid license to practice as an independent provider at the highest level certified or approved by California where services are performed for the provider's specialty (individual practitioners)
- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements) and valid license to practice and/or operate independently at the highest level certified or approved by California where services are performed for the facility's/program's status (organizations)
- Accreditation currently accepted by Carelon Behavioral Health of California for organizations (currently TJC, CARF, COA, HFAP, AAAHC, NIAHO, CHAP and AOA) (organizations). Structured site visits are required for all unaccredited organizations.
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the ability to independently practice in their specialty (individual practitioners)
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure (individual practitioners)
- Current specialty board certification, if indicated on the application (individual practitioners)
- A copy of a current Drug Enforcement Agency (DEA) certificate, and/or Controlled Dangerous Substance (CDS) Certificate where applicable (individual practitioners)

- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the provider which disclose an instance of, or pattern of, behavior which may endanger members
- Good standing with state and federal authorities and programs (organizations)
- No exclusion or sanctions from government sponsored health benefit programs (e.g., Medicare/Medi-Cal) (individual practitioners and organizations)
- Current specialized training as required for certain levels or areas of specialty care (individual practitioners)
- Malpractice and/or professional liability coverage in amounts consistent with Carelon Behavioral Health of California policies and procedures (individual practitioners and organizations)
- An appropriate work history for the provider's specialty (individual practitioners)

Changes or updates to any of the above noted information is subject to re-verification from primary sources during the recredentialing process, or at the time of notice of such a change or update from the provider. Additionally, providers must have:

- No adverse record of failure to follow Carelon Behavioral Health of California policies and procedures or quality activities
- No adverse record of provider actions that violate the terms of the provider agreement
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating potential or actual member endangerment
- No criminal charges filed relating to the provider's ability to render services to members
- No action or inaction taken by a provider that, in the sole discretion of Carelon Behavioral Health of California, results or may result in a threat to the health or well-being of a member or is not in the member's best interest

Site Visits

Carelon Behavioral Health of California, or its designee, conducts site visits at provider facilities and/or offices in the course of credentialing and/or recredentialing in the following circumstances:

- For all non-accredited facilities prior to the initial credentialing decision and every three years prior to the recredentialing decision;
- When a previously accredited facility does not maintain or loses accreditation;
- When a non-accredited facility relocates or opens an additional site; and/or
- Providers with two or more documented member complaints in a six month time frame relating to physical accessibility, physical appearance, adequacy of waiting/examining room space; and/or

Site visits are arranged in advance. The current Facility Envioronmental Site Review tool and Practitioner Environmental Site Visit Review tool are available for review www.carelonbehavioralhealth.com. Carelon Behavioral Health of California reserves the right to modify or replace the site visit tool and associated forms without notice.

A Center for Medicare & Medicaid Services (CMS) or state review may be substituted in lieu of a site visit for non-accredited facilities provided that the CMS or state review criteria are reviewed and determined to be similar to Carelon Behavioral Health of California criteria. A copy of the survey report or a letter from CMS or the applicable state agency indicating the facility was reviewed and passed the inspection must be obtained and included in the facility's file.

Carelon Behavioral Health of California may limit site visits to a main facility if the main facility and all satellite offices are held to the same standards and policies as the main facility.

Following the site visit, Carelon Behavioral Health of California provides a written report detailing the findings, which may include required monitoring where applicable and/or requirements for the provider to submit an action plan.

Site Visits for Quality Reviews

A site visit may also be conducted as part of an investigation stemming from a member complaint or other potential quality issue.

Carelon Behavioral Health of California will contact the provider to arrange a mutually convenient time for the site visit. The quality site visit process is intended to be consultative and educational. Following the site visit, the provider will receive a written report detailing the findings of the site visit. If necessary, the report will include an action plan that will provide guidance in areas that the provider needs to strengthen in order to comply with Carelon Behavioral Health of California's standards.

Updates

Participating providers are required to report material changes to information included in credentialing and/or recredentialing applications submitted to Carelon Behavioral Health of California. Except as noted below, all such changes must be reported in writing within five business days of the participating provider becoming aware of the information. Failure to comply may result in immediate termination of network participation. The following are of examples of the types of material changes for which the above report is required:

- Any action against licenses, certifications, registrations, and/or accreditation status
- Any legal or government action initiated that could materially affect the rendering of services to members
- Any legal action commenced by or on behalf of a member
- Any initiation of bankruptcy or insolvency proceedings, whether voluntary or involuntary
- Any other occurrence that could materially affect the rendering of services to members
- Discovery that a claim, suit or criminal or administrative proceeding is being brought against the provider relating to the provider's delivery of care (i.e. malpractice suit), compliance with community standards and/or to applicable laws, including, but not limited to any action by licensing or accreditation entities and/or exclusions from a government sponsored health benefit program (e.g., Medicare/Medi-Cal)

Expiration, non-renewal and/or material change (such as a decrease in required malpractice or professional liability coverage) must be reported 30 calendar days prior to such change in coverage.

Any changes in demographic information or changes in practice patterns such as change of services and/or billing address, name change, coverage arrangements, tax identification number, hours of operation, and/or changes in ownership must be provided to Carelon Behavioral Health of California in

advance of such changes. Carelon Behavioral Health of California must receive 60 calendar days advance notice of any new programs or services offered by a facility provider in order to allow for completion of the credentialing process prior to provision of services to members.

Changes in ownership and/or management of providers may require negotiation and execution of consent to assignment and assumption agreements as related to provider agreements and the parties to provider agreements. **Practice Full**

Individual providers are required to notify Carelon Behavioral Health of California within five business days of the date in which the provider is no longer accepting new patients. If a provider remains on "practice full" status and is unable to accept new referrals for more than six months, the network participation of the provider may be reevaluated.

Sanctions

While efforts are made to resolve provider credentialing/recredentialing issues and/or quality issues through consultation and education, occasionally further action is necessary to provide for quality service delivery and protection of members. Sanctions may be imposed for issues related to member complaints/grievances, credentialing/recredentialing issues, professional competency and/or conduct issues, quality of care concerns/issues, and/or violations of state and/or federal laws, rules and/or regulations. Carelon Behavioral Health of California processes comply with all applicable local, state and/or federal reporting requirements regarding professional competence and/or conduct. The provider agrees to screen any employee, temporary employee, volunteer, consultants, governing body member, vendors prior to hire or contract, and monthly thereafter against U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities & Most Wanted Fugitives, the System for Award Management, and any other list of individuals excluded from participation in any Federal or State health care program and disclose to Carelon Behavioral Health of California all exclusions and events that would make them ineligible to perform work related, directly or indirectly, to federal health care programs.

Subject to modification based on the facts and circumstances in a given case, the following is a list of possible sanctions that may be imposed on providers by the Carelon Behavioral Health of California Credentialing Committee, and/or the Carelon Behavioral Health of California Provider Appeals Committee. The descriptions below are not in any specific order and should not be interpreted to mean that there is a series of sanctions; any one or more possible sanctions described below may be imposed in any order or sequence.

TYPE	DEFINITION

Consultation	An interactive educational discussion between Carelon Behavioral Health of California staff and the provider to address administrative, quality, contractual, and/or professional issues. The call is documented to include the date and subject of the consultation. If applicable, appropriate educational materials are sent via certified mail.
Written Warning	A written notice sent to the provider notifying them of the improper action and an explanation of how to correct the identified behavior. Possible sanctions, if corrective actions are not taken, are explained. A copy of the letter is retained in the provider's file. If applicable, educational materials are sent via certified mail. Corrective action is monitored as necessary.

TYPE	DEFINITION
Monitoring	The provider may be placed on monitoring. When data indicates nonconformance with standards, an increased level of oversight (e.g. scheduled site visits, treatment record reviews, monitoring of member complaints) is implemented. Monitoring requires Carelon Behavioral Health of California Credentialing Committee action. An action plan may be provided consisting of steps that, when taken, will remedy the deficiencies or concerns that created the need for monitoring. The provider is expected to use best efforts to comply with the monitoring action plan. If an action plan has been sent, the provider is expected to notify Carelon Behavioral Health of California in writing of the status of the issue for which monitoring was initiated at the end of the action plan timeline, or sooner if applicable. The provider is expected to keep Carelon Behavioral Health of California updated in writing of all changes in the issue/concern that triggered monitoring. The written notice includes the date and circumstances leading to the monitoring determination. Monitoring lasts no more than 90 calendar days from the date of notification, during which time the provider continues network participation. At the completion of the monitoring period, the provider is re-evaluated to determine further action and network status.

TYPE	DEFINITION
Reduction of Privileges	The provider's privileges may be reduced to prevent new member referrals and authorizations, pending resolution of issues raised. A reduction of privileges requires Carelon Behavioral Health of California Credentialing Committee action. During the suspension period, an investigation in to the alleged improper action is conducted. The provider is notified by written notice via facsimile and certified mail of the issues for which the reduction of privileges occurred. The reduction of privileges lasts for a period of no more than 30 calendar days, during which time an investigation may take place. The suspension period may be extended if necessary, in which case the provider receives written notification of the extension. If it is determined that the alleged improper action has taken place, the provider may be subject to further actions, up to and including disenrollment from the network.

TYPE	DEFINITION
Summary Suspension	The provider may be suspended from network participation without prior notice or hearing where the failure to take that action may result in an imminent danger to the health of any individual, preventing new member referrals, new patient authorizations, and/or redirecting all current patients to other providers. Summary suspension requires Carelon Behavioral Health of California Credentialing Committee action. The provider is notified by written notice via facsimile and certified mail of the issues for which the summary suspension occurred. The suspension lasts for a period of no more than 14 calendar days during which time an investigation may take place. The suspension period may be extended if necessary, in which case the provider receives written notification of the extension. If the summary suspension remains in effect for more than 14 calendar days, Carelon Behavioral Health of California is required to file a report with the relevant state licensing agency. If it is determined that the alleged improper action has taken place, the provider may be subject to further actions, up to and including disenrollment from the network.
Termination	The provider may be terminated from the network. Termination requires Carelon Behavioral Health of California Credentialing Committee action. The provider is given written notice via facsimile and certified mail that the provider is being terminated from the network and the reason for the termination. A copy of the letter is put in the provider's file. Members in care are notified and given assistance for a referral to a new provider for continuing care, as necessary.

Provider Appeals of Carelon Behavioral Health of California Credentialing Committee Decisions

Providers have the right to formally appeal the decisions of the Carelon Behavioral Health of California Credentialing
Committee. The Carelon Behavioral Health of California Credentialing Committee gives providers written notice of the Committee's decision regarding adverse credentialing/recredentialing decisions regarding acceptance into the network, corrective and/or disciplinary actions (not related to an individual provider's quality of care, competence, or professional conduct reasons) or change in network participation, the reason for the decision, appeal rights, and an explanation of the appeal procedures. Provider appeals of adverse credentialing or recredentialing decisions by the Carelon Behavioral Health of California Credentialing Committee may be appealed to the Carelon Behavioral Health of California Provider Appeals Committee. Providers have 30 calendar days from the date of the Committee's notice of an adverse decision to file a written request for an appeal. The Provider Appeals Committee is comprised of representatives from major clinical disciplines and at least one participating provider, none of whom participated in the original Carelon Behavioral Health of California adverse decision under review.

Requests for an appeal of adverse credentialing or recredentialing decisions of the Carelon Behavioral Health of California Credentialing Committee should include an explanation of the reasons the provider believes the Carelon Behavioral Health of California Credentialing Committee reached a decision to be in error and include supporting documentation. The Carelon Behavioral Health of California Provider Appeals Committee reviews the explanation provided, the information previously reviewed by the Carelon Behavioral Health of California Credentialing Committee and any additional information determined to be relevant. The Carelon Behavioral Health of California Provider Appeals Committee may request additional information from the provider in order to make a determination or decision. The Carelon Behavioral Health of California Provider Appeals Committee will support, modify, or overturn the decision of the
Carelon Behavioral Health of California Credentialing Committee. Written notification of the Carelon Behavioral Health of California Provider Appeals Committee's decision and an explanation of the decision is sent to the provider within 14 business days after the Carelon Behavioral Health of California Provider Appeals Committee's record is complete. All decisions of the Carelon Behavioral Health of California Provider Appeals Committee relative to provider appeals are final.

Fair Hearing Process for Individual Providers/Individual Participating Providers

Individual providers, where required by law, may request a fair hearing for issues related to quality of care, competence and/or professional conduct as a result of a proposed action or recommendation as determined by the Carelon Behavioral Health of California Credentialing Committee. The affected individual provider may request a formal fair hearing when the proposed action or written recommendation is for one of the following causes:

- Medical disciplinary cause or reason, meaning an aspect of an individual provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

- Conduct or professional competence of an individual provider, which adversely affects or could adversely affect the health or welfare of a patient(s).

Only the following types of actions or recommendations give rise to hearing rights:

- An individual provider's application for Carelon Behavioral Health of California network participation is denied or rejected for a medical disciplinary cause or reason as described above;
- Termination or non-renewal of an agreement for a medical disciplinary cause or reason as described above;
- Suspension or reduction of privileges to perform patient care services for a cumulative total of 30 calendar days or more in any 12-month period for a medical disciplinary cause or reason as described above; and/or
- Summary suspension of privileges to perform patient care service for more than 14 consecutive days for a medical disciplinary cause or reason as described above.

The Carelon Behavioral Health of California Credentialing Committee gives individual providers written notice of the Committee's decision regarding the adverse decision based on quality of care, competence, and/or professional conduct, the reason for the decision, fair hearing rights, and an explanation of fair hearing procedures. A request for a fair hearing must be submitted within 30 calendar days of the date of receipt of notification of an adverse action. The request must be submitted in writing and directed to the Chairperson of the Carelon Behavioral Health of California Credentialing Committee. The individual provider receives written notice of the place, time and date of the fair hearing, which shall not be less than 30 calendar days or more than 60 calendar days after the date the request for a fair hearing is received from the individual provider. If the individual provider does not request a formal hearing within the time and in the manner prescribed, the individual provider shall be deemed to have accepted the recommendation, decision, or action involved and it may be adopted by Carelon Behavioral Health of California as final action.

A supplemental notice, if applicable, is provided at the same time as the notice of the fair hearing and charges. The supplemental notice includes a list of the patient records, if any, which are to be discussed at the hearing and the names and addresses of individuals who are expected to give testimony or evidence in support of the original Carelon Behavioral Health of California Credentialing Committee action at the hearing. At least 10 calendar days prior to the hearing, the individual provider provides a written list of the names and addresses of the individuals who will give testimony or evidence in support of the individual provider at the hearing to the Carelon Behavioral Health of California Credentialing Committee Chairperson.

The Chairperson of the Carelon Behavioral Health of California Credentialing Committee will identify peer reviewers who will participate on the fair hearing panel. The following criteria are utilized in selecting panel members:

- A minimum of three California licensed individual participating providers who have the requisite expertise to ensure a fair hearing.
- Panel members shall be impartial and not have actively participated in the formal consideration of the matter at any previous level (i.e., they should not have acted as an accuser, investigator, fact finder or initial decision maker in the same matter).

- Panel members shall not be in direct economic competition with the affected individual provider and shall stand to gain no direct financial benefit from the outcome of the hearing.
- Whenever possible, at least one member should practice the same specialty as the affected individual provider.

One member of the fair hearing panel is selected to act as the hearing officer and will preside over the fair hearing. In lieu of appointing a hearing panel, the Carelon Behavioral Health of California Credentialing Committee has the discretion to hold the hearing before an arbitrator or arbitrators mutually acceptable to the individual provider and the Committee.

Fair hearings are provided for addressing issues of professional conduct or competence in healthcare. Accordingly, neither the individual provider nor the Carelon Behavioral Health of California Credentialing Committee may be represented by an attorney at the hearing unless the Hearing Officer, in their discretion, permits both sides to be represented. In no case may the Carelon Behavioral Health of California Credentialing Committee be represented by an attorney if the individual provider is not represented. Within 30 calendar days of the final adjournment of the hearing, the Hearing Panel shall issue a decision, which shall include finding of fact and conclusions articulating the connection between the evidence produced at the hearing and the result. A copy is sent to the Chairperson of the Carelon Behavioral Health of California Credentialing Committee, and via certified mail to the individual provider involved. The Hearing Panel's decision is final and there are no further rights of individual provider to appeal to Carelon Behavioral Health of California following a formal hearing.

Office Procedures

Member Rights and Responsibilities

Carelon Behavioral Health of California's Member Rights and Responsibilities is available in English and Spanish for download from the Carelon Behavioral Health of California website. Providers are encouraged to post the statement in their offices or waiting rooms or distribute the Statement to members at their initial visit. Carelon Behavioral Health of California members have the right to:

- Receive information about Carelon Behavioral Health of California services, benefits, providers, member rights and responsibilities, and clinical guidelines.
- Be treated with respect, dignity, and privacy regardless of race, gender identify, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.
- Receive information in a manner and format that is understandable and appropriate and to receive oral interpretation services free of charge for any Carelon Behavioral Health of California materials in any language.
- Be free from restraint and seclusion as a means of coercion, discipline, convenience, or retaliation.
- Have anyone choose to speak on their behalf in contacts with Carelon Behavioral Health of California, the right to decide who will make medical decisions for them if they cannot make them, and the right to refuse treatment, to the extent allowed by the law.
- Be a part of decisions that are made about plans for care, talk with their provider about the best treatment options for the condition, regardless of the cost of such care, or benefit coverage.

- Obtain information regarding their own treatment record with signed consent in a timely manner and have the right to request an amendment or correction be made to their medical records.
- A copy of the member rights and responsibilities, and a right to tell Carelon Behavioral Health of California what they think of the member rights and responsibilities.
- Exercise these rights without having treatment adversely affected in any way.
- Make complaints (verbally or in writing) about Carelon Behavioral Health of California staff, services or the care given by providers.
- Appeal if they disagree with a decision made by Carelon Behavioral Health of California about care.
- Have all communication regarding health information kept confidential by Carelon Behavioral Health of California staff and providers, to the extent required by law.
- Know about covered services, benefits, and decisions about health care payment with their plan, and how to seek these services, and receive timely care consistent with the need for care.
- Expect that providers will provide physical access, reasonable accommodations, and accessible equipment that is compliant with the Americans with Disabilities Act (ADA).
- Know the facts about any charge or bill received.
- Provide prior consent for services provided through telehealth.

For services offered by a third-party corporate telehealth provider (a corporation contracted with Carelon Behavioral Health of California for the delivery of services exclusively through a telehealth technology platform; provider has no physical location at which a member can receive services), Carelon Behavioral Health of California members have the right to:

- Access medical records related to services rendered.
- Object to medical records of any services provided through a third-party corporate telehealth provider being shared with their primary care provider.

Please note that all services rendered through a third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

Carelon Behavioral Health of Cifornia members have a responsibility to:

- Provide information, to the best of their ability that Carelon Behavioral Health of California or the provider may need to plan treatment.
- Learn about their condition and work with their provider to develop a plan for care and be responsible for following the agreed upon plans and instructions for care.
- Understand their benefits, what is covered and what is not covered, and understanding that they may be a responsible for payment of services that are not included in the Covered Services List.
- Notify their health plan and/or Carelon Behavioral Health of California and their provider of changes such as address changes, phone number change, or change in insurance.
- If required by their benefit, choosing a primary care provider and site for the coordination of all medical care.

- Contact their behavioral health provider if they are experiencing a mental health or substance use emergency.

Access to Treatment Records and Treatment Record Reviews/Audits

Carelon Behavioral Health of California may request access to and/or copies of member treatment records and/or conduct member treatment record reviews and/or audits:

- On an unplanned basis as part of continuous quality improvement and/or monitoring activities
- As part of routine quality and/or billing audits
- In response to an identified or alleged potential quality issue, professional competency or professional conduct issue or concern
- In the course of claims reviews and/or audits
- As may be necessary to verify compliance with the provider agreement.

Carelon Behavioral Health of California's treatment record standards and guidelines for member treatment record reviews conducted as part of quality management activities are described in the quality management section of this handbook.

Access to and any copies of member treatment records requested by Carelon Behavioral Health of California should be at no cost.

Providers must grant access for members to the member's treatment records upon written request and with appropriate identification. Providers should review member treatment records prior to granting access to members to ensure that confidential information about other family members and/or significant others that may be referenced and/or included therein are redacted.

Non-Discrimination Policy and Regulations

Providers agree to treat members without discrimination. Providers may not refuse to accept and treat a Carelon Behavioral Health of California member on the basis of their income, physical or mental condition, age, gender identity, sexual orientation, religion, creed, color, national origin, English proficiency, ancestry, marital status, veteran's status, occupation, claims experience, duration of coverage, race/ethnicity, ethnic group identification, pre-existing conditions, health status or ultimate payer for services. In the event that the provider does not have the capability or capacity to provide appropriate services to a member, the provider should direct the member to call Carelon Behavioral Health of California for assistance in locating needed services.

Providers may not close their practice to members unless it is closed to all patients. The exception to this rule is that a provider may decline to treat a member for whom it does not have the capability or capacity to provide appropriate services. In that case, the provider should either contact Carelon Behavioral Health of California or have the member call Carelon Behavioral Health of California for assistance in locating appropriate services.

State and federal laws prohibit discrimination against any individual who is a member of federal, state, or local public assistance, including medical assistance or unemployment compensation, solely because the individual is such a member.

Confidentiality, Privacy and Security of Identifiable Health Information

Providers are:

- Expected to comply with applicable federal and state privacy, confidentiality and security laws, rules and/or regulations, including without limitation the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules and regulations of the Substance Abuse Confidentiality Regulations 42 C.F.R. Part 2, Health Information Technology for Economic and Clinical Health Act (HITECH Act), and the California Confidentiality of Medical Information Act
- Responsible for meeting their obligations under these laws, rules and regulations, by implementing such activities as monitoring changes in the laws, implementing appropriate mitigation and corrective actions, and distributing notices timely to patients (members), government agencies and the media, when applicable.
- Responsible for obtaining from members written release of authorizations to share Substance

  Use Disorder PHI for payment or healthcare operations purposes. The release should be retained on file.

With the enactment of the federal HIPAA and HITECH Act, members or their legal guardian give consent for the release of information regarding treatment, payment, and health care operations at the signup for health insurance. Treatment, payment, and health care operations involve many different activities, including but not limited to:

- Submission and payment of claims
- Seeking authorization for extended treatment
- Quality Improvement initiatives, including information regarding the diagnosis, treatment, and condition of members to ensure compliance with contractual obligations
- Member information reviews in the context of management audits, financial audits, or program evaluations
- Chart reviews to monitor the provision of clinical services and ensure that authorization criteria are applied appropriately

In the event that Carelon Behavioral Health of California receives a complaint or becomes aware of a potential violation or breach of an obligation to secure or protect member information, Carelon Behavioral Health of California will notify the provider utilizing the general complaint process, and request that the provider respond to the allegation and implement corrective action when appropriate. Providers must respond to such requests and implement corrective action as indicated in communications from Carelon Behavioral Health of California.

Providers and their business associates interacting with Carelon Behavioral Health of California staff should make every effort to keep protected health information (PHI) and personally identifiable information (PII) secure. If a provider does not use email encryption, Carelon Behavioral Health of California recommends sending protected health information to Carelon Behavioral Health of California through an inquiry in the Provider Portal or by secure fax.

Appointment and Availability Standards

Providers are expected to maintain established office/service hours and access to appointments with standards established by Carelon Behavioral Health of California and as required by the Knox-Keene Act and all relevant State and Federal requirements. Carelon Behavioral Health of California's provider contract requires that the hours of operation of all providers are convenient to the population served and do not discriminate against members and that services are available twenty-four hours a

day, seven days a week, when medically necessary. The following are standards of availability for appointments, which providers are required to maintain:

Emergencies

In emergencies, the member must be offered the opportunity to be seen in person immediately. Providers who do not maintain coverage 24 hours per day, seven days per week are required to maintain a system for referring members to a source of emergency assistance during non-business hours. The preferred methods are through a live answering service or an on-call pager system. However, providers may elect to maintain a reliable recorded answering machine system, through which members experiencing an emergency are given clear instructions about how to access immediate assistance after hours.

Non-Life Threatening Emergencies

When there is significant risk of serious life deterioration such as impending inpatient hospitalization, the member must be seen within six hours of the request for an appointment.

Urgent

In an urgent situation, a member must be offered the opportunity to be seen within 48 hours of the request for an appointment.

Non-Urgent

In a non-urgent situation, a member must be offered the opportunity to be seen within 10 business days of the request for an appointment.

Follow-Up Appointments

When it is necessary for a provider or member to reschedule an appointment, the appointment must be promptly rescheduled in a manner that is appropriate for the member's health care needs, and ensures continuity of care consistent with good provider practice.

Non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider must be offered to a member within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition.

Non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider must not be limited to once every 10 business days.

Non-urgent appointments with a non-physician mental health care or substance use disorder provider will be offered within 10 business days of the request for an appointment.

Out-of-Office Coverage

Providers should:

- Contact Carelon Behavioral Health of California's Provider Relations team via email at provider.inquiry@carelon.com or the National Provider Service Line at 800-3971630 during normal business hours Monday through Friday, 8 a.m. to 8 p.m. ET to inform Carelon Behavioral Health of California of any unavailability or absence
- Submit a Leave of Absence/Out of Office Notification Form, located at www.Carelonbehavioralhealth.com.com to the address below and advise of coverage

arrangements in advance of vacation, sabbatical, illness, maternity leave (where applicable), and/or any other situation when a provider is unable to actively continue to treat Carelon Behavioral Health of California members. Such advance written notice should include the provider's name, licensure, practice locations affected, the reason for unavailability or absence and date range of unavailability or absence.

Mail to: Carelon Behavioral Health , Inc.
P.O. Box 989
Latham, NY 12110

OR

Fax: 866-612-7795

Upon return, providers should contact the National Provider Service Line at 800-397-1630 Monday through Friday, 8 a.m. to 8 p.m. ET and notify Carelon Behavioral Health of California at the address above in writing. Failure to contact Carelon Behavioral Health of California within 30 calendar days of return may result in referral, utilization management and claims processing delays due to the provider's inactive status. Failure to respond to communications from Carelon Behavioral Health of California related to inactive or out-of-office within the time period provided for such communications may result in termination of participation in Carelon Behavioral Health of California provider networks.

Termination and Leave of Absence

If a provider remains on inactive status for longer than six months, a reminder is sent informing the provider of the expiration date and the disenrollment process for failure to respond to said notice. **Catastrophic Event**

In the event that a provider is unable to meet any regulatory deadlines due to a catastrophic event, then the provider must notify Carelon Behavioral Health of California within five days of the event. Within 10 days after return to normal business operations, the provider must provide a certification in the form of a sworn affidavit that identifies the nature of the event, and the length of interruption of network status, claims submission or other administrative impact.

Requests for Additional Information

To maintain in-network status, providers must furnish Carelon Behavioral Health of California with any requested documentation or information promptly. Failure to do so may result in the provider's status being changed from active to inactive. Inactive providers are ineligible to receive referrals or reimbursement for services rendered to members of Carelon Behavioral Health of California.

Services to Members

Pursuant to the terms of the provider agreement, providers are contracted and credentialed to provide identified covered services to members. Covered services should be rendered in:

- The same manner as services rendered to other patients
- Accordance with accepted medical standards and all applicable state and/or federal laws, rules and/or regulations
- A quality and cost-effective manner

Providers should note that coverage for behavioral health services and any limitations and/or exclusions as well any pre-authorization and/or certification requirements for non-emergency services vary by benefit plan.

Providers must:

- Verify member eligibility and benefits using the Provider Portal prior to rendering non-emergency services;
- Document other or third party health benefit coverage for members (claims should be submitted to the primary payer initially);
- Preauthorize or certify care where required in Carelon Behavioral Health of California policies and procedures or the applicable member benefit plan, prior to rendering non-emergency services, using the Provider Portal;
- Collect member expenses from the member prior to, at the time of, or subsequent to services being rendered;
- Provide continuous care for members or arrange for on-call coverage by other Carelon Behavioral Health of California participating providers;
- Adhere to the accessibility and availability standards established by Carelon Behavioral Health of California;
- Provide equal treatment to patients in a non-discriminatory manner, regardless of source of payment or coverage type or product;
- Update demographic, office and/or provider profile information promptly and in advance of changes,
- Notify Carelon Behavioral Health of California of potential inpatient discharge problems;
- Advise members in writing of financial responsibility regarding services that are not covered, prior to rendering such service;
- Cooperate with Carelon Behavioral Health of California in coordinating continued care through alternative agencies, other vendors or community resources when benefits end;
- Notify Carelon Behavioral Health of California of members who may be candidates for potential Care Management;
- Coordinate care with a member's other health/medical care provider(s), either behavioral and/or medical providers who are treating the same or related (co-morbid) conditions;
- Screen, evaluate, and treat as medically necessary, any behavioral health problem
- Refer members to other participating providers when alternative or different mental health or substance use disorder services are required;
- Submit claims on behalf of members;
- Upon written request by Carelon Behavioral Health of California, submit copies of member treatment records without charge; and
- Make resources available to members who require culturally, linguistically, and/or disability competent care, such as, but not limited to disability and language assistance services.

Emergency Services

In the event of an emergency admission, providers should notify Carelon Behavioral Health of California of the date of admission as soon as reasonably practicable and in any event within 48 hours. Retrospective review of such admissions and associated services is subject to the terms of the member's benefit plan.

For employer sponsored behavioral health benefit members and Medi-Cal members, authorization is not required for any emergency services necessary to screen and stabilize patients when the member, who is seeking emergency services, believes in their subjective point of view that an emergency condition exists.

For Medicare members, emergency services that are necessary to screen and stabilize a member are authorized without prior approval when:

- A prudent layperson, acting reasonably, believes that an emergency behavioral health condition exists
- An authorized representative, acting on behalf of Carelon Behavioral Health of California, has authorized the provision of emergency services
- As otherwise required under applicable law

Carelon Behavioral Health of California will, at all times authorize an emergency psychiatric evaluation as per the member's benefit plan. **Referrals**

Providers may receive referrals from several sources, including but not limited to:

- Providers and/or other participating providers
- Self-referral of members
- From Carelon Behavioral Health of California
- Through an Employee Assistance Program (EAP)

Providers needing to refer a member for other or additional services should contact Carelon Behavioral Health of California to identify what are covered services under the member's benefit plan and any limitations, exclusions and/or notice, pre-authorization or certification or notification requirements under their benefit plan.

EAP Transition to MHSUD Benefits

For those members participating in an EAP administered by Carelon Behavioral Health of California and who may schedule and/or be referred for appointments for behavioral health services by providers under their benefit plan, providers must be sure to obtain pre-authorization or certification as may be required under the member's benefit plan. Questions regarding what are covered services under the member's benefit plan and associated member expenses for covered services should be directed to Carelon Behavioral Health of California by calling the number on the back of the member's identification card or by viewing a member's benefits on the "Benefit" tab in the Provider Portal.

Coordination with Primary Care/Treating Providers

As part of care coordination activities, providers should identify all providers involved in the medical and/or behavioral health care and treatment of a member. Subject to any required consent or authorization from the member, providers should coordinate the delivery of care to the member with

these providers. All coordination, including PCP coordination, should be documented accordingly in the member treatment record.

Tips to Improve Coordination of Care

1. Request a release of information from the member to coordinate with their medical providers. Use motivational interviewing techniques to encourage information sharing across providers.
    a. Educate the member that care coordination improves patient safety and can lead to improved treatment outcomes. Explain in detail what will be shared and why.
    b. Discuss any concerns about care coordination with the member. Encourage questions and provide adequate time for discussion.
2. Use a standard form to share information.
3. Follow a standard process for sharing and requesting information with the member's medical provider(s).
    a. Call the PCP office and ask the office manager or receptionist how best to communicate and share information. Discuss a protocol for any urgent medical needs.
    b. Routinely communicate with medical providers at specific points in treatment, such as when treatment begins, when there are changes in the member's status, or upon discharge.
4. Ensure that this coordination of care is documented in the member's medical record. Audit your own records for compliance with your policies and procedures
5. Ensure that your intake paperwork/process includes medical history.
6. Keep the member in the communication loop, as clinically appropriate. Provide ongoing updates on communication between you and other providers.

Continuation following Provider Agreement Expiration or Termination

Non-renewal and termination of the provider agreement is the process by which the provider agreement is not renewed at the end of the identified period and accordingly ends by its own terms, or the provider agreement is terminated as provided for in the terms of the provider agreement.

All notices of non-renewal and/or termination of the provider agreement should be in writing and in accordance with the applicable terms of the provider agreement.

- If a provider chooses to resign from the network and voluntarily surrender participation status, the provider must send Carelon Behavioral Health of California written notice of such request and/or notice of termination of the provider agreement 30 calendar days prior to the renewal date pursuant to the without cause termination provisions of the provider agreement. Carelon Behavioral Health of California will send the provider written acknowledgement of receipt of the provider's written request/notice and confirmation of the effective date of disenrollment/termination consistent with the provisions of the provider agreement. Providers who resign from the network or voluntarily/involuntarily terminate the provider agreement are not eligible for re-application for six months following the effective date of disenrollment/termination. Exceptions to the six-month timeframe may be considered in certain situations

The effective date of non-renewal or termination of the provider agreement is that date:

- Identified in the notice of non-renewal or termination of the provider agreement and consistent with the end of the specific notice period
- Mutually agreed upon in writing by the provider and Carelon Behavioral Health of California

On or before the effective date of non-renewal or any termination of the provider agreement, providers must provide Carelon Behavioral Health of California with a list of members for whom the provider has rendered services in the six-month period prior to the effective date of non-renewal or any termination of the provider agreement.

Providers must continue to provide covered services to members following the non-renewal or termination of the provider agreement until the course of treatment is complete or until Carelon Behavioral Health of California makes reasonable and medically appropriate arrangements to have another participating provider render services. Payment for such covered services rendered to members following non-renewal or termination are at the rates in the provider agreement.

Special Circumstances Continuing Care Obligations

For reasons other than medical disciplinary cause or reason, fraud or other criminal activity, providers at the request of the applicable member and in accordance with Carelon Behavioral Health of California policies and procedures, continue to provide covered services in Special Circumstances to members as described in this section. Providers must continue to provide covered services in Special Circumstances to members, at the rates and pursuant to the requirements specified in the provider agreement, at the time of termination of the provider agreement until the course of treatment is completed in accordance with the time periods listed below. This section does not require providers to cover services or provide benefits that are not otherwise covered under the terms and conditions of the provider agreement. **Time Periods for the Provision of Covered Services in Special Circumstances**

- **Acute Conditions** – Completion of covered services shall be provided for the duration of the acute condition or until the member's benefits are exhausted, whichever comes first.
- **Serious Chronic Conditions** – Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another participating provider, as determined by Carelon Behavioral Health of California in consultation with the member and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the provider's contract termination date or until the member's benefits are exhausted, whichever comes first.
- **Newborn Child between Birth and Age 36 Months** – Completion of covered services shall not exceed 12 months from the provider's contract termination date or until the member's benefits are exhausted, whichever comes first.
- **Surgery/Other Procedure** – Performance of a surgery or other procedure that is authorized by Carelon Behavioral Health of California as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the provider's contract termination
- **Terminal Illness** – Completion of covered services shall be provided for the duration of the illness, which may exceed 12 months from the provider's contract termination date.
- **Pregnancy** – Completion of covered services for the duration of the pregnancy. For a member who presents written documentation of being diagnosed with a maternal mental health

condition from the individual's treating healthcare provider, covered services shall not exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later.

Members and providers are encouraged to contact Carelon Behavioral Health of California to learn what options are available for continuing treatment after the transition period.

Certain Regulatory Requirements

Provider agreements include provisions requiring providers to comply with all applicable state and/or federal laws, rules and/or regulations, including without limitation those related to the provision of mental health and substance use disorder services (e.g., required licensure/certification, workplace standards, non-discrimination, etc.); child or elder abuse, and duty to warn or obligation to report certain types of disclosures by patients; and those related to fraud, waste and abuse. It is the responsibility of providers to understand and comply with the professional and legal requirements within California.

By way of example, the Americans with Disabilities Act of 1990, as amended (ADA) contains provisions regarding services to certain individuals identified as covered under the ADA. Providers are encouraged to adapt services and their offices/locations to meet the special needs of members.

Member or Member Representative Grievance Process

Carelon Behavioral Health of California has a grievance procedure for receiving and resolving member grievances involving Carelon Behavioral Health of California and/or providers. A grievance is a written or oral expression of dissatisfaction with Carelon Behavioral Health of California and/or a provider, including quality of care concerns, complaints, disputes, requests for reconsideration or appeals made by a member or the member's representative. A grievance may be submitted up to 180 calendar days following receipt of an adverse determination notice, or following any incident or action, that is the subject of the member's dissatisfaction.

As a participating provider for Carelon Behavioral Health of California, a provider may occasionally have a patient who requests assistance in submitting a grievance or appeal related to a determination or issue involving the member's Carelon Behavioral Health of California coverage. A copy of the Grievance Form, a description of the Grievance Process and assistance in filing a grievance must be readily available at each provider's service location.

A member, member's representative, or provider may submit a grievance to Carelon Behavioral Health of California in writing, by telephone, by fax, by email, by secure website, or by informing the provider. Upon request, a Carelon Behavioral Health of California representative will mail a grievance form and a copy of the grievance process. An Online Grievance Form can also be found at the Carelon Behavioral Health of California website for use by the member or provider. Member grievance forms are currently available in English and Spanish. If a grievance form is needed in another language, contact Carelon Behavioral Health of California directly. A Carelon Behavioral Health of California Member Services representative will assist in completing the grievance form, if needed.

A grievance may be submitted to Carelon Behavioral Health of California through the client specific telephone number printed on the member's identification card or at one of the following:

Phone: 800-228-1286 extension 262422

Fax: 877-635-4602 **Mail:**

Carelon Behavioral Health of California
C/o Grievance Unit
P.O. Box 6065
Cypress, CA 90630

Email: CAComplaints@carelon.com
Secure web site: www.carelonbehavioralhealthca.com

For grievances that are not resolved by the end of the next business day, Carelon Behavioral Health of California will send written acknowledgment of receipt of a grievance within five calendar days and will respond in writing with a resolution to a grievance within 30 calendar days of receipt.

Urgent Grievances

Carelon Behavioral Health of California also maintains a process for the expedited review of urgent grievances. The member has the right to an expedited review for cases involving an imminent and serious threat to the health of the member, including but not limited to severe pain, potential loss of life, limb, or major bodily functions. The request may be initiated by the member, member's representative or provider by calling 800-2281286 extension 262422 (TTY 800-735-2929) and notifying the Carelon Behavioral Health of California representative that an expedited review is being requested for an urgent grievance. Carelon Behavioral Health of California will notify the member's provider of the decision in no more than 72 hours and send the member a written statement on the disposition or pending status of the grievance, dispute or appeal within the same 72 hours from receipt of the grievance.

Independent Medical Review of Grievances Involving a Disputed Behavioral Health Care Service

A member may request an independent medical review (IMR) of Disputed Behavioral Health Care Services from the California Department of Managed Health Care if a member believes that behavioral health care services have been improperly denied, modified, or delayed by Carelon Behavioral Health of California in whole or in part because the service is not medically necessary. The IMR process is in addition to any other procedures or remedies that may be available to the member. The member pays no application or processing fees of any kind for IMR. Carelon Behavioral Health of California will provide an IMR application form with any grievance disposition letter that denies, modifies, or delays behavioral health care services. A decision not to participate in the IMR process may cause the member to forfeit any statutory right to pursue legal action against Carelon Behavioral Health of California regarding the Disputed Behavioral Health Care Service. Once a member has applied for an IMR, the provider agrees to cooperate with Carelon Behavioral Health of California in complying with all requirements of the IMR process.

Review by the Department of Managed Health Care (DMHC)

The California Department of Managed Health Care is responsible for regulating health care service plans. If a member has a grievance against Carelon Behavioral Health of California, the member

should first telephone Carelon Behavioral Health of California at 800-228-1286 (TTY 800-735-2929) Monday through Friday, 8 a.m. to 5 p.m. Pacific Time and use Carelon Behavioral Health of California's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the member. If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Carelon Behavioral Health of California, or a grievance that has remained unresolved for more than thirty (30) calendar days, the member may call the DMHC for assistance. The member may also be eligible for an Independent Medical Review (IMR). If the member is eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The DMHC also has a toll-free telephone number (**1-888-466-2219**) and a **TDD** line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Copies of the Carelon Behavioral Health of California Provider Dispute and Grievance policies are available upon request by calling 800-228-1286 extension 26244 Monday through Friday, 8 a.m. – 5 p.m. Pacific Time.

If a member has an administrative question or inquiry regarding eligibility, benefit coverage or any other matter relating to the benefit plans, the member may telephone Carelon Behavioral Health of California's Member Services Department at the toll-free number on the back of the member's identification card or by calling the telephone number listed in the Combined Evidence of Coverage and Disclosure Form. Carelon Behavioral Health of California's Member Services staff will work with the member to resolve the matter.

Claims Procedures

Carelon Behavioral Health of California maintains claims processing procedures designed to comply with the requirements of client plans and applicable California laws, rules and/or regulations.

Providers must file or submit claims within 90 calendar days from the date of service or the date of discharge for inpatient admission, or where applicable from date of determination by the primary payer.
Claims after the above noted 90 calendar daytime period may be denied due to lack of timely filing. Claims must match the authorization, certification, or notification applicable to covered services for which the claim applies to avoid potential delays in processing.

Providers in the Carelon Behavioral Health of California networks are strongly encouraged to electronically submit all claims. To electronically submit claims, participating providers may use the Provider Portal or one of the electronic claims resources detailed further in the section titled *Electronic Resources.* These resources will expedite claims processing.

Providers should not submit claims in their name for services that were provided by a physician's assistant, nurse practitioner, psychological assistant, intern or another clinician. In facility or program settings, supervising clinicians should not submit claims in their name for services that were provided by a resident, intern or psychological assistant. Separate claim forms must be submitted for each

member for whom the provider bills and it must contain all of the required data elements. Each billing line should be limited to one date of service and one procedure code.

When billing for CPT codes that include timed services in the code description, the actual time spent must clearly be documented within the member's treatment record. This time should indicate a session's start and stop times (e.g., 9:00-9:50).

Providers should submit claims consistent with national and industry standards. To ensure adherence to these standards, Carelon Behavioral Health of California relies on claims edits and investigative analysis processes to identify claims that are not in accordance with national and industry standards and therefore were paid in error. The claims' edits and investigative analysis process includes CMS's National Correct Coding Initiative (NCCI), which consists of:

- Procedure-to-Procedure edits that define pairs of HCPCS/CPT codes that should not be reported together.
- Medically Unlikely Edits (MUE) or units of service edits. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct and therefore needs to be supported by medical records.
- Other Edits for Improperly Coded Claims – regulatory or level of care requirements for correct coding.

Examples of claims edits can include but are not limited to the following:

- Invalid procedure and/or diagnosis codes
- Invalid code for place of service
- Invalid or inappropriate modifier for a code
- Edits to support Medi-Cal requirements
- Diagnosis codes that do not support the procedure
- Add-on codes reported without a primary procedure code
- Charges not supported by documentation based on review of medical records
- Claims from suspected fraudulent activities of providers and members that warrant additional review and consideration
- Services provided by a sanctioned provider or provider whose license has been revoked or restricted
- Incorrect fee schedule applied
- Duplicate claims paid in error
- No authorization on file for a service that requires prior authorization

All billings by the provider are considered final unless adjustments or a request for review is received by Carelon Behavioral Health of California through the provider dispute resolution process. Payment for covered services is based upon authorization, certification or notification (as applicable), coverage under the member's benefit plan and the member's eligibility at the time of service.

In the event Carelon Behavioral Health of California contests or denies a claim or portion thereof, Carelon Behavioral Health of California will notify the provider in writing within 30 business days after receipt of the claim. Such notice identifies the portion of the claim that is contested and the specific reasons for contesting the claim, and will advise the provider of any additional information required. A

claim, or portion thereof, is reasonably contested when Carelon Behavioral Health of California has not received all required information or if Carelon Behavioral Health of California has not been granted reasonable access to information concerning the services. Carelon Behavioral Health of California has an additional 30 business days upon receipt of the requested information to complete a reconsideration of the claim.

In the event a contested or uncontested claim is not paid by Carelon Behavioral Health of California within the respective time periods, interest will accrue at the rate of 15% per annum beginning with the first calendar day after the applicable 30 business day period. In the event Carelon Behavioral Health of California fails to pay such interest charge as described above, Carelon Behavioral Health of California will pay the provider an additional $10.00 fee per claim.

Required Claim Elements

Claims for covered services rendered to members should be submitted using UB-04 or CMS-1500 forms, or their respective electronic equivalent or successor forms, with all applicable fields completed and all elements/information required by Carelon Behavioral Health of California included. Claims that are not submitted on a UB-04 or CMS-1500 form may not contain the information needed to consider the claim clean and could cause the claim to reject or take a longer processing time. Claims submitted on old claim forms may be returned.

All required data elements must be provided, but they must also be current and match what Carelon Behavioral Health of California has on file. If the member's ID on the claim is illegible, or does not match what is on file, Carelon Behavioral Health of California may not be able to determine the claimant. It is strongly recommend that you obtain a copy of the member's ID card, and validate that it is current at the time of each visit.

There are times when supporting information is required to approve payment; if supporting documentation is not included, the claim may not be considered clean. Electronically submitted claims must also be in a HIPAA 5010 compliant format and conform to Carelon Behavioral Health of California requirements to be considered clean.

In addition, the claim should be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the provider must forward information reasonably requested for the purpose of consideration and in obtaining necessary information relating to coordination of benefits, subrogation, and verification of coverage, and health status.

Claims submission guidance, including required claim fields to make a clean claim, is available on the Carelon Behavioral Health website at www.carelonbehavioralhealth.com.

For paper claims, the use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. The following elements are required to take advantage of this automated process. If the provider does not follow these guidelines, claims may be returned from the scanning vendor:

- Use machine print
- Use original red claim forms
- Use black ink
- Print claim data within the defined boxes on the claim form
- Use all capital letters

- Use a laser printer for best results
- Use correction tape for corrections
- Submit any notes on 8 ½" x 11" paper
- Use an eight-digit date format (e.g., 10212013)
- Use a fixed width font (Courier, for example)

Requests for Additional Information

To maintain in-network status and upon request by Carelon Behavioral Health of California, or its authorized designee, providers must promptly furnish requested documentation or information related to and/or in support of claims submitted. Failure to do so may result in a change in network participation status from active to inactive. Inactive providers are ineligible to receive referrals or payment as a provider for covered services rendered to members.

Claim Processing

Carelon Behavioral Health of California, or its designee, processes complete and accurate claims submitted by providers for covered services rendered to members in accordance with normal claims processing policies and procedures, the payment terms included in the provider agreement, and applicable state and/or federal laws, rules and/or regulations with respect to timeliness of claims processing.

Normal claims processing procedures may include, without limitation, the use of automated systems, which compare claims submitted with diagnosis codes and/or procedure codes and associated billing or revenue codes. Automated systems may include edits that result in an adjustment of the payment to the provider for covered services or in a request for submission of treatment records.

A provider agrees that no payment is due for covered services or claims submitted unless the covered services are clearly and accurately documented in the treatment record prior to submission of the claim.

Reimbursement for covered services provided in an inpatient facility, inpatient rehabilitation or residential setting/level of care is at the contracted reimbursement rate in effect on the day of the admission.

Payment for services rendered to members is impacted by the terms in the provider agreement, the member's eligibility at the time of the service, whether the services were covered services, if the services were medically necessary, compliance with any preauthorization/certification/notification requirements, member expenses, timely submission of the claim, claims processing procedures, overpayment recovery, and/or coordination of benefits activities.

Note: Regardless of any provision to the contrary, providers acknowledge and agree that the payment rates in the provider agreement extend and apply to covered services rendered to members of benefit plans administered in whole or in part by Carelon Behavioral Health of California.

Provider Summary Vouchers

Provider Summary Vouchers (PSVs) or remittance advices are the documents that identify the amount(s) paid and member expenses due from the member. Providers should access PSVs through the Provider Portal or request copies of PSVs via facsimile through Carelon Behavioral Health of California's automated PSV faxback service at 866-409-5958.

Member Expenses

Member expenses due for covered services are determined by the member's benefit plan. Detailed information about most of the amounts of member expenses due for inpatient, outpatient or emergency covered services can be obtained by viewing a member's benefits on the "Benefit" tab in the Provider Portal. Providers are encouraged to contact Carelon Behavioral Health of California for questions regarding member expenses.

It is the responsibility of the provider to collect member expenses for covered services rendered.

Preauthorization, Certification or Notification

Preauthorization, certification or notification requirements vary from plan to plan. Providers must determine if such requirements exist prior to the provision of non-emergency services to members. Information regarding Carelon Behavioral Health of California's policies and procedures on authorization, certification or notification is located in the utilization management/review section of this handbook. Providers may not bill, charge or seek reimbursement or a deposit from members for services determined not to be medically necessary.

Providers may verify member eligibility, submit and review authorization/certification requests, and view authorizations/certifications through the Provider Portal.

No Balance Billing

Providers may not balance bill members for covered services rendered. This means that the provider may not bill, charge or seek reimbursement or a deposit from the member for covered services except for applicable member expenses, and non-covered services. Providers are required to comply with provisions of Carelon Behavioral Health of California's code of conduct where applicable, including, without limitation, cooperation with claims and billing procedures and participation in training and education. Balance billing education is provided and included in quarterly Fraud, Waste, and Abuse provider training. It is the provider's responsibility to check benefits prior to beginning treatment of the member, to obtain appropriate authorization to provide services, if applicable, and to follow the procedures set forth in this Handbook.

Coordination of Benefits

Some members may have health benefits coverage from more than one source. In these instances, benefit coverage is coordinated between primary and secondary payers.

Providers should obtain information from members as to whether the member has health benefits coverage from more than one source, and if so provide this information to Carelon Behavioral Health of California.

Coordination of benefits amongst different sources of coverage (payers) is governed by the terms of the member's benefit plan and applicable state and/or federal laws, rules and/or regulations. To the extent not otherwise required by applicable laws or regulations, providers agree that in no event will payment from primary and secondary payers for covered services rendered to members exceed the rate specified in the provider agreement.

Participating providers must submit a copy of the EOB through the Provider Portal that includes the primary payer's determination when submitting claims to Carelon Behavioral Health of California. The services included in the claim submitted to Carelon Behavioral Health of California should match the services included in the primary payer EOB.

Authorization, certification or notification requirements under the member's benefit plan still apply in coordination of benefits situations.

Note: Some benefit plans require that the member update at designated time periods (e.g., annually) other health benefit coverage information. Claims may be denied in the event the member fails to provide the required other coverage updates.

Overpayment Recovery

Providers should routinely review claims and payments in an effort to assure that they code correctly and have not received any overpayments. Carelon Behavioral Health of California will notify providers of overpayments identified by Carelon Behavioral Health of California, clients and/or government agencies, and/or their respective designees. Overpayments include, but are not limited to:

- Claims paid in error
- Claims allowed/paid greater than billed
- Inpatient claim charges equal to the allowed amounts
- Duplicate payments
- Payments made for individuals whose benefit coverage is or was terminated
- Payments made for services in excess of applicable benefit limitations
- Payments made in excess of amounts due in instances of third party liability and/or coordination of benefits.
- Claims submitted contrary to national and industry standards such as the CMS National Correct Coding Initiative (NCCI) and medically unlikely edits (MUE) described in the Claims Submission Guidelines

Subject to the terms of the provider agreement and applicable state and/or federal laws and/or regulations, Carelon Behavioral Health of California or its designee will pursue recovery of overpayments through:

- Adjustment of the claim or claims in question creating a negative balance reflected on the Provider Summary Voucher (PSV) (claims remittance)
- Written notice of the overpayment and request for repayment of the claims identified as over paid

Failure to respond to any written notice of and/or request for repayment of identified overpayments in the time period identified in the notice/request is deemed approval and agreement with the overpayment; thereafter Carelon Behavioral Health of California will adjust the claim or claims in question creating a negative balance. Any negative balance created will be offset against future claims payments until the negative balance is zeroed out and the full amount of the overpayment is recovered. Carelon Behavioral Health of California may use automated processes for claims adjustments in the overpayment recovery process.

In those instances, in which there is an outstanding negative balance because of claims adjustments for overpayments for more than 90 calendar days, Carelon Behavioral Health of California reserves the right to issue a demand for re-payment. Should a provider fail to respond and/or provide amounts demanded within the 30 calendar days of the date of the demand letter, Carelon Behavioral Health of California would pursue all available legal and equitable remedies, including without limitation placing the outstanding overpayment amount (negative balance) into collections.

If the provider disagrees with an overpayment recovery and/or request for re-payment of an overpayment, the provider may request a review in writing, such that the written request for review is received by Carelon Behavioral Health of California on or before the date identified in the notice of overpayment recovery or request for re-payment of an overpayment.

Provider Dispute Resolution Process

Carelon Behavioral Health of California has a provider dispute resolution process that is intended to provide for the fast, fair and cost-effective resolution of disagreements related to unresolved or disputed claims. In the event a provider has any dispute with respect to the performance or interpretation of the provider agreement, the provider agrees to attempt in good faith to resolve any matters of controversy according to Carelon Behavioral Health of California policies and procedures prior to the initiation by the provider of any legal action. Any disputes between the parties that cannot be resolved following such procedures shall be resolved through binding arbitration pursuant to the Rules of the American Arbitration Association for Arbitration of Commercial Disputes.

A provider dispute is a provider's written notice to Carelon Behavioral Health of California challenging, appealing or requesting reconsideration of:

- A claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested
- Seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered)
- Disputing a request for reimbursement of an overpayment of a claim
- Disputing a denial for authorization of payment for not following correct authorization procedures in requesting services

Each provider dispute must contain, at a minimum, the following information: provider's name, billing provider's tax ID number or provider ID number, provider's contact information, and:

- If the provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Carelon Behavioral Health of California to a provider, the following must be provided: original claim form number (located on the RA), a clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.
- If the provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue.
- If the provider dispute involves a patient or group of patients, the name and identification number(s) of the patient or patients, a clear explanation of the disputed item, including the date of services and the provider's position on the dispute, and the patient's written registration for the provider to represent said benefits.

A copy of the Provider Dispute Resolution Form can be found on the Carelon Behavioral Health of California website or by contacting a Carelon Behavioral Health of California representative at 800-228-1286 Monday through Friday, 8 a.m. to 5:00 p.m. PT.

Provider disputes may be submitted to the Carelon Behavioral Health of California Provider Dispute Department through email or address below: providerdisputeresolution@carelon.com

Carelon Behavioral Health
Provider Dispute Resolution
P.O. Box 1864
Hicksville, NY 11802-1864

National Provider Service Line at 800-397-1630

A provider dispute may be received by Carelon Behavioral Health of California within 365 calendar days of the date of the remittance statement. Carelon Behavioral Health of California will acknowledge the dispute within 15 business days if received by mail or two business days if received electronically of the date of receipt of the provider dispute. A provider dispute that does not include all required information may be returned to the submitter for completion. An amended provider dispute that includes the missing information may be submitted to Carelon Behavioral Health of California within 45 calendar days of receipt of a returned provider dispute. The written determination is sent within 45 business days of receipt of the provider dispute or the amended provider dispute.

At no time does Carelon Behavioral Health of California discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a dispute. There is no charge to providers for the dispute process and Carelon Behavioral Health of California has no obligation to reimburse a provider for any costs incurred in connection with utilizing the provider dispute resolution mechanism.

Substantially similar multiple claims, billing or contractual disputes, should be filed in batches as a single dispute per member, and may be submitted using either the Provider Dispute Resolution Multiple Requests or a personalized form with the required information.

If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, Carelon Behavioral Health of California will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five calendar days of the issuance of the written determination.

Providers have the right to formally appeal the decisions made through the provider dispute resolution process to the Carelon Behavioral Health of California Provider Appeals Committee. Providers have 30 calendar days from the date of the notice of the decision to file a written request for an appeal. The Carelon Behavioral Health of California Provider Appeals Committee is comprised of representatives from major clinical disciplines and at least one participating provider, none of whom participated in the original Carelon Behavioral Health of California decision under review.

Requests for an appeal should include an explanation of the reasons the provider believes the decision made through the provider dispute resolution process to be in error and include supporting documentation. The Carelon Behavioral Health of California Provider Appeals Committee reviews the explanation provided, the information previously reviewed through the provider dispute resolution process and any additional information determined to be relevant. The Carelon Behavioral Health of California Provider Appeals Committee may request additional information from the provider in order to make a determination or decision. The Carelon Behavioral Health of California Provider Appeals Committee will support, modify, or overturn the decision made through the provider dispute resolution process. Written notification of the Carelon Behavioral Health of California Provider Appeals Committee's decision and an explanation of the decision are sent to the provider within 14 business days after the Carelon Behavioral Health of California Provider Appeals Committee's record is

complete. All decisions of the Carelon Behavioral Health of California Provider Appeals Committee relative to provider appeals are final.

Claims Billing Audits

Carelon Behavioral Health of California reviews and monitors claims and billing practices of providers in response to referrals. Referrals may be received from a variety of sources, including without limitation:

- Members
- External referrals from state, federal and other regulatory agencies
- Internal staff
- Data analysis
- Whistleblowers

Carelon Behavioral Health of California also conducts unplanned audits. Carelon Behavioral Health of California conducts the majority of its audits by reviewing records that providers submit to Carelon Behavioral Health of California; in some instances, however, on-site audits are performed. Record review audits, or discovery audits, entail requesting an initial sample[1] of records from the provider to compare against claims submission records. Following the review of the initial sample, Carelon Behavioral Health of California may request additional records and pursue a full/comprehensive audit. Records reviewed may include, but are not limited to financial, administrative, current and past staff rosters, and treatment records. For the purposes of Carelon Behavioral Health of California audits, the treatment record includes, but is not limited to progress notes, medication prescriptions and monitoring, documentation of counseling sessions, the modalities and frequency of treatment furnished and results of clinical tests. It may also include summaries of the diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

Providers must supply copies of requested documents to Carelon Behavioral Health of California within the required timeframe. The required timeframe will vary based on the number of records requested, but will not normally be less than 10 business days when providers are asked to either scan or mail records to Carelon Behavioral Health of California. For the purpose of on-site audits, providers must make records available to Carelon Behavioral Health of California staff during the provider's audit. Providers are required to sign a form certifying all requested records and documentation were submitted or made available for the audit. Carelon Behavioral Health of California does not accept additional or missing documentation and/or records once this form is signed, including for the purposes of a request for appeal. Carelon Behavioral Health of California does not reimburse providers for copying fees related to requests for documents and/or treatment records requested during a claims billing audit.

In the course of an audit, documents and records provided are compared against the claims submitted by the provider. Claims must be supported by adequate documentation of the treatment and services rendered. Providers' strict adherence to these guidelines is required. A member's treatment record must include the following core elements: member name, date of service, rendering provider signature and/or rendering provider name and credentials, diagnosis code, start and stop times (e.g. 9:00 to

[1] Unless otherwise required by a specific client or government agency, Carelon Behavioral Health of California utilizes the Office of Inspector General's (OIG) Random Sample Determination Tool (RAT-STATS) to select a random and statistically valid sample of eligible records.

9:50), time based CPT codes and service code to substantiate the billed services. Documentation must also meet the requirements outlined in the *Treatment Record Standard and Guidelines* section of the Provider Handbook. Carelon Behavioral Health of California coordinates claims billing audits with appropriate Carelon Behavioral Health of California clinical representatives when necessary. The lack of proper documentation for services rendered could result in denial of payment, or, if payment has already been issued, a request for refund.

Following completion of review of the documents and records received, Carelon Behavioral Health of California provides a written report of the findings to the provider. In some instances, such report of the findings may include a request for additional records.

Carelon Behavioral Health of California has established an audit error rate threshold of 10 percent to determine whether the provider had accurate, complete and timely claim/encounter submissions for the audit review period. Depending on the audit error rate and the corresponding audit results, Carelon Behavioral Health of California's report of findings may include specific requirements for corrective action to be implemented by the provider if the audit identifies improper or unsubstantiated billings. Requirements may include, but are not limited to:

- **Education/Training** – Carelon Behavioral Health of California may require the provider to work with Provider Relations to develop an educational/training program addressing the deficiencies identified. Carelon Behavioral Health of California can provide tools to assist the provider in correcting such deficiencies.
- **Corrective Action Plan** – Carelon Behavioral Health of California may require the provider to submit a corrective action plan identifying steps the provider must take to correct all identified deficiencies. Corrective action plans should include, at a minimum, confirmation of the provider's understanding of the audit findings and agreement to correct the identified deficiencies within a specific timeframe.
- **Repayment of Claims** – The audit report specifies any overpayments by Carelon Behavioral Health of California. The overpayment amount is based on the actual deficiency determined in the audit process, or the value of the claims identified as billed without accurate or supportive documentation. Carelon Behavioral Health of California does not use extrapolation to determine recovery amounts. The provider is responsible for paying the actual amount owed, based on Carelon Behavioral Health of California findings within 10 business days, unless the provider has an approved installment payment plan.
- **Monitoring** – Carelon Behavioral Health of California may require monitoring of claims submissions and treatment records in 90-day increments until compliance is demonstrated. The provider's monitored claims are not submitted for payment until each is reviewed for accuracy and correctness.
- **Referral to the Carelon Behavioral Health of California Credentialing Committee** – Carelon Behavioral Health of California's audit team may determine that the results of an audit warrant a referral to the Carelon Behavioral Health of California Credentialing Committee for further action, up to and including disenrollment from the network.

Appeal

If the provider disagrees with an audit report's findings, the provider may request an appeal of the audit report of findings. All appeals must be submitted in writing and received by Carelon Behavioral Health of California or its designee on or before the due date identified in the report of findings letter.

Carelon Behavioral Health of California has no obligation to consider late filed appeals. Appeals must include:

- A copy of the audit report of findings letter;
- The provider's name and identification number;
- Contact information;
- Identification of the claims at issue, include the name or names of the members, dates of service, and an explanation of the reason/basis for the dispute.

Absent extraordinary circumstances, Carelon Behavioral Health of California will not accept or consider documentation and/or records that were not submitted with the original audit submission.

The provider's appeal will be presented to Carelon Behavioral Health (Carelon Behavioral Health) National Compliance – Corporate SIU Subcommittee within 45 calendar days of receiving the provider's request for an appeal. The subcommittee is comprised of staff who have not been involved in reaching the prior findings. The subcommittee will review the provider's appeal documentation, discuss the facts of the case, as well as any applicable contractual, state or federal statutes. The staff member/auditor who completed the provider's audit will present their audit findings to the subcommittee but will not vote on the appeal itself. The subcommittee will uphold, overturn, uphold in part or pend the appeal for more information. Once a vote is taken, it will be documented and communicated to the provider within 10 business days of the subcommittee meeting. If additional time is needed to complete the appeal, a letter of extension is sent to the provider requesting any additional information required of the provider and estimating a time of completion. If repayments or corrective action plan (CAP) are required, the provider must submit the required repayments or CAP within 10 business days of receiving the subcommittee's findings letter, unless an installment payment plan is approved.

Carelon Behavioral Health of California will take appropriate legal and administrative action in the event a provider fails to supply requested documentation and member records or fails to cooperate with a Carelon Behavioral Health of California corrective action plan. Carelon Behavioral Health of California may also terminate the provider agreement and/or take actions to recover amounts previously paid on claims. Carelon Behavioral Health of California reports any suspicion or knowledge of fraud, waste and abuse to the appropriate authorities or regulatory agency as required or when appropriate.

Fraud, Waste, and Abuse

Carelon Behavioral Health of California interacts with employees, clients, vendors, providers and members using the highest clinical and business ethics seeking to establish a culture that promotes the prevention, detection and resolution of possible violations of laws and unethical conduct. In support of this, Carelon Behavioral Health of California's compliance and anti-fraud plan was established to prevent and detect fraud, waste or abuse in the behavioral health system through effective communication, training, review and investigation. The plan, which includes a code of conduct, is intended to be a systematic process aimed at monitoring operations, subcontractors and provider's compliance with applicable laws, regulations, and contractual obligations, as appropriate. Providers are required to comply with provisions of the code of conduct where applicable, including without limitation cooperation with claims billing audits, post-payment reviews, benefit plan oversight and monitoring activities, government agency audits and reviews, and participation in training and education.

Examples of provider fraud, waste, and abuse include altered medical records, patterns for billing that include billing for services not provided, up-coding, or bundling and unbundling, or medically unnecessary care. Examples of member fraud, waste, and abuse include under/unreported income, household membership (spouse/absent parent), out-of-state residence, third party liability, or narcotic use/sales/distribution.

Fraud

Fraud is the intentional deception or misrepresentation made by a person or provider with the knowledge that the deception could result in payment of an unauthorized benefit. It includes any act that constitutes fraud under applicable Federal or State law.

Elements of Fraud:

- The act (evidence of wrong-doing);
- Knowledge and intent (willfully intended to commit act – generally evidenced by a pattern of wrong-doing); and
- Benefit (some type of measurable benefit obtained from the act by the person committing the act

Waste

Waste is considered thoughtless, careless expenditure, consumption, mismanagement, use or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices, systems or controls.

Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary costs to Medicare/Medi-Cal or other programs, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. Members receiving care in the healthcare system can also commit acts of abuse (e.g., by loaning or selling their identification cards).

Elements of Abuse:

- Inconsistency (pattern of not following known laws, rules, regulations, contracts or industry practices/procedures);
- Costs (unnecessary loss of money to a governmental program); and/or
- Medically unnecessary/does not meet standards (general disregard for professional or industry standards and practices).

Reporting Fraud, Waste, and Abuse

The reporting of suspected fraud and abuse is intended to avoid the misappropriation of Federal, State, and other funding sources. Fraud, waste and abuse can result in the misuse of Federal and State funds, can jeopardize the care and treatment of persons receiving services, and can result in monetary fines, criminal prosecution, termination of providers, and prohibition from participation in Medicare/Medi-Cal Programs.

Providers are required to report any suspicion of potential fraud, waste and abuse. To the extent practical, Carelon Behavioral Health of California maintains and respects the confidentiality and privacy of all members, providers and vendors in the course of the investigation and resolution of any

reported incident. Providers must cooperate fully with any investigation. Carelon Behavioral Health of California does not discriminate or retaliate against a member or provider for reporting potentially fraudulent activity or cooperating in any government or law enforcement authority's investigation of prosecution.

Providers should report fraud, waste and abuse, or suspicious activity thereof, such as inappropriate billing practices (e.g., billing for services not rendered, or use of CPT codes not documented in the treatment record).Report questionable billing practices or suspected fraud to https://www.fighthealthcarefraud.com/report-fraud-form/. From the drop down menu "Who is the insurance company?" select **Carelon Behavioral Health** .

If Carelon Behavioral Health of California identifies that fraud, waste, or abuse has occurred based on information, data, or facts, Carelon Behavioral Health of California must immediately notify relevant state and federal program integrity agencies following the completion of ordinary due diligence regarding a suspected fraud, waste, or abuse case.

Utilization Management

The Carelon Behavioral Health of California utilization management program encompasses management of care from the point of entry through discharge using objective, standardized, and widely distributed clinical protocols and enhanced outpatient care management interventions. Specific utilization management activities may apply for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk. Providers are required to comply with utilization management policies and procedures and associated review processes.

Examples of review activities included in Carelon Behavioral Health of California's utilization management program are determinations of medical necessity, preauthorization, certification, notification, concurrent review, retrospective review, care/case management, discharge planning and coordination of care.

The Carelon Behavioral Health of California utilization management program includes processes to address:

- Easy and early access to appropriate treatment
- Working collaboratively with providers in promoting delivery of quality care according to accepted best-practice standards
- Addressing the needs of special populations, such as children and the elderly
- Identification of common illnesses or trends of illness
- Identification of high-risk cases for intensive care management
- Screening, education and outreach

Objective, scientifically based medical necessity criteria and clinical practice guidelines, in the context of provider or member supplied clinical information, guide the utilization management processes.

All utilization management decisions are based on the approved medical necessity criteria. Additionally, criteria are applied with consideration to the individual needs of the member and an assessment of the local delivery system.

1. Individual needs and characteristics of the member include age, linguistic, or ethnic factors, comorbidities and complications, progress of treatment, psychosocial situation, and home environment.
2. Characteristics of the local delivery system available to the member include aspects such as availability of alternative levels of care, benefit coverage for the available alternatives, and ability of local providers to provide all recommended services within the estimated length of stay.

Prior to beginning a course of outpatient treatment and/or a non-emergency admission, providers must verify member eligibility and obtain authorization or certification (where applicable). Providers are encouraged to verify eligibility and benefits and to submit authorization requests (where applicable) via the Provider Portal.

In order to verify member eligibility, the provider needs to have the following information available:

- Patient's name, date of birth and member identification number
- Insured or covered employee's name, date of birth and member identification number
- Information about other or additional insurance or health benefit coverage

Based on the most recent data provided by the employer or health plan, Carelon Behavioral Health of California will:

- Verify member eligibility
- Identify benefits and associated member expenses under the member's benefit plan
- Identify the authorization or certification procedures and requirements under the member's benefit plan

Note: Verification of eligibility and/or identification of benefits and member expenses are not authorization, certification, or a guarantee of payment.

New and Emerging Technologies

Carelon Behavioral Health of California recognizes the need for knowledge of emerging technologies to provide access to optimum care for members. Carelon Behavioral Health of California evaluates these technologies in terms of their overall potential benefits to members and in some instances recommends these technologies to clients for inclusion in their respective benefit packages. Examples of new technologies are psychotropic medications or new, approved uses of current medications, innovative community service programs and new approaches to provision of psychotherapy and treatment. Carelon Behavioral Health of California has established committees that conduct formal reviews of potential new technologies. The effectiveness of new service technologies is considered in medical necessity decisions.

Treatment Planning

Providers must develop individualized treatment plans that utilize assessment data, address the member's current problems related to the behavioral health diagnosis, and actively include the member and significant others, as appropriate, in the treatment planning process. Clinical Care Managers (CCMs) review the treatment plans with the providers to ensure that they include all elements required by the provider agreement, and at a minimum:

- Specific measurable goals and objectives

- Reflect the use of relevant therapies
- Show appropriate involvement of pertinent community agencies
- Demonstrate discharge planning from the time of admission
- Reflect active involvement of the member and significant others as appropriate

Providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.

Clinical Review Process

Provider cooperation in efforts to review care prospectively is an integral part of care coordination activities. Subject to the terms of the member's benefit plan and applicable state and/or federal laws and/or regulations, providers must notify Carelon Behavioral Health of California prior to admitting a member to any nonemergency level of care. The Mental Health Parity & Addiction Equity Act of 2008 requires that mental health and substance use disorder benefits provided by group health plans with more than 50 employees must be available on an equivalent or better basis to any medical or surgical benefits. Some benefit plans, but not all, may fall under this guideline and do not require notification or authorization for standard outpatient services. Others may allow for a designated number of outpatient sessions without priorauthorization, certification, or notification. Carelon Behavioral Health of California may request clinical information at various points in treatment to ensure the ongoing need for care and treatment that is appropriate and effective in improving health outcomes for members.

In all cases, providers are encouraged to contact Carelon Behavioral Health of California prior to initiating any nonemergency treatment to verify member eligibility and to clarify what the authorization or certification requirements are, if any, for the proposed treatment.

Coverage and payment for services proposed for and/or provided to members for the identification or treatment of a member's condition or illness is conditioned upon member eligibility, the benefits covered under the member's benefit plan at the time of service, and on the determination of medical necessity of such services and/or treatment. Overpayments made because of a change in member eligibility are subject to recovery.

Subject to verification of eligibility under the member's benefit plan, upon request for authorization or certification of services, the Clinical Care Manager (CCM) gathers the required clinical information from the provider, references the appropriate medical necessity criteria for the services and/or level of care, and determines whether the services and treatment meets criteria for medical necessity. The CCM may authorize or certify levels of care and treatment services that are specified under the member's benefit plan (e.g., acute inpatient, residential, partial hospitalization, intensive outpatient, or outpatient). Authorizations or certifications are for a specific number of services/units of services/days and for a specific time period based on the member's clinical needs and provider characteristics. Carelon Behavioral Health of California reserves the right to reject or return authorization requests that are incomplete, lacking in specificity, or incorrectly filled out. Carelon Behavioral Health of California provides an explanation of action, which must be taken by the provider to resubmit the request.

Carelon Behavioral Health of California is required by the state, federal government, and applicable accreditation entities such as NCQA to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. Carelon Behavioral Health of California has adopted the strictest timeframe for all UM decisions to comply with the various requirements.

Carelon Behavioral Health of California's internal timeframes for rendering a UM determination and notifying members of such determination begin at the time of Carelon Behavioral Health of California's receipt of the request. The maximum timeframes may vary on a case-by-case basis in accordance with state, federal government, or NCQA requirements.

Prior to initial determinations of medical necessity, the member's eligibility status and coverage under a benefit plan administered by Carelon Behavioral Health of California should be confirmed. If eligibility information is not available in non-emergency situations, a CCM may complete a screening assessment and pend the authorization/certification awaiting eligibility verification. CCMs will work with members and providers in situations of emergency, regardless of eligibility status.

If a member's benefits have been exhausted or the member's benefit plan does not include coverage for behavioral health services, the CCM, in coordination with the provider as appropriate, will provide the member with information about available community support services and programs, such as local or state-funded agencies or facilities that might provide sliding scale discounts for continued care.

Definition of Medical Necessity

Commercial

Medically necessary services for **Commercial** behavioral health care plans vary as noted below:

- Medically necessary treatment of a mental health or substance use disorder means a service or product addressing the specific needs of that patient for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
    - In accordance with the generally accepted standards of mental health and substance use disorder care.
    - Clinically appropriate in terms of type, frequency, extent, site, and duration.
    - Not primarily for the economic benefit of the health care service plan and members or for the convenience of the patient, treating physician, or other health care provider.

A mental health condition or substance use disorder or mental disorder is defined as a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems will not affect the conditions covered by this section, as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

Medicare

For Medicare members, a reasonable and necessary service is:

- Safe and effective;
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and

- Appropriate, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
    - Furnished in a setting appropriate to the patient's medical needs and condition;
    - Ordered and furnished by qualified personnel;
    - One that meets, but does not exceed, the patient's medical need; and
    - At least as beneficial as an existing and available medically appropriate alternative.

Medi-Cal

Per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5), Carelon Behavioral Health of California applies the definition of medically necessary services for Medi-Cal members as services that:

- Are reasonable and necessary to protect life, prevent illness or disability
- Alleviate severe pain through the diagnosis or treatment of disease, illness or injury,
- Achieve age-appropriate growth and development; and
- Attain, maintain, or regain functional capacity

Additionally, when determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).

Where there is an overlap between Medicare and Medi-Cal benefits (e.g., durable medical equipment services), the Carelon Behavioral Health of California definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards will apply.

Medical Necessity Criteria

Carelon Behavioral Health of California's medical necessity criteria, also known as clinical criteria, are reviewed and updated at least annually to ensure that they reflect the latest developments in serving individuals with behavioral health diagnoses. The Carelon Behavioral Health of California Quality Management/Utilization Management/Case Management (QMUMCM) Committee and the Carelon Behavioral Health of California Board of Directors adopts, reviews, revises and approves medical necessity criteria on an annual basis.

Clinical staff identifies the correct medical necessity criteria, which can vary according to individual contractual obligations, state/federal requirements and member benefit coverage. Medical Necessity Criteria is available on Carelon Behavioral Health of California's website via hyperlink whenever possible and is available upon request. To order a copy of the ASAM criteria, please go the following website: www.asam.org/asam-criteria.. In addition, Carelon Behavioral Health of California disseminates criteria sets via the websites, provider handbook, provider forums, newsletters, and individual training sessions. Training, reference materials, and decision trees are provided to ensure clinical staff chooses the correct criteria. To determine the proper medical necessity criteria, the following can be used as a guide based on plan type and type of service being requested:

1. For all Medicare members, identify relevant Centers for Medicare and Medicaid (CMS) National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.
2. If no CMS criteria exist for Medicare members, Change Healthcare's InterQual® Behavioral Health Criteria would be appropriate.
3. For **behavioral health services**, custom criteria is often state or plan/contract specific:
    - California Commercial plans utilize LOCUS/CALOCUS/ECSII and WPATH Standards of Care.

      * *Exception: InterQual® Behavioral Health Criteria is utilized for ABA services, as there are no non-profit criteria currently available.*
    - County Medi-Cal Plans: Title 9 of the California Code of Regulations

      * *Exception: InterQual® Behavioral Health Criteria is utilized for Neuropsychological and Psychological Testing requests*
4. For **substance use related services**, Carelon Behavioral Health of California uses the American Society of Addiction Medicine (ASAM) criteria for all lines of business.

   ** Exception: Substance Use Lab Testing Criteria is in InterQual® Behavioral Health Criteria is applied to Medicare membership.*
5. If the applicable level of care is not found within the criteria above or 1-4 are not met, Carelon Behavioral Health of California's Medical Necessity Criteria would be appropriate to use for Clinical Practice Guidelines

Clinical Practice Guidelines

Carelon Behavioral Health of California reviews and endorses clinical practice guidelines on a regular basis to support providers in making evidence-based care treatment decisions on a variety of topics. The most up-to-date, endorsed, clinical practice guidelines are posted on the Carelon Behavioral Health of California website.

Carelon Behavioral Health of California develops, revises, and/or adopts treatment guidelines from nationally recognized sources, and scientific bodies including professional organizations (e.g., American Psychiatric Association) based on scientific evidence, best practice professional standards and expert input from board certified physicians from appropriate specialties. Input may also be gathered from practitioners, members and/or community agencies, especially when required by contract or regulation.

Other clinical practice resources, while not considered current, still contain information that continues to be clinically relevant. For example, some of the guidelines may recommend specific treatment interventions without adequately addressing the sufficiency of the evidence to support the recommendation. Continued use of the guidelines is warranted because resultant positive clinical contribution outweighs the fact that the summaries of the supporting research may have lacked adequate transparency related to the process of ranking the studies necessary to meet today's standards of guideline development.

For health plans managed under the purview of the Department of Managed Health Care, guidelines are required to be evaluated, and updated if necessary, at least annually. These clinical practice guidelines are used in collaboration with providers to help guide appropriate and clinically effective care for a variety of complex psychiatric conditions. They may also may be referred to by Clinical Care Managers and peer reviewers during reviews.

Carelon Behavioral Health of California's Quality Management/Utilization Management/Case Management (QMUMCM) Committee assesses and makes determinations on all clinical practice guidelines. Recommendations for clinical practice guidelines can also be made to Carelon Behavioral Health of California by the Scientific Review Committee , which is a committee operated by Carelon Behavioral Health . Carelon Behavioral Health Scientific Review Committee is responsible for the maintenance of: Clinical Practice Guidelines, the determination of technologies and therapies as evidence based, and the establishment of best practice standards. Recommendations received by Carelon Behavioral Health of California from the Scientific Review Committee are reviewed by the QMUMCM Committee and the Carelon Behavioral Health of California Board of Directors for final approval.

As Carelon Behavioral Health of California providers, you are expected to ensure your standards of practice align with the endorsed clinical practice guidelines.

Carelon Behavioral Health of California's Care Management System

Members and providers may access the Carelon Behavioral Health of California care management system through any of the following avenues:

- 24-hour toll-free emergency care/clinical referral line
- Direct registration/certification of care through the Provider Portal for participating providers
- Direct authorization/certification of all levels of care through referral by a Carelon Behavioral Health of California Clinical Care Manager (CCM)
- Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms or crisis response teams

If a call is received from a member requesting a referral and/or information about providers in the member's location, CCMs may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to participating providers, taking into account member preferences such as geographic location, hours of service, cultural or language requirements, type of degree the provider holds and gender. Additionally, the member may require a clinician with a specialty such as the treatment of eating disorders. In all cases, where available, the CCM will assist in arranging care for the member. The name, location and phone number of at least three participating providers are given to the member.

Clinical Care Manager Reviews

Carelon Behavioral Health of California Clinical Care Managers (CCMs) base reviews on established criteria adopted or developed by Carelon Behavioral Health of California. CCMs are trained to match the needs of members to appropriate services, levels of care, treatment and length of stay, and community support. This requires careful consideration of the intensity and severity of clinical data presented, with the goal of quality treatment in the least restrictive environment. The clinical integrity of the utilization management program seeks to provide that members are appropriately monitored and that comprehensive reviews of all levels of care are provided. Those cases that appear to be outside of best practice guidelines or appear to have extraordinary treatment needs are referred for specialized reviews. These may include evaluation for intensive care management, clinical rounds, peer advisor review or more frequent CCM review.

CCMs obtain clinical data from the provider or designee relating to the need for care and treatment planning. The CCM evaluates this information and references applicable clinical criteria to determine medical necessity of the requested level of care or service. Where appropriate, care is pre-certified for a specific number of services/days for a specific time period at a specific level of care, based on the needs of the member.

Except where disclosure of certain information is expressly prohibited by or contrary to applicable state or federal laws or regulations, providers must be prepared to provide Carelon Behavioral Health of California with the following information at the time of the review, as necessary and appropriate:

- Demographics
- Diagnosis (current DSM or ICD)
- Reason for admission/precipitant
- Suicidal/homicidal risk, including:
  - Ideation
  - Plan
  - Intent
  - psychotic/non-psychotic (e.g., command hallucinations, paranoid delusions)
- Substance use disorder history
  - Type
  - Amount
  - Withdrawal symptoms
  - Vital signs
  - Date(s) of initial use and last use
  - Date(s) of periods of sobriety
- Other presenting problem/symptomatology description, if applicable
- Progress since admission (if concurrent review)
- Medical problems
  - Medical history
  - Organic cause of psychiatric symptoms/behaviors
  - Medical problems which exacerbate psychiatric or substance use symptoms/behaviors
- Current medications
  - Types(s)
  - Dosage(s)
  - Date(s)

- Duration
- Response
- Provider(s)

- Primary care physician (PCP) interface, if applicable
- Other behavioral health care provider interface, if applicable
- General level of functioning
  - Sleep
  - Appetite
  - Mental status
  - ADLs (Activities of Daily Living)
- Psychological stressors and supports
  - Socioeconomic
  - Family
  - Legal
  - Social
  - Abuse, neglect, domestic violence (as appropriate)
- Response to previous treatment
  - Previous treatment history, most recent treatment, past treatment failures
  - Relapse/recidivism, motivation for treatment
  - Indications of compliance with treatment recommendations
- Treatment plan
  - Estimated length of stay
  - Treatment goals
  - Specific planned interventions
  - Family involvement
  - Precautions for specific risk behaviors

- Educational component for regulatory compliance and substance use disorder situations

- Discharge plan
  - Aftercare required upon discharge
  - Barriers to discharge

Inpatient or Higher Levels of Care

All inpatient and alternative level of care programs (this does not include outpatient therapy rendered in a provider's office or outpatient therapy in a clinic or hospital setting) is subject to the review requirements described in this section. Prior to non-emergency admission and/or beginning treatment, the provider must contact Carelon Behavioral Health of California:

- For notification
- To confirm benefits and verify member eligibility
- To provide clinical information regarding the member's condition and proposed treatment
- For authorizations or certifications, where required under the member's benefit plan

It is preferred that providers use the Provider Portal, available 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues) to confirm benefits and provide notification and clinical information as appropriate. Participating providers can secure copies of the authorization/certification requests at time of submission for their records. The web portal can be utilized for concurrent reviews and discharge reviews as well as initial or precertification reviews.

Clinical Care Managers (CCMs) and/or Referral Line Clinicians are available 24 hours a day, seven days a week, 365 days a year and can provide assessment, referrals, and conduct authorization or certification reviews if such processes are unavailable through the Provider Portal.

Where authorization, certification or notification is required by the member's benefit plan and unless otherwise indicated in the provider agreement, providers should contact Carelon Behavioral Health of California within 48 hours of any emergency admission for notification and/or to obtain any required authorization or certification for continued stay.

If prior to the end of the initial or any subsequent authorization or certification, the provider proposes to continue treatment, the provider must contact Carelon Behavioral Health of California by phone or the Provider Portal for a review and recertification of medical necessity. It is important that this review process be completed more than 24 hours prior to the end of the current authorization or certification period.

Continued stay reviews:

- Focus on continued severity of symptoms, appropriateness and intensity of treatment plan, member progress and discharge planning
- Involve review of treatment records and discussions with the provider or appropriate facility staff, Employee Assistance Program (EAP) staff or other behavioral health providers and reference to the applicable medical necessity criteria.

In instances where the continued stay review by a CCM does not meet medical necessity criteria and/or where questions arise as to elements of a treatment plan or discharge plan, the CCM will forward the case file to a Peer Advisor for review.

Discharge Planning

Discharge planning is an integral part of treatment and begins with the initial review. As a member is transitioned from inpatient and/or higher levels of care, the Clinical Care Manager (CCM) reviews/discusses the discharge plan with the provider. The following information may be requested and must be documented:

- Discharge date
- Aftercare date
    - Date of first post-discharge appointment (must occur within seven days of discharge)
    - With whom (name, credentials)
    - Where (level of care, program/facility name)
- Other treatment resources to be utilized
    - Types
    - Frequency
- Medications
    - Patient/family education regarding purpose and possible side effects
    - Medication plan including responsible parties
- Support systems
    - Familial, occupational and social support systems available to the patient. If key supports are absent or problematic, how has this been addressed
    - Community resources/self-help groups recommended (note purpose)
- EAP linkage
    - If indicated (e.g., for substance use aftercare, workplace issues, such as Return-to- Work Conference, enhanced wrap-around services) indicate how this will occur
- Medical aftercare (if indicated, note plan, including responsible parties)
- Family/work community preparation
    - Family illness education, work or school coordination, (e.g., EAP and Return-to-Work Conference) or other preparation done to support successful community reintegration. Note specific plan, including responsible parties and their understanding of the plan.

Case Management Services (for select patients who meet high-risk criteria)

As part of the case management program at Carelon Behavioral Health of California, assistance is offered with:

- Discharge planning
- Assessment and integration of service for on-going needs
- Coordination with behavioral health services
- Collaboration with healthcare providers and care givers
- Providing information about what benefits might be available
- Medication education and monitoring

Hospitals may be asked for assistance in enrolling patients in case management during inpatient admissions.

When requested:

1. Have the patient complete the authorization form, with help if needed.
2. Send the authorization to Carelon Behavioral Health of California by faxing it to the number on the form.
3. Schedule a discharge appointment within seven days after discharge. If you need help with getting an appointment within seven days, please contact Carelon Behavioral Health of California.

Adverse Clinical Determination/Peer Review

If a case does not appear to meet medical necessity criteria at the requested level of care, the CCM attempts to discuss the member's needs with the provider and to work collaboratively to find an appropriate alternative level of care. If no alternative is agreed upon, the CCM cannot deny a request for services. Requests that do not appear to meet medical necessity criteria or present potential quality issues are referred to a peer reviewer for second level review. It is important to note that only a physician or doctoral level clinical psychologist peer reviewer can clinically deny a request for services.

The peer reviewer considers the available information and may elect to conduct a Peer-to-Peer Review, which involves a direct telephone conversation with the attending or primary provider to discuss the case. Through this communication, the peer reviewer may obtain clinical data that was not available to the CCM at the time of the review. This collegial clinical discussion allows the peer reviewer the opportunity to explore alternative treatment plans with the provider and to gain insight into the attending provider's anticipated goals, interventions and timeframes. The peer reviewer may request more information from the provider to support specific treatment protocols and ask about treatment alternatives.

When an adverse determination is made, the treating provider (and hospital, if applicable) is notified telephonically of the decision. In urgent care cases, notification is given telephonically at the time of the determination. Written notification of an adverse determination is issued to the member or member representative and the provider within decision timeframes.

If an adverse decision is rendered, the provider has the right to speak with the peer reviewer who made the adverse determination by calling Carelon Behavioral Health of California at the toll-free phone number of the member's plan. For substance use treatment and treatment of minors, Carelon

Behavioral Health of California follows federal and state guidelines regarding release of information in determining the distribution of adverse determination letters.

All written or electronic adverse determination notices include:

- The specific reason(s) for the determination not to certify
- A statement that the clinical rationale criteria (or copy of the relevant clinical criteria), guidelines, or protocols used to make the decision will be provided, in writing, upon request
- Information regarding how the member may file a grievance or appeal with Carelon Behavioral Health of California
- Information regarding the member's right to file a complaint with the Department of Managed Health Care
- Disclosures required by Sections 1368.01, 1368.02, (Grievance rights) and 1374.30 (Independent Medical Review process) of the Knox-Keene Act
- The name and direct telephone number of the health care professional responsible for the denial
- The right of the provider to request a reconsideration within three business days of receipt of the notice when a medical necessity denial is issued without a Peer-to-Peer conversation having taken place, or when an administrative denial is issued because of the failure of a provider to respond to a request for Peer-to-Peer conversation within a specified timeframe

Lack of Information (LOI) Process

When there is insufficient information to make a medical necessity determination, the peer reviewer may elect to make the decision based on the information that has been received, or may invoke the Lack of Information (LOI) process. If the decision is made based on available information, written notification is issued within the determination timeframe for the type of care request (e.g. urgent, non-urgent). If the peer reviewer invokes the LOI process, the provider is notified of the information needed within prescribed timeframes based on the type of care requested. A minimum period of time is given for the provider to furnish the necessary information. A Peer-to-Peer conversation may be initiated by either the peer advisor or the provider in order to discuss the needed information. Once information is received, or the time period for furnishing the information has expired, the decision and notice must be issued within the specified timeframe for the type of care requested.

Determination Timeframes

The following tables represent determination timeframes that clinicians must follow, unless more stringent by contract or regulation. In deciding which timeframe applies, the clinician considers the *line of business* (Medicare, Medi-Cal or Commercial), the *type of review* (prospective, concurrent, or retrospective); the *urgency of the review* (routine or urgent); and the *timing of the review* (prior to treatment, greater or less than 24 hours before the end of the current authorization, or after services have been rendered).

Medicare specific timeframes:

REQUEST TYPE	TIMEFRAME	DETERMINATION	WRITTEN NOTICE

Prospective Urgent	Prior to treatment	Within 72 hours	Same as determination or within 72 hours of documented verbal notification
Prospective Non-urgent	Prior to treatment	Within 14 calendar days	Same as determination
Concurrent Urgent	>24 hours of authorization expiration	Within 24 hours	Same as determination or within 72 hours of documented verbal notification
Concurrent Urgent	<24 hours of authorization expiration	Within 72 hours	Same as determination, or within 72 hours of documented verbal notification
Concurrent Non-Urgent	Prior to authorization expiration	Reverts to Prospective: Within 72 hours or 14 calendar days	Same as determination
Retrospective	After services	Within 30 calendar days	Same as determination

Oral notification of denial decisions for urgent preservice and urgent concurrent requests must involve communication with a live person; Carelon Behavioral Health of California may not leave a voicemail.

Medicare specific timeframes and actions associated with Lack of Information situations:

REQUEST TYPE	TIMEFRAME TO NOTIFY ADDITIONAL INFORMATION IS NEEDED	TIME ALLOWED TO PROVIDE INFORMATION	TIMEFRAME TO MAKE A DETERMINATION
Prospective Urgent	24 hours	At least 2 calendar days	Within 2 calendar days
Prospective Non-Urgent	Within 14 calendar days *	At least 45 calendar days	W/in time left from 14 calendar days
Concurrent Urgent	24 hours	At least 2 calendar days	Within 1 calendar days

Concurrent Non-Urgent to Prospective-Urgent	24 hours	At least 2 calendar days	Within 2 calendar days
Concurrent Non-Urgent to Prospective-Non-Urgent	Within 14 calendar days *	At least 45 calendar days	Within time left from 14 calendar days
Retrospective	14 calendar days *	At least 45 calendar days	Within 14 calendar days

*The notice of extension must specifically describe the required information, and the member/provider must be given at least 45 calendar days from receipt of notice to respond to the request for more information.

Note: If additional information is not provided within the timeframe, the appropriate administrative or clinical denial determination is issued.

Medi-Cal specific timeframes:

MEDI-CAL	TYPE OF DECISION	APPROVAL	VERBAL NOTIFICATION	WRITTEN NOTIFICATION	DENIAL	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
PRE-SERVICE							
Inpatient	**Emergent Inpatient**	30 minutes	30 minutes	24 hours of request	30 minutes	30 minutes	24 hours of request
	Non-Emergent Inpatient	2 hours	2 hours	24 hours of request	2 hours	2 hours	24 hours of request
	Urgent Expedited	72 hours	24 hours of decision (not to exceed 72 hours of request)	2 business days from decision (not to exceed 72 hours of request)	72 hours	24 hours of decision (not to exceed 72 hours of request)	2 business days from decision (not to exceed 72 hours of request)
	Non-Urgent Expedited	5 business days	24 hours of decision	2 business days of decision	5 business days	24 hours of decision	2 business days of decision

Outpatient	**Urgent Pre-Service**	72 hours	Practitioners: 24 hours of decision (not to exceed 72 hours of request)	Practitioners and Members: 2 business days from decision (not to exceed 72 hours of request)	72 hours	Practitioners: 24 hours of decision (not to exceed 72 hours of request)	Practitioners and Members: 2 business days from decision (not to exceed 72 hours of request)
	Non-Urgent Pre-Service	5 business days	Practitioners: 24 hours from decision	Practitioners and Members: 2 business days from decision	5 business days	Practitioners: 24 hours from decision	Practitioners and Members: 2 business days from decision
CONCURRENT							
	Urgent	24 hours	Practitioners: 24 hours from request	Practitioners and Members: 24 hours from request	24 hours	Practitioners: 24 hours from request	Practitioners and Members: 24 hours from request
POST-SERVICE							
	Non-Urgent Standard	30 calendar days	30 calendar days	30 calendar days	30 calendar days	30 calendar days	30 calendar days

In accordance with CMS, the decision may be deferred and the time limit extended an additional 14 calendar days only where the member or the member's provider requests an extension; or the Health Plan/Provider Group can provide justification upon request by the State for the need for additional information and how it is in the member's interest for non-urgent pre-service and post-service requests. A member and practitioner are notified of the decision to defer, in writing, within five business days of receipt of the request and are provided 14 calendar days from the date of the receipt of the original request for submission of requested information.

Oral notification of a denial decision for urgent pre-service or urgent concurrent requests must involve communication with a live person; Carelon Behavioral Health of California may not leave a voicemail.

Commercial specific timeframes:

NOTIFICATION TIMEFRAMES			
TYPE OF REQUEST	**DECISION TIMEFRAMES AND DELAY NOTICE REQUIREMENTS**	**PRACTITIONER INITIAL NOTIFICATION AND MEMBER NOTIFICATION (NOTIFICATION MAY BE ORAL AND/OR ELECTRONIC/WRITTEN)**	**WRITTEN/ELECTRONIC NOTIFICATION TO PRACTITIONER AND MEMBER**
Urgent Pre-Service • All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition (not to exceed 72 hours after receipt of the request)	Practitioner: Within 24 hours of the decision for approvals and denials (not to exceed 72 hours of receipt of request Member: Within 72 hours of receipt of the request (for approval decisions) Document date and time of oral notifications	Within 72 hours of receipt of the request. Note: If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension needed • Additional clinical information required	Additional clinical information required: Notify member and practitioner within 24 hours of receipt of request and provide 48 hours for the submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information: Note: Decision must be made in a timely fashion appropriate for the member's condition not to	Additional information received or incomplete: Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials). Member: Within 48 hours after receipt of information (for approval decisions)	Additional information received or incomplete: Within 48 hours after receipt of information. Note: If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

TYPE OF REQUEST	DECISION TIMEFRAMES AND DELAY NOTICE REQUIREMENTS	PRACTITIONER INITIAL NOTIFICATION AND MEMBER NOTIFICATION (NOTIFICATION MAY BE ORAL AND/OR ELECTRONIC/WRITTEN)	WRITTEN/ELECTRONIC NOTIFICATION TO PRACTITIONER AND MEMBER
	exceed 48 hours after receipt of information.	Document date and time of oral notifications.	
	Additional information not received: If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. Note: Decision must be made in a timely fashion appropriate for the member's condition (not to exceed 48 hours after the deadline for extension has ended)	Additional information not received: Practitioner: Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner and member to supply the information (for approvals and denials). Member: Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions) Document date and time of oral notifications.	Additional information not received: Within 48 hours after the timeframe given to the practitioner and member to supply the information. Note: If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Concurrent (i.e., Inpatient, ongoing/ambulatory services) • Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at	Within 24 hours of receipt of request.	Practitioner: Within 24 hours of receipt of request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions) Document date and time of oral notifications.	Within 24 hours of receipt of the request. Note: If oral notification is given within 24 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

TYPE OF REQUEST	DECISION TIMEFRAMES AND DELAY NOTICE REQUIREMENTS	PRACTITIONER INITIAL NOTIFICATION AND MEMBER NOTIFICATION (NOTIFICATION MAY BE ORAL AND/OR ELECTRONIC/WRITTEN)	WRITTEN/ELECTRONIC NOTIFICATION TO PRACTITIONER AND MEMBER
least 24 hours prior to the expiration of the prescribed period of time or number of treatments. **Exceptions:** • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to ***Urgent Pre-Service*** category. • If the request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to ***Non-Urgent Pre-Service*** category.			
Non-Urgent Pre-Service • All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days after receipt of the request.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member:	Within 2 business days of making the decision

TYPE OF REQUEST	DECISION TIMEFRAMES AND DELAY NOTICE REQUIREMENTS	PRACTITIONER INITIAL NOTIFICATION AND MEMBER NOTIFICATION (NOTIFICATION MAY BE ORAL AND/OR ELECTRONIC/WRITTEN)	WRITTEN/ELECTRONIC NOTIFICATION TO PRACTITIONER AND MEMBER
		Within 2 business days of the decision (for approval decisions) Document date and time of oral notifications.	
Non-Urgent Pre-Service Extension Needed • Additional clinical information required • Require consultation by Expert Reviewer	Additional clinical information required: Notify member and practitioner ***in writing*** within 5 business days of receipt of request and provide at least 45 calendar days for the submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for the member's condition not to exceed 5 business days of receipt of information.	Additional information received or incomplete: Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions)	Additional information received or incomplete: Within 2 business days of the decision (for approval decisions)
	Additional information not received: If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information,	Additional information not received: Practitioner: Within 24 hours of the decision (for approvals and denials).	Additional information not received: Within 2 business days of the decision (for approval decisions)

TYPE OF REQUEST	DECISION TIMEFRAMES AND DELAY NOTICE REQUIREMENTS	PRACTITIONER INITIAL NOTIFICATION AND MEMBER NOTIFICATION (NOTIFICATION MAY BE ORAL AND/OR ELECTRONIC/WRITTEN)	WRITTEN/ELECTRONIC NOTIFICATION TO PRACTITIONER AND MEMBER
	decision must be made with the information that is available in a timely fashion as appropriate for the member's condition not to exceed an additional 5 business days.	Member: Within 2 business days of the decision (for approval decisions)	
	Requires consultation with an Expert Reviewer: Upon the expiration of the 5 business days or as soon as it is aware that the 5 business day timeframe will not be met, whichever comes first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Requires consultation with an Expert Reviewer: Decision must be in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	Requires consultation with an Expert Reviewer: Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions)	Requires consultation with an Expert Reviewer: Within 2 business days of the decision.

TYPE OF REQUEST	DECISION TIMEFRAMES AND DELAY NOTICE REQUIREMENTS	PRACTITIONER INITIAL NOTIFICATION AND MEMBER NOTIFICATION (NOTIFICATION MAY BE ORAL AND/OR ELECTRONIC/WRITTEN)	WRITTEN/ELECTRONIC NOTIFICATION TO PRACTITIONER AND MEMBER
Post-Service • All necessary information received at time of initial request (decision and notification is required within 30 calendar days from request).	Within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request (for approvals). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
Post-Service Extension Needed • Additional clinical information required • Requires consultation by Expert Reviewer	Additional clinical information required: Notify member and practitioner within 30 calendar days of receipt of request and provide at least 45 calendar days for the submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	Additional information received or incomplete: Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	Additional information received or incomplete: Within 15 calendar days of receipt of information.

	Additional information not received: If no additional information is received within the 45	Additional information not received: Practitioner:	Additional information not received: Within 15 calendar days after the timeframe given

TYPE OF REQUEST	DECISION TIMEFRAMES AND DELAY NOTICE REQUIREMENTS	PRACTITIONER INITIAL NOTIFICATION AND MEMBER NOTIFICATION (NOTIFICATION MAY BE ORAL AND/OR ELECTRONIC/WRITTEN)	WRITTEN/ELECTRONIC NOTIFICATION TO PRACTITIONER AND MEMBER
	calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions)	to the practitioner and member to supply the information.
	Requires consultation with an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as is becomes aware that the 30 calendar day timeframe will not be met, whichever comes first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		

	Requires consultation with an Expert Reviewer: Within 15 calendar days from the date of the delay notice.	Requires consultation with an Expert Reviewer: Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approvals).	Requires consultation with an Expert Reviewer: Within 15 calendar days from the date of the delay notice.
TYPE OF REQUEST	**DECISION TIMEFRAMES AND DELAY NOTICE REQUIREMENTS**	**PRACTITIONER INITIAL NOTIFICATION AND MEMBER NOTIFICATION (NOTIFICATION MAY BE ORAL AND/OR ELECTRONIC/WRITTEN)**	**WRITTEN/ELECTRONIC NOTIFICATION TO PRACTITIONER AND MEMBER**
Standing Referrals to Specialists/Specialty Care Centers • All information necessary to make a determination is received.	Decision must be made in a timely fashion as appropriate for the member's condition not to exceed 3 business days of receipt of request. Note: Once the determination is made, the referral must be made within 4 business days of the date of the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.

Transition Requests for Non-Standard Vital Documents 1. Urgent (i.e., preservice pend or denial notifications with immediate medical necessity) 2. Non-Urgent (i.e., post-service pend or denial notifications)	Language Assistance Program Services Not Delegated: All requests are forwarded to the contracted health plan. 1. Request forwarded within 1 business day of member's request. 2. Request forwarded within 2 business days of member's request.		Language Assistance Program Services Delegated: All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.

For denial decisions for urgent concurrent or urgent preservice requests, oral notification must involve communication with a live person; Carelon Behavioral Health of California may not leave a voicemail.

Retrospective Review

When a provider requests a retrospective review for services previously rendered, Carelon Behavioral Health of California will first determine whether such a retrospective review is available under the member's benefit plan and request the reason for the retrospective review (e.g., emergency admission, no presentation of a Carelon Behavioral Health of California member identification card, etc.). In cases where a retrospective review is available, services are reviewed as provided for in this handbook. In cases where a retrospective review is not available under the member's benefit plan and/or where the provider fails to follow administrative process and requirements for authorization, certification and/or notification, the request for retrospective review may be administratively denied. Subject to any client health benefit program and/or benefit plan specific requirements, the chart below references the standard timeframes applicable to all lines of business for retrospective review requests.

TYPE OF REVIEW	URGENCY OF CASE	TIMEFRAME TO MAKE DECISION	TIMEFRAME TO PROVIDE NOTIFICATION	
			CERTIFICATIONS	NON-CERTIFICATIONS
Retrospective	Non-urgent (all levels of care)	30 calendar days after receipt of request for retrospective review.	Written notice to member, provider, and facility within the overall time frame of 30 calendar days of request for retrospective review	Written notice to member, provider, and facility within the overall time frame of 30 calendar days of request for retrospective review

Carelon Behavioral Health of California's procedures for authorization, certification and/or notification apply to services and treatment proposed and/or previously rendered in instances where the member

benefit plan administered by Carelon Behavioral Health of California is primary and instances where the member benefit plan administered by Carelon Behavioral Health of California is secondary.

Carelon Behavioral Health of California, at times, may administer both primary and secondary benefit plans of a given member. To avoid possible duplication of the review process in these cases, providers should notify Carelon Behavioral Health of California of all pertinent employer and other insurance or health plan information for the member being treated.

Note: Failure to follow authorization, certification and/or notification requirements, as applicable, may result in administrative denial/non-certification and require that the member be held harmless from any financial responsibility for the provider's charges.

Electroconvulsive Therapy

Prior to conducting Electroconvulsive Therapy (ECT), providers must contact Carelon Behavioral Health of California for precertification of such therapy. All pre-certification requests for ECT are reviewed for medical necessity.

Telehealth

Telehealth services are services provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between a member and a Carelon Behavioral Health of California provider.

Carelon Behavioral Health of California has adopted several guidelines with recommendations when telehealth is used:

- American Psychological Association (APA) Guidelines for the Practice of Telepsychology
- American Psychiatric Association (APA) and American Telemedicine Association (ATA) Best Practice in Videoconferencing-Based Telemental Health
- American Academy of Child & Adolescent Psychiatry (AACAP) Telepsychiatry Toolkit
- National Association of Social Workers (NASW), Association of Social Work Boards (ASWB), Council on Social Work Education (CSWE) and Clinical Social Work Association (CSWA) Standards for Technology in Social Work Practice

The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face visit. Telehealth services do not include telephone conversations or internet-based communication between providers or between providers and members.

Providers must utilize a HIPAA-compliant tool for the networking environment when providing telehealth services. Medical record requirements for telehealth services are the same as those for face-to-face services; however, a notation must also be made in the medical record that indicates that the service was provided via telehealth.

Reimbursement for telehealth services is subject to the same restrictions as face-to-face contacts. Providers must get parental consent for treatment of minors, as defined by state regulations, and consequently a parent must participate in a portion of the initial session. The parent is not required to participate in additional sessions unless clinically appropriate. The member must provide informed consent to the provider rendering services via telehealth in order to participate in any telehealth services. The member has the right to refuse these services and must be made aware of the

alternatives such as face-to-face services, including any delays in service, need to travel, or risks associated with not having services provided by telehealth.

The member must be informed and aware of the location of the provider rendering services via telehealth and all questions regarding the equipment, technology, etc. must be addressed. The member has the right to be informed of all parties who will be present at each end of the telehealth transmission and has the right to exclude anyone from either site unless the provider is a child in which case the guardian has that right.

All telehealth transmissions must be performed on dedicated, secure telephone lines or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the information being transmitted via other methods, including the internet.

Transmissions must employ acceptable authentication and identification procedures by both sites. All telehealth providers must have a written procedure detailing the contingency plan when there is a transmission failure or other technical difficulties that render the service undeliverable. The technology utilized to provide the service must conform to industry wide compressed audio-video communication standards for real-time, two-way interactive audio-video transmission.

Internet-based services including internet-based phone calls (e.g., skype) or chat rooms are not considered telehealth. Carelon Behavioral Health of California does not provide coverage of internet-based services because they do not offer adequate privacy and security. The following are not considered telehealth services because they do not meet the definition of interactive telecommunication system:

- Phone-based services including phone counseling, email, texting, voicemail, or facsimile;
- Remote medical monitoring devices;
- Virtual reality devices.

All telehealth providers must have a written process detailing availability of face-to-face assessments by a physician or other clinician in an emergency. These policies and processes may be requested for review by Carelon Behavioral Health of California.

All telehealth providers should have established written quality of care protocols to ensure that the services meet the requirements of state and federal laws and established patient care standards. The provider performing the telehealth services must abide by the laws, regulations and policies of California and must hold an independent license in California where they are performing the service.

Telehealth services are offered according to client arrangements and may not be available to all members. Telehealth services can be accessed by calling Carelon Behavioral Health of California member services. Members may still receive in-person counseling sessions pursuant to their particular benefits.

Outpatient Services

Prior to beginning a course of outpatient treatment, providers must verify member eligibility and obtain authorization or certification (where applicable). For some plans, members are allowed a specific set of initial therapy sessions without prior authorization. These sessions are provided by providers and are subject to meeting medical necessity criteria.

Carelon Behavioral Health of California's model is to count the initial encounter to the provider, not member. This means that if the member changes providers, the count of initial encounters restarts with the new provider. Initial therapy sessions may also be refreshed when a member has a break in treatment of more than six months. These initial therapy sessions are not renewed annually, rather are applied towards each member's episode of care with a provider. An episode of care is defined as continuous treatment with no gap greater than six months. A member is considered new to outpatient treatment if the member has not been in outpatient treatment within the previous six-month period as a member. Each initial therapy session is counted as one regardless of session duration and the total can be reviewed through the Provider Portal.

Providers are asked a series of clinical questions to support medical necessity for the service requested. If sufficient information is provided to support the request, the service is authorized. If additional information is needed, the provider is prompted to contact Carelon Behavioral Health of California via phone to continue the request for authorization.

Applied Behavior Analysis (ABA)

Applied behavior analysis (ABA) is the science that involves using modern behavioral learning theory to modify behaviors. The use of these techniques and principles are implemented to bring about meaningful and positive change in behavior. ABA services are offered according to client arrangements and may not be available to all members. ABA services can be accessed by calling Carelon Behavioral Health of California.

It is Carelon Behavioral Health of California's policy to assist members in optimizing their benefits by coordinating the utilization management process with the appropriate client health plan or payor while overseeing the care to ensure treatment is evidenced-based and outcome-focused. When members contact Carelon Behavioral Health of California for a referral, our philosophy is to refer them to clinicians who best fit their needs and preferences, taking into account factors including provider geography, accessibility, availability (number of BCBAs and ABA Therapists), and specialization. As a participating provider, you are asked to:

- Participate in the utilization management processes, often necessary before beginning care, and at intervals during treatment, as required by the member's benefit plan
- Contact Carelon Behavioral Health of California to request information regarding an initial authorization, when necessary, or concurrent review authorization of care, as required by the member's benefit plan
- Pursue coordination of care with member's primary care physicians as well as other treating medical and behavioral health clinicians

As a general guide for requesting ABA services, the ABA Authorization Request Form and the Treatment Report Guidelines are available on the Carelon Behavioral Health of California website.

Appeals (Grievance) Process

Carelon Behavioral Health of California has an established system to allow for appeals of determinations of no medical necessity. Appeals for Carelon Behavioral Health of California members

are considered a form of grievance and subject to the requirements of Section 1368 et seq. of the California Knox-Keene Health Care Service Plan Act of 1975 as amended, and Rules 1300.68 and 1300.68.01 of Title 28 of the California Code of Regulations. The process allows for a review subsequent to a no medical necessity determination, with health professionals who are clinical peers, hold active, unrestricted license to practice medicine, are board certified if applicable, are in the same profession and in a similar specialty as typically manages the clinical condition, procedure or treatment, and are neither the individual who made the original noncertification, nor the subordinate of such an individual. Appeals are conducted, as appropriate to the nature of the case, by a peer reviewer, committee, or external reviewer having the qualifications stated above. This allows for objectivity and impartiality.

Carelon Behavioral Health of California allows the member, member's representative, and/or provider rendering services at least 180 calendar days after the receipt of a non-certification to initiate the appeal process by telephone, by facsimile, in person, by e-mail, by an on-line member grievance submission process at Carelon Behavioral Health of California's web site, or in writing. The member, member's representative, or provider may submit any information they feel is pertinent to their appeal request and all such information is considered in the appeal review, whether such information was available to Carelon Behavioral Health of California reviewers during the initial consideration.

Non-Urgent Appeals

All non-urgent appeals (grievances) are resolved and responded to within 30 calendar days (or sooner) of Carelon Behavioral Health of California's receipt of the appeal/grievance. This 30-calendar day period includes completion of any/all multiple internal/external levels of review that Carelon Behavioral Health of California may need to utilize due to the nature of an appeal/grievance. For example, the Carelon Behavioral Health of California Medical Director may review a clinical appeal/grievance but may determine a committee or external review is needed due to the nature of the issues involved.

Urgent Appeals

All urgent appeals (grievances) are resolved and responded to within 72 hours or less of receipt of the appeal/grievance by Carelon Behavioral Health of California. This 72-hour period includes completion of any/all multiple internal/external levels of review that Carelon Behavioral Health of California may need to utilize due to the nature of an appeal/grievance. An urgent appeal/grievance is a case requiring expedited review because it involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function.

Additional Appeal (Grievance) Rights

Review by Department of Managed Health Care (DMHC)

After completing the appeal (grievance) process as described in Carelon Behavioral Health of California policies and procedures or after participating in the process for at least 30 calendar days (the 30 day period is not required if the case meets the urgent definition above) or after completing voluntary mediation, the member or member's representative may submit their grievance/appeal to the DMHC. The DMHC has a toll-free telephone number (**1-888-466-2219**) and a **TDD** line (**1-877-688-9891**) for the hearing and speech impaired. The DMHC's Internet Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Grievances can be mailed to Help Center Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814 or sent via fax to 916-255-5241.

Independent Medical Review

Under California law, the member may be entitled to an external, independent medical review (IMR) when a determination for a member's health care service has been denied, delayed, or modified by Carelon Behavioral Health of California in whole or in part due to a determination that the service is not medically necessary. If the member is eligible for IMR, the IMR process provides an impartial review of medical decisions made by Carelon Behavioral Health of California related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. If the case meets these criteria, the written notification responding to the grievance/appeal request must advise the member of the availability of an independent review and how to request such a review.

Fair Hearing

In a case where services have been denied, delayed, or modified after the completion of the internal appeal process, a Medi-Cal member may ask for a State Fair Hearing, within 120 days from the date of receiving the resolution letter. In the event a Medi-Cal member wants to continue ongoing treatment, the member must ask for a State Fair Hearing within 10 days from the date that the resolution letter was postmarked or received, or before the date services expire. A State Fair Hearing can be requested by calling 800-952-5253, or TTY/TDD 1-800-952-8349 or in writing by submitting a State Hearing form or sending a letter to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430

Voluntary Mediation

In the event the member is dissatisfied with the Carelon Behavioral Health of California appeal/grievance process determination, the member may request voluntary mediation (process required to be available by California law) with Carelon Behavioral Health of California prior to exercising the right to submit a grievance to the DMHC as described above. The request must be made within 60 calendar days of the receipt of the Carelon Behavioral Health of California determination.

Arbitration

If the member is not satisfied with Carelon Behavioral Health of California's response to an appeal/ grievance, the member may submit a request to Carelon Behavioral Health of California for binding arbitration within 60 calendar days of receipt of Carelon Behavioral Health of California's response. However, in the case of binding arbitration, if the member has legitimate health or other reasons that would prevent the member from electing binding arbitration within 60 calendar days, the member may have as long as reasonably necessary to accommodate special needs in order to elect binding arbitration.

Appeal Notification Requirements

For Carelon Behavioral Health of California members, written notification of the clinical appeal decision rendered is sent to the member and provider as soon as the review is completed, and a

determination is made but no later than within 30 calendar days after receipt of a non-urgent appeal request or 72 hours from receipt of an urgent appeal request.

Quality Management/Quality Improvement

To assure services are appropriately monitored and continuously improved, Carelon Behavioral Health of California has developed and implemented a comprehensive Quality Management Program. As a Knox-Keene Plan, Carelon Behavioral Health of California is regulated by the California Department of Managed Health Care (DMHC) and the Quality Management Program reflects the Knox-Keene regulations for Carelon Behavioral Health of California business.

Carelon Behavioral Health of California utilizes a Continuous Quality Improvement philosophy through which Carelon Behavioral Health of California directly or through its authorized designees, monitors and evaluates appropriateness of care and service, identifies opportunities for improving quality and access, establishes quality improvement initiatives, and monitors resolution of identified problem areas. This includes monitoring and evaluation of services performed by Carelon Behavioral Health of California or its designees, as well as behavioral health services rendered by providers.

Carelon Behavioral Health of California's comprehensive Quality Management Program includes quality management policies and procedures applicable to all providers, strategies and major activities performed to provide for consistency and excellence in the delivery of services, includes a program description, an annual work plan that includes goals and objectives, and specific quality management related activities for the upcoming year and the evaluation of the effectiveness of those activities. Providers are responsible for adhering to the Quality Management Program and are encouraged to provide comments to Carelon Behavioral Health of California regarding ongoing Quality Management Program activities.

Quality Management/Utilization Management/Care Management (QMUMCM) Committee

The Carelon Behavioral Health of California Board of Directors has ultimate accountability for the oversight and effectiveness of the Quality Management Program. The Board has delegated authority for the Quality Management Program implementation and planning to the multi-disciplinary QMUMCM Committee.

Carelon Behavioral Health of California's President is administratively responsible for the direction and overall functioning of the Quality Management Program and ensures allocation of adequate resources and staffing. The Medical Director is responsible for implementation of the Quality Management Program.

The Board of Directors reviews and approves the Quality Management Program Description, Quality Management Program Evaluation, and Quality Management Work plan at least annually, and at the time of any revision. The Board receives a quarterly summary of all quality management activities included in the work plan from the QMUMCM Committee.

In addition, certain functional areas within Carelon Behavioral Health of California maintain quality management programs specific to the activities and services performed. Quality programs within functional areas are responsible for coordinating their quality management programs with the Quality Management Program.

Scope of the Quality Management Program

The Carelon Behavioral Health of California Quality Management Program monitors and evaluates quality across the entire range of services provided by Carelon Behavioral Health of California. The Quality Management Program is intended to ensure that structure and processes are in place to lead to desired outcomes for members, clients, providers, and Carelon Behavioral Health of California functional areas.

The scope of the Quality Management Program includes:

- Clinical services and Utilization Management Programs
- Supporting improvement of continuity and coordination of care
- Case Management/Intensive Case Management/Targeted Case Management
- Quality Improvement Activities (QIAs)/Projects (QIPs)
- Outcome measurement and data analysis
- Network Management/Provider Relations Activities
- Member Experience Survey
- Clinical Treatment Record Evaluation
- Service Availability and Access to Care
- Provider Quality Performance
- Annually evaluating member complaints and grievances using valid methodology
- Member Rights and Responsibilities
- Patient Safety Activities (including identification of safety issues during prospective reviews)
- Clinical and Administrative Denials and Appeals
- Performance Indicator development and monitoring activities
- Health Literacy and Cultural Competency assurance
- Compliance with Section 1557, non-discrimination law of the Affordable Care Act (ACA)

- Promotion of e-technologies to improve member access and understanding of health benefits
- Promotion of the use of member self-management tools
- Screening programs
- Establishment and ongoing monitoring of the Language Assistance Program in accordance with the standards and requirements of the Knox-Keene Act.
- Development, communication, and ongoing monitoring of access and availability guidelines to ensure accessibility to behavioral healthcare and Employee Assistance Program services in accordance with the standards and requirements of the Knox-Keene Act

Role of Participating Providers

Carelon Behavioral Health of California providers are informed about the Quality Management Program through this handbook, provider newsletters, the Carelon Behavioral Health of California website, direct mailings, email provider alerts, seminars and training programs. Participating providers agree to cooperate and/or engage with Quality Improvement activities to improve the quality of care and services and member experience. Many of these media venues provide participating providers with the opportunity to be involved and provide input in to the quality management and utilization management programs. Additional opportunities to be involved include representation on the Quality Management/Utilization Management/Care Management (QMUMCM) Committee, Credentialing Committee, Provider Appeals Committee, and the Public Policy Committee. Involvement includes, but is not limited to:

- Providing input into the Carelon Behavioral Health of California medical necessity criteria
- Providing peer review and feedback on proposed practice guidelines, clinical quality monitors and indicators, new technology and any critical issues regarding policies and procedures of Carelon Behavioral Health of California
- Reviewing Quality Improvement activities and making recommendations to improve quality of clinical care and services
- Reviewing, evaluating and making recommendations for the credentialing and recredentialing of providers
- Reviewing, evaluating and making recommendations regarding sanctions that result from provider performance issues

If a provider is interested in participating in one of Carelon Behavioral Health of California's Committees, please send an email to CACompliance@carlon.com for more information.

As part of the Quality Management Program, Carelon Behavioral Health of California incorporates principles designed to encourage the provision of care and treatment in a culturally competent and sensitive manner. These principles include:

- Emphasis on the importance of culture and diversity
- Assessment of cross-cultural relations
- Expansion of cultural knowledge

- Consideration of sex and gender identity
- Adaptation of services to meet the specific cultural and linguistic needs of members

Providers are reminded to take the cultural background and needs of members into account when developing treatment plans and/or providing other services.

Role of Members/Consumers

Carelon Behavioral Health of California values its members/consumers and believes that members/consumers are resources and active participants in their treatment and recovery. Consequently, Carelon Behavioral Health of California invites and includes member/consumer input in the Quality Management Program, which is reflected in member participation on Carelon Behavioral Health of California's Public Policy Committee. This participation allows them to speak to health plan member issues. Carelon Behavioral Health of California also utilizes member suggestions that may be received through Carelon Behavioral Health of California's grievance or inquiry processes. If a member is interested in participating in Carelon Behavioral Health of California's Public Policy Committee, please direct them to send an email to CACompliance@carelon.com for more information.

Quality Performance Indicator Development and Monitoring Activities

A major component of the quality management process is the identification and monitoring of meaningful performance indicators. These performance indicators are selected by functional areas along with associated goals or benchmarks and are approved by Carelon Behavioral Health of California's Quality Management/Utilization Management/Care Management (QMUMCM) Committee. Measures are reported to the Carelon Behavioral Health of California Board of Directors at least quarterly.

All functional areas are responsible for prioritizing their resources to meet or exceed performance goals or benchmarks established for each indicator. When performance is identified below established goals and/or trends are identified, a corrective action plan is established to improve performance.

Behavioral health care access and service performance is monitored regularly, including but not limited to:

- Access and availability to behavioral health services
- Telephone service factors
- Utilization decision timeliness and adherence to medical necessity and regulatory requirements
- Member and provider complaints and grievances
- Member and provider satisfaction with program services
- Nationally recognized quality indicators such as HEDIS® measures whenever possible
- Potential member safety concerns, which are addressed in the Member Safety Program section of this handbook, include:
    - Serious reportable events (SREs), as defined by the National Quality Forum (NQF) and Carelon Behavioral Health of California

- Trending Events (TEs)

Potential quality of care and/or service indicators monitored by Carelon Behavioral Health of California include, but are not limited to:

- Provider Inappropriate/Unprofessional Behavior
  - Sexual relationship with member
  - Seductive behavior, inappropriate physical contact
  - Aggressive behavior
  - Threats of aggressive behavior
  - Displays signs of substance use
  - Displays signs of mental health problems
  - Displays signs of organicity
  - Inappropriate pharmacy/drug prescribing
  - Inappropriate boundaries/relationship with member
  - Practitioner not qualified to perform services
- Clinical Practice-Related Issues
  - Treatment setting not safe
  - Adequacy of assessment
  - Timeliness of assessment
  - Accuracy of diagnosis
  - Delay in treatment
  - Appropriateness of treatment
  - Effectiveness of treatment
  - Adequacy of referral
  - Failure to appropriately refer
  - Timeliness of referral
  - Failure to coordinate care
  - Abandoned member
  - Premature discharge

- Inadequate discharge planning
- Prescribed wrong, too much, too many, too little medication
- Medication error
- Failure to follow practice guidelines o Failure to involve family in treatment
- Over or under utilization of services
- Site, materials or equipment dirty/unsanitary or in disrepair

- Access to Care-Related Issues
  - Failure to provide appropriate appointment access
  - Lack of timely response to telephone calls
  - Prolonged in-office wait time o Session too short
  - Falling asleep
  - Failure to keep an appointment
  - Non-compliance with ADA requirements
  - Refusal to schedule appointment
  - Services not available or accessible
- Attitude and Service-Related Issues
  - Failure to maintain confidentiality
  - Poor communication skills
  - Lack of caring/concern
  - Poor or lack of documentation
  - Fraud and Abuse
  - Failure to release medical records
  - Failure to allow a site visit
- Quality of Care-Related issues
  - Any action or failure to take action on the part of a provider that has the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the member at risk. Examples of quality of care issues may include, but are not limited to:

- Any performance outside established parameters, structures, policies and procedures that may be viewed as contributing to unexpected outcomes.
- Treatment and/or discharge planning issue
- Medication management issues
- Access to appropriate treatment
- Inappropriate or unprofessional behavior
- Over- and under-utilization
- Clinical guideline adherence
- Fraud and abuse
- Adverse Incidents

Healthcare Effective Data and Information Set (HEDIS®)

There are a number of ways to monitor the treatment of individuals with mental health and/or substance use conditions. Providers may measure performance based on quality indicators such as those to meet CMS reporting program requirements, specific state or insurance commission requirements, managed care contracts, and/or internal metrics. In most cases, there are specific benchmarks that demonstrate quality care.

Carelon Behavioral Health of California utilizes a number of tools to monitor population-based performance in quality across the state, lines of business and diagnostic categories. One such tool is the Healthcare Effectiveness Data and Information Set (HEDIS) behavioral health best practice measures as published by the National
Committee for Quality Assurance (NCQA) as one of the tools. Like the quality measures utilized by Centers for Medicare and Medicaid Services (CMS), Joint Commission, and other external stakeholders, these measures have specific, standardized rules for calculation and reporting. The HEDIS measures allow consumers, purchasers of health care and other stakeholders to compare performance across different health plans.

While the HEDIS measures are population-based measures of our partner health plan performance and major contributors to health plan accreditation status, our partner health plans rely on Carelon Behavioral Health of California to ensure behavioral health measure performance reflects best practice. Providers are the key to guiding their patient to keep an appointment after leaving an inpatient psychiatric facility; taking their antidepressant medication or antipsychotic medication as ordered; ensuring a child has follow up visits after being prescribed an ADHD medication; and ensuring an individual with schizophrenia or bipolar disorder has annual screening for diabetes and coronary heart disease.

There are six domains of care and service within the HEDIS library of measures:

1. **Effectiveness of Care**: Measures that are known to improve how effective care is delivered. One very important measure in this domain is Follow-up after Mental Health Hospitalization (Aftercare). In effect, this means how long someone waits to get mental health care after they are discharged from an inpatient mental health hospital. To prevent readmission and help people get back into the community successfully, best practice is from seven to thirty days after discharge.

2. **Access/Availability**: Measures how quickly and frequently members receive care and service within a specific time. For example, the Initiation and Engagement of Drug and Alcohol Abuse Treatment measure relies on frequency and timeliness of treatment to measure treatment initiation and treatment engagement. Studies show that an individual who engages in the treatment process have better outcome and success in recovery and sobriety.
3. **Utilization and Relative Resource Use**: This domain includes evidence related to the management of health plan resources and identifies the percentage of members using a service. For example, Carelon Behavioral Health of California measures Mental Health Utilization and Plan All Cause Readmissions.
4. **Measures Collected Using Electronic Clinical Data Systems (ECDS)**: This is the newest domain, and it requires calculation of outcomes by accessing data through the electronic submission of a member's electronic health record (EHR). An example of an ECDS measure is

   the Utilization of the PHQ-9. This demonstrates whether a PHQ-9 was administered to a patient with depression four months after initiation of treatment to measure response to treatment.
5. **Experience of Care**: This domain is specific to health plans.
6. **Health Plan Descriptive Information**: We supply Board Certification of physicians and psychologists to the plan; all other information is specific to the health plan.

Below is a brief description of the HEDIS measures that apply to the behavioral health field requirements associated with each:

1. Follow-up after Hospitalization for Mental Illness

Best practice for a member aged six or older to transition from acute mental health treatment to the community is an appointment with a licensed mental health practitioner (outpatient or intermediate treatment) within seven and/or 30 calendar days of discharge.

For this measure, NCQA requires organizations to substantiate by documentation from the member's health record all nonstandard supplemental data that is collected to capture missing service data not received through claims, encounter data, laboratory result files, and pharmacy data feeds. Carelon Behavioral Health of California requires proof-of-service documentation from the member's health record that indicates the service was received. All proof-of-service documents must include all the data elements required by the measure. Data elements included as part of the patient's legal medical record are:

- Member identifying information (name and DOB or member ID)
- Date of service
- DSM diagnosis code
- Procedure code/Type of service rendered
- Provider site/facility
- Name and licensure of mental health practitioner rendering the service
- Signature of rendering practitioner, attesting to the accuracy of the information The critical

  pieces of this measure for providers are:

- Inpatient facilities need to:
    - Use accurate diagnoses when submitting claims for inpatient treatment. If the diagnosis on admission is a mental health diagnosis but subsequent evaluation during the stay confirms that the primary diagnosis is substance use, use the substance use diagnosis on the claim submitted at discharge.
    - Ensure that discharge planners educate patients about the importance of aftercare for successful transition back to their communities.
    - Ensure that follow-up visits are within seven calendar days of discharge. It is important to notify the provider that the appointment is post hospital discharge and that an appointment is needed in seven calendar days.
        - Ensure that the appointment was made with input from the patient. If the member has a preexisting provider and is agreeable to going back to the provider, schedule the appointment with that provider. If not, the location of the outpatient provider or PHP, IOP, or other alternative level of care, must be approved by the member and be realistic and feasible for the member to keep that appointment.
- Outpatient providers need to make every attempt to schedule appointments within seven calendar days for members being discharged from inpatient care. Providers are encouraged to contact those members who are "no show" and reschedule another appointment.

2. Initiation and Engagement of Alcohol and other Drug Use Treatment

This measure aims to define best practice for initial and early treatment for substance use disorders by calculating two rates using the same population of members who receive a new diagnosis of Alcohol and Other Drug (AOD) use from any provider (dentist, primary care physician, etc.):

- **Initiation of AOD Use Treatment**: The percentage of adults diagnosed with AOD Use who initiate treatment through either an inpatient AOD admission, or an outpatient service for AOD from a substance abuse provider AND an additional AOD service within 14 calendar days.
- **Engagement of AOD Treatment**: An intermediate step between initially accessing care and completing a full course of treatment. This measure is designed to assess the degree to which the members engage in treatment with two additional AOD services within 34 calendar days after the initiation phase ends. The services that count as additional AOD services include IOP, Partial Hospital, or outpatient treatment billed with CPT-4 or revenue codes associated with substance use treatment.

3. Antidepressant Medication Management (AMM)

The components of this measure describe best practice in the pharmacological treatment of newly diagnosed depression treated with antidepressant by any provider by measuring the length of time the member remains on medication. There are two treatment phases:

- **Acute Phase**: The initial period of time the member must stay on medication for the majority of symptoms to elicit a response in 12 weeks.

- **Continuation Phase**: The period of time the member must remain on medication in order to maintain the response for at least six months.

4. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

The components of this measure describe best practice in the pharmacological management of children 6-12 years newly diagnosed with ADHD and prescribed an ADHD medication by measuring the length of time between initial prescription and a follow up psychopharmacology visit in the continuation and maintenance phases of treatment.

- **Initiation Phase**: For children, 6–12 years of age, newly prescribed ADHD medication best practice requires a follow up visit with a prescriber within 30 days of receiving the medication.

For ongoing treatment with an ADHD medication, best practice requires:

- **Continuation and Maintenance (C&M) Phase**: At least two additional follow up visits with a prescriber in the preceding nine months; and, the child remains on the medication for at least seven months.

5. Diabetes Screening for People with Bipolar Disorder or Schizophrenia Who Are Using Antipsychotic Medications (SSD)

For members with Schizophrenia or Bipolar diagnosis who were being treated with an antipsychotic medication, this measure monitors for potential Type 2 Diabetes with an HbA1C test.

6. Diabetes Monitoring for People with Diabetes and Schizophrenia Who Are Using Antipsychotic Medications (SMD)

For members who have Type 2 Diabetes, a Schizophrenic or Bipolar diagnosis and are being treated with an antipsychotic this measure's best practice is an annual or more frequent LDL-C test and an HbA1c test (SMD).

7. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

For members with Schizophrenia or Bipolar diagnosis who are being treated with an antipsychotic medication this measure monitors for potential cardiac disease with a LDL-C test.

8. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

This measure is described as the percentage of members 19 – 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

9. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

For child and adolescent members (1-17) prescribed antipsychotic medication on an ongoing basis, best practice requires testing at least annually during the measurement year to measure glucose levels (Blood Glucose or HbA1C) and cholesterol levels to monitor for development of metabolic syndrome.

10. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

This measure identifies children and adolescents who are on two or more concurrent antipsychotic medications.

The best practice here is that multiple concurrent use of antipsychotic medications is not best practice nor approved by the FDA. While there are specific situations where a child or adolescent requires concurrent medications, the risk/benefit of the treatment regime must be carefully considered and monitoring in place to prevent adverse outcome.

11. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

For children and adolescents with a new prescription for an antipsychotic, best practice requires that the child receive psychosocial care as part of first line treatment.

First line treatment is associated with improved outcomes and adherence.

12. Utilization of the PHQ-9 to Monitor Depression for Adolescents and Adults (DMS)

For members diagnosed with depression treated in outpatient settings the PHQ-9 or PHQ-A (adolescent tool) must be administered by the outpatient treater at least once during a four-month treatment period.

13. Depression Remission or Response for Adolescents and Adults (DRR)

The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within five to seven months of the elevated score. Four rates are reported:

- **ECDS Coverage**. The percentage of members 12 and older with a diagnosis of major depression or dysthymia, for whom a health plan can receive any electronic clinical quality data.
- **Follow-Up PHQ-9**. The percentage of members who have a follow-up PHQ-9 score documented within the five to seven months after the initial elevated PHQ-9 score.
- **Depression Remission**. The percentage of members who achieved remission within five to seven months after the initial elevated PHQ-9 score.
- **Depression Response**. The percentage of members who showed response within five to seven months after the initial elevated PHQ-9 score.

Note: These measures are collected utilizing Electronic Clinical Data Sets (ECDS) as found in the provider's Electronic Medical Record. While NCQA/HEDIS is looking to expand the options for collecting this data, Carelon Behavioral Health of California has yet to begin discussing this requirement with providers.

14. Follow-up After Emergency Department Visit for Mental Illness (FUM)

The percentage of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:

- Follow-up visit to occur within seven days of ED discharge.
- If the seven-day visit goal is missed, the next goal is a visit within 30 days of ED discharge.

15. Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA)

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD. Two rates are reported:

- Follow-up visit to occur within seven days of ED discharge.
- If the seven-day visit goal is missed, the next goal is a visit within 30 days of ED discharge.

Here is the complete list of HEDIS Behavioral Health measures:

Effectiveness of Care:

- **AMM:** Antidepressant Medication Management
- **ADD:** Follow-Up Care for Children Prescribed ADHD Medication
- **FUH:** Follow-Up After Hospitalization for Mental Illness
- **SSD:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- **SMD:** Diabetes Monitoring for People with Diabetes and Schizophrenia
- **SMC:** Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
- **SAA:** Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- **APC:** Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- **APM:** Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **FUM:** Follow-up After Emergency Department Visit for Mental Illness
- **FUA:** Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence **Other Domains:**

Access and Availability

- **IET:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **APP:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Utilization/Relative Resource Use - **Utilization**

- **PCR:** Plan All-Cause Readmissions
- **IAD:** Identification of Alcohol and Other Drug Services
- **MPT:** Mental Health Utilization **Health Plan Descriptive Information**
- **BCR:** Board Certification

Electronic Clinical Data Systems

- **DMS:** Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
- **DRR:** Depression Remission or Response for Adolescents and Adults

Service Availability and Access to Care

Carelon Behavioral Health of California uses a variety of mechanisms to measure members' access to care with a provider. Behavioral health service availability is assessed based on the following standards for providers:

- An individual with life-threatening emergency needs is seen immediately
- An individual with non-life-threatening emergency needs is seen within six hours
- An individual with urgent needs is seen within 48 hours
- Routine office visits are available within 10 business days

The following methods may be used to monitor provider behavioral health service availability and member access to care:

- Analysis of member complaints and grievances related to availability and access to care.
- Member satisfaction surveys specific to their experience in accessing care and routine appointment availability.
- Open shopper staff surveys for appointment availability – an approach to measuring timeliness of appointment access in which a surveyor contacts participating provider's offices to inquire about appointment availability and identifies from the outset of the call that they are calling on behalf of Carelon Behavioral Health of California.
    - Referral line calls are monitored for timeliness of referral appointments given to members.

- Analysis and trending of information on appointment availabiltiy obtained during site visits.
- Analysis of call statistics (e.g. average speed of answer, abandonment rate over five seconds)
- Annual Geo-Access and network density analysis.

In addition to these monitoring activities, providers are required by contract to report to Carelon Behavioral Health of California when they are at capacity. This assists Clinical Care Managers in selecting appropriate, available providers for a member referral.

Continuity and Coordination of Care

Carelon Behavioral Health of California monitors continuity and coordination of care throughout its continuum of behavioral health services. Monitoring may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient providers, and monitoring provider performance on pre-determined coordination of care indicators. Processes are established seeking to avoid disruption of care for the member when there is a change in their treating provider. Such changes may include, but are not limited to:

- A member requires a change in level of care, necessitating a new provider
- There are multiple providers involved in treatment simultaneously (psychiatrist for medication management, therapist for on-going treatment)
- A change in health plans or benefit plans
- Termination of a provider
- A member is being treated for several (co-morbid) conditions simultaneously with multiple providers (both behavioral health specialists, primary care, medical specialists, or providers specializing in development disabilities)

Screening Programs

Carelon Behavioral Health of California supports the early detection and treatment of depressive and comorbid disorders to promote optimal health for members 13 years and older.

A few helpful reminders:

- Carelon Behavioral Health of California offers many screening tools and programs available at no cost:
  - PCP/Provider Toolkit
  - Depression Screening Program
  - Comorbid Mental Health and Substance Use Disorder Screening Program
- Use screening tools at the first visit and repeat at regular intervals as clinically indicated to identify potential symptoms that need may need further evaluation
- Depression
  - Patient Health Questionnaire 9 (PHQ-9) is a brief, multi-purpose tool for assessing depression, and is available in English, Spanish, and variety of other languages in Carelon Behavioral Health of California's PCP/Provider Kit.
  - When assessing for depression, remember to rule out bipolar disorders; you may choose to use the Mood Disorder Questionnaire (MDQ).
- Suicide
  - Carelon endorses the National Alliance for Suicide Prevention's Recommended Standard Care for

People with Suicide Risk, which screens individuals for suicide and includes a list of screening tools in the Appendix.

- Comorbid issues
  - Remember to screen for possible mental health disorders when a diagnosis of a substance use disorder is present and conversely to screen for a potential substance use disorder when a mental health disorder is present.

The CRAFT screening interview (PDF) assesses for substance use risk specific to adolescents.

Learn more about Carelon's Behavioral Health of California's Depression Screening Program and Comorbid Screening Program at the attached links.

Treatment Record Standards and Guidelines

Member treatment records should be maintained in compliance with all applicable medical standards, laws, rules and regulations, as well as Carelon Behavioral Health of California's policies and procedures and in a manner that is current, comprehensive, detailed, organized and legible to promote effective patient care and quality review. Providers are encouraged to use only secure electronic medical record technology when available. Carelon Behavioral Health of California policies and procedures incorporate standards of accrediting organizations to which Carelon Behavioral Health of California is or may be subject (e.g., the National Committee for Quality Assurance (NCQA)), as well as the requirements of applicable state and federal laws, rules and regulations.

References to 'treatment records' mean the method of documentation, whether written or electronic, of care and treatment of the member, including without limitation medical records, charts, medication records, physician/practitioner notes, test and procedure reports and results, the treatment plan, and any other documentation of care and/or treatment of the member.

Progress notes should include what psychotherapy techniques were used, and how they benefited the member in reaching their treatment goals. Progress notes do not have to include intimate details of the member's problems but should contain sufficient documentation of the services, care and treatment to support medical necessity. Intimate details documenting or analyzing the content of conversations during a private counseling session or a group, joint or family counseling session should be maintained within the psychotherapy notes and kept separate from the member's treatment record made available for review and audit.

Member treatment record reviews and audits are based on the record keeping standards set out below:

- Each page (electronic or paper) contains the member's name or identification number.
- Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- All entries in the treatment record are dated and include the responsible clinician's name, professional degree, and relevant identification number, if applicable. The length of the visit/session is recorded, including visit/session start and stop times.
- Reviews may include comparing specific entries to billing claims as part of the record review.
- The record, when paper based, is legible to someone other than the writer.
- Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the individual has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
- Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status and the results of a mental status exam, are documented.
- Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with written protocols.
- Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data and relevant family information.
- For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events (when available), along with a developmental history (physical, psychological, social, intellectual and academic).
- For members 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.
- A DSM (most current version) diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.
- Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.

- Treatment plans are updated as needed to reflect changes/progress of the member.

  Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers and health care institutions are documented, as appropriate.
- Informed consent for medication and the member's understanding of the treatment plan are documented.
- Additional consents are included when applicable (e.g., alcohol and drug information releases).
- Progress notes describe the member's strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives.
- Documented interventions include continuity and coordination of care activities, as appropriate.
- Dates of follow-up appointments or, as applicable, discharge plans are noted.

In addition to other requests for member treatment records included in this handbook and/or the provider agreement, member treatment records are subject to targeted and/or random audits by Carelon Behavioral Health of California's Quality Management Department, as well as audits required by state, local and federal regulatory agencies and accreditation entities to which Carelon Behavioral Health of California is or may be subject.

Treatment Record Reviews

Providers are required to cooperate with treatment record reviews and audits conducted by Carelon Behavioral Health of California and associated requests for copies of member records. For conducting retrospective case reviews, treatment records for Carelon Behavioral Health of California members should be maintained for at least 10 years from the date of service or as required by applicable state and federal law, whichever is longer.

Carelon Behavioral Health of California may conduct treatment record reviews and/or audits:

- On an unplanned basis as part of continuous quality improvement and/or monitoring activities
- As part of routine quality and/or billing audits
- As may be required by clients of Carelon Behavioral Health of California
- In the course of performance under a given client contract
- As may be required by a given government or regulatory agency
- As part of periodic reviews conducted pursuant to accreditation requirements to which Carelon Behavioral Health of California is or may be subject
- In response to an identified or alleged specific quality of care, professional competency or professional conduct issue or concern
- As may be required by state and/or federal laws, rules and/or regulations
- In the course of claims reviews and/or audits
- As may be necessary to verify compliance with the provider agreement

Treatment record reviews and/or audits may be conducted through on-site reviews in the provider's office or facility location, and/or through review of electronic or hard copy of documents and records supplied by the provider. Unless otherwise specifically provided for in the provider agreement and/or other sections of this handbook with respect to a particular type of record review or audit, providers must supply copies of requested records to Carelon Behavioral Health of California within five business days of the request.

Carelon Behavioral Health of California will use and maintain treatment records supplied by providers for review and/or audit in a confidential manner and in accordance with applicable laws and regulations regarding the privacy or confidentiality of protected health information and/or patient identifying information. Never send original records, as they will not be returned at the completion of the review or audit. Only send those sections of the record that are requested. Access to any copies of member treatment records requested by Carelon Behavioral Health of California shall be at no cost. Treatment records reviews and/or audits conducted as part of Quality Management activities include application of an objective instrument. The instrument is reviewed no less than annually; Carelon Behavioral Health of California reserves the right to alter/update, discontinue and/or replace such instrument in its discretion and without notice.

Following completion of treatment record reviews and/or audits, Carelon Behavioral Health of California gives the provider a written report that details the findings. If necessary, the findings report will include a corrective action plan with specific recommendations that will enable the provider to comply with Carelon Behavioral Health of California standards for treatment records.

Providers must grant access for members to the member's treatment records upon written request and with appropriate identification. Providers should review member treatment records prior to granting access to members to ensure that confidential information about other family members and/or significant others that may be referenced and/or included therein are redacted.

Member Safety Program

Carelon Behavioral Health of California has a defined procedure for the identification, reporting, investigation, resolution and monitoring of potential quality issues and trends. Quality of care issues and trends are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. Provider quality of service issues involve administrative or operational concerns or processes where a provider does not comply with Carelon Behavioral Health of California standards or contractual requirements. These types of issues may be identified from a variety of sources, including without limitation member and provider complaints, internal reviews, clients, government agencies and others. These concerns are resolved and monitored through Carelon Behavioral Health of California's Quality of Care Committee, in which the Medical Director co-chairs. The Committee oversees the investigation and resolution of these issues through to completion.

Carelon Behavioral Health of California's member safety program includes the following components: reporting and investigation of potential Serious Reportable Events (internal and external events), trend analysis of member and provider and client complaints, annual evaluation and updating of existing member safety policies, prevention activities and the promotion of evidenced-based practice by our providers and Carelon Behavioral Health of California employed clinicians.

Carelon Behavioral Health of California's Member Safety Program utilizes a model of Potential Quality of Care (PQOC) Concerns including Serious Reportable Events (SREs) and Trending Events (TE). Carelon Behavioral Health of California adopted the National Quality Forum's (NQF) Serious Reportable Event classification system as a base for its Member Safety Program. This allows the use of a standard taxonomy across a wide variety of settings and supports standard definitions across our diverse organization.

Serious Reportable Events (SRE) include, but are not limited to:

Surgical or Invasive Procedures (i.e., wrong site, wrong patient, wrong procedure, foreign object, and death of ASA class 1 patient)

- Product or Device Events (i.e., contamination, device malfunction, and embolism)
- Patient Protection Events (i.e. discharge of someone unable to make decisions, elopement, completed suicide, attempted suicide, and self-injurious behaviors)
- Care Management Events (i.e., medication error, fall)
- Environmental Events (i.e., electric shock, gas, burn, restraint, seclusion, restrictive interventions)
- Potential Criminal Events (i.e., impersonation, abduction, physical assault, and sexual behavior)
- Carelon Behavioral Health of California Specific (such as disaster management, accidents, staff misconduct, standards of care, and natural death)

Trending Events (TEs) include, but are not limited to the following categories/sub-categories:

- Provider inappropriate/unprofessional behavior
    - Inappropriate boundaries/relationship with member
    - Practitioner not qualified to perform services
    - Aggressive behavior
    - Displays signs of cognitive, mental health, or substance use concerns impacting the care being provided
- Clinical practice-related issues
    - Abandoned member or inadequate discharge planning
    - Timeliness, accuracy, or adequacy of diagnosis, assessment, or referral
    - Delay in treatment
    - Effectiveness of treatment
    - Failure to coordinate care or follow clinical practice guidelines
    - Failure to involve family in treatment when appropriate
    - Medication error or reaction

    - Treatment setting not safe
- Access to care-related issues
    - Failure to provide appropriate appointment access
    - Lack of timely response to telephone calls
    - Prolonged in-office wait time or failure to keep appointment
    - Provider non-compliant with American Disabilities Act (ADA) requirements
    - Services not available or session too short
- Attitude and service-related issues
    - Failure to allow site visit
    - Failure to maintain confidentiality
    - Failure to release medical records
    - Fraud and abuse
    - Lack of caring/concern or poor communication skills
    - Poor or lack of documentation
    - Provider/staff rude or inappropriate attitude
- Other monitored events
    - Adverse reaction to treatment
    - Failure to have or follow communicable disease protocols
    - Human rights violations
    - Ingestion of an unauthorized substance in a treatment setting
    - Non-serious injuries (including falls)
    - Property damage and/or fire setting
    - Sexual behavior

Providers are required to report to Carelon Behavioral Health of California within 24 hours all potential quality issues involving members. Potential quality issues are investigated and the data used to generate and identify opportunities for improvement in the clinical care and service members receive. Carelon Behavioral Health of California tracks and trends potential quality issues and when necessary, investigates patterns or prevalence of incidents and uses the data generated to identify opportunities for quality improvement. Based on the circumstances of each incident, or any identified trends, Carelon

Behavioral Health of California may undertake an investigation designed to provide for member safety. As a result, providers may be asked to furnish records and/or engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. Providers may also be subject to disciplinary action through the Carelon Behavioral Health of California Credentialing Committee based on the findings of an investigation or any failure to cooperate with a request for information pursuant to an adverse incident investigation.

Quality Improvement Activities/Projects

One of the primary goals of Carelon Behavioral Health of California's Quality Management Program is to improve care and services. Through data collection, measurement, and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities. Data collected for quality improvement projects and activities are frequently related to key industry measures of quality that tend to focus on high-volume diagnoses or services and at high-risk special populations. Data collected are valid, reliable and comparable over time. Carelon Behavioral Health of California takes the following steps to ensure a systematic approach to the development and implementation of quality improvement activities:

- Monitoring of clinical quality indicators
- Review and analysis of the data from indicators
- Identification of opportunities for improvement
- Prioritization of opportunities to improve processes or outcomes of behavioral healthcare delivery based on risk assessment, ability to impact performance, and resource availability
- Identification of the affected population within the total membership
- Identification of the measures to be used to assess performance
- Establishment of performance goals or desired level of improvement over current performance
- Collection of valid data for each measure and calculation of the baseline level of performance
- Thoughtful identification of interventions that are powerful enough to impact performance
- Analysis of results to determine where performance is acceptable and, if not, the identification of current barriers to improving performance

Experience Surveys

Carelon Behavioral Health of California, either directly or through authorized designees, conducts some form of experience survey to identify areas of improvement as a key component of the Quality Management Program. Experience survey participation may include members, providers and/or clients.

Member experience surveys measure opinions about clinical care, participating providers, and Carelon Behavioral Health of California's administrative services and processes. Members are asked to complete satisfaction surveys at various points in the continuum of care and/or as part of ongoing quality improvement activities. The results of these member surveys are summarized on an annual basis. Where appropriate, corrective actions are implemented in the Carelon Behavioral Health of California's functional department.

Annual provider satisfaction surveys measure opinions regarding clinical and administrative practices. The results of provider surveys are aggregated and used to identify potential improvement opportunities within Carelon Behavioral Health of California and possible education or training needs for providers. Where appropriate, corrective actions are implemented in the Carelon Behavioral Health of California's functional department.

Provider Survey – Access to Care

The State of California's Timely Access to Non-Emergency Health Care Services Regulation (§1300.67.2.2, Title 28, California Code of Regulations) requires Carelon Behavioral Health of California to maintain an adequate provider network to ensure members receive timely access to care appropriate for their condition. In order to ensure compliance in this area, Carelon Behavioral Health of California conducts a provider survey on an annual basis. Carelon Behavioral Health of California is required to solicit feedback from participating providers about their perspective and satisfaction with their Carelon Behavioral Health of California patient's access to care within the timelines set forth under California law. Carelon Behavioral Health of California must also assess the provider's perspective and concerns with Carelon Behavioral Health of California's language assistance program regarding the:

- Coordination of appointments with an interpreter;
- Availability of an appropriate range of interpreters; and
- Training and competency of available interpreters.

Language Assistance Program

As a California health plan, Carelon Behavioral Health of California is required to provide language assistance services to members with limited English proficiency, including members who require sign language services. Carelon Behavioral Health of California has established a Language Assistance Program designed to provide its members translation and interpretation services at no charge. Services, materials, and information are provided to members in a language that they speak and understand. Providers should be aware of Carelon Behavioral Health of California's standards and mechanisms for providing language assistance services at no cost to all members.

Carelon Behavioral Health of California providers are required to comply with Carelon Behavioral Health of California's Language Assistance Program. Members may request certain Carelon Behavioral Health of California documents, which are translated into a language that they speak and understand. Members may also request they be provided with translator services when they seek treatment with a provider.

Carelon Behavioral Health of California has contracted with a company that can provide telephonic interpreter services. The phone interpreter services are available 24 hours per day, seven days a week. Providers need to have available a speakerphone or dual headset phone in the areas in which telephone interpreter services will be provided. For members requiring American Sign Language (ASL), Carelon Behavioral Health of California has contracted with a company able to provide interpreter services 24 hours per day, seven days a week. Providers should provide as much advance notice as possible when requesting an ASL interpreter, as well as at least 24 hours in advance for cancellations.

Providers must comply with all HIPAA requirements when providing interpreter services to members.

While the law does not prohibit adult family members from serving as interpreters for members, Carelon Behavioral Health of California discourages this practice. Minor children should not be used as interpreters, except in emergencies where any delay could result in harm to a member and only until a qualified interpreter is available. Providers should remind members that Carelon Behavioral Health of California provides free interpreter services with qualified interpreters.

When providing language assistance services to members with limited English proficiency, providers must document the following in medical records:

- How the language assistance was provided (i.e. name of interpreter, employee name and ID, over the phone or in-person, etc.)
- If language assistance was refused by the member, specifically why it was refused (i.e. patient preferred to use own English skills, etc.)

If a member needs assistance in receiving services, material and/or information in a language that they speak and understand, if a provider needs assistance in communicating with a member in a language that they speak and understand, or if there is a question about the Carelon Behavioral Health of California Language Assistance Program, call the toll-free number on the back of the member's identification card.

Cultural Competency

Culture refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people. Cultural competence is the capability of effectively dealing with people from different cultures. Culture informs:

- Concepts of health and healing;
- How illness, disease, and their causes are perceived;
- The behaviors of patients who are seeking health care; and
- Attitudes toward health care providers

Culture influences every health care encounter. Because health care is a cultural construct based in beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services, including who provides treatment, what is considered a health problem, what type of treatment should be received, where the care is sought, and how symptoms are expressed.

In order for providers to participate in certain Carelon Behavioral Health of California networks, providers must be able to demonstrate cultural competence towards members with diverse values, beliefs, and feelings. Providers must take into consideration of the individual social, cultural, and psychological needs of patients in order to provide optimal care to patients regardless of their race, gender, ethnic background, native languages spoken, and religious or cultural beliefs.

For those provides that deliver state and federal health care services, Carelon Behavioral Health of California requires providers to complete the Carelon Behavioral Health of California Cultural Competency Training on an annual basis.

Providers are expected to provide services in a culturally competent manner at all times and to contact Carelon Behavioral Health of California if they are referred a member who presents with cultural and/or linguistic needs they may not be qualified to address.

State and Federal Health Care Programs

Carelon Behavioral Health of California partners with health plans to provide behavioral health care services for Medi-Cal and Medicare members in certain counties.

Medi-Cal

Medi-Cal is California's Medicaid program. This is a public health insurance program that provides needed health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low income people with specific diseases. Medi-Cal is financed equally by the state and federal government.

Medi-Cal emphasizes prevention-oriented health care that promotes health and well-being and works to ensure members receive the right care at the right time.

Medi-Cal is health coverage. All of the health plans offered by Medi-Cal include the same comprehensive set of benefits known as "essential health benefits," including, but not limited to Mental Health and Substance Use Disorder Services.

In accordance with the requirements set forth in Title 42 of the CFR, Section 438.602(b), and as required by the California Department of Health Care Services (DHCS), practitioners participating in a Medi-Cal provider network must be enrolled in Medi-Cal. To enroll through Carelon Behavioral Health of California, providers must complete the Medi-Cal Fee for Service-Enrollment document or by contacting the DHCS Provider Enrollment Division:

Department of Health Care Services Provider Enrollment Division
P.O. Box 997412
Sacramento, CA 95899-7412
Telephone: (916) 323-1945

Failure to enroll prohibits providers from participating in a Medi-Cal network and are not eligible to receive Medi-Cal funded reimbursement of claims.

Providers participating in the Medi-Cal network are required to complete Medi-Cal training through Carelon Behavioral Health of California in order to operate in full compliance with all applicable federal and State statutes and regulations. Carelon Behavioral Health of California's Medi-Cal training provides information about Medi-Cal managed care services, policies, procedures and any modifications to existing services, policies or procedures. The training includes, but is not limited to, information on all member rights, member services, including the right to full disclosure of health care information and the right to participate in health care decisions. Training must be completed within 10 business days after a provider's Medi-Cal network effective date with Carelon Behavioral Health of California.

Monthly, all Medi-Cal providers are validated against the Medi-Cal Sanction list. Any providers who have been sanctioned are removed from all Carelon Behavioral Health of California networks.

When a provider elects to verify a member's Medi-Cal eligibility, the provider has agreed to accept an individual as a Medi-Cal patient once the information obtained verifies that the individual is eligible to receive Medi-Cal benefits. The provider is then bound by the rules and regulations governing the MediCal program once a Medi-Cal patient has been accepted into the provider's care. After receiving verification that a recipient member is Medi-Cal eligible, a provider cannot deny services because:

- The member has other health insurance coverage in addition to Medi-Cal. Providers must not bill the recipient for private insurance cost-sharing amounts such as deductibles, coinsurance or copayments because such payments are covered by Medi-Cal up to the Medi-Cal maximum allowances. Providers are reminded that Medi-Cal is the payer of last resort. Medicare and Other Health Coverage must be billed prior to submitting claims to Medi-Cal.
- The member has both Medicare and Medi-Cal. Providers must not treat the member as if the recipient is eligible only for Medicare and then collect Medicare deductibles and coinsurance from the member.
- The service requires the provider to obtain authorization.

Providers must hold Medi-Cal managed care plan members and the state of California harmless in the event Carelon Behavioral Health of California cannot pay for services performed by the provider. DHCS prohibits providers from charging members for Medi-Cal covered services, or having any recourse against the member or DHCS for Medi-Cal covered services rendered to the member. The prohibition on billing of the member includes, but is not limited to, the following:

- Covered services
- Covered services provided during a period of retroactive eligibility
- Covered services once the member meets their share of cost requirement
- Co-payments, coinsurance, deductible or other cost-sharing required under a member's other health coverage
- Pending, contested or disputed claims
- Fees for missed, broken, cancelled or same day appointments
- Fees for completing paperwork related to the delivery of care (e.g., immunization cards, WIC forms, disability forms, PM160 forms, forms related to Medi-Cal eligibility, PM160 well-child visit forms.)

Adverse Childhood Experiences Screening Services (ACEs)

The California Department of Health Care Services has training opportunities available for providers and ancillary staff to receive general training about trauma-informed care as well as training on using the ACEs questionnaire and the Pediatric ACEs and Related Life-events Screener (PEARLS) tool. The training also includes a review on the ACEs Screening Clinical Algorithms that will help providers assess a patient's risk of toxic stress physiology as well as a demonstration on how to incorporate ACEs screening results into clinical care. Information about the training can be found at https://www.acesaware.org/

Providers must complete the state sponsored training or an approved course recognized by the California Department of Health Care Services. In addition to training, providers must also:

- Use either the PEARLS tool or a qualifying ACEs questionnaire as appropriate

- Bill using the G9919 or G9920 HCPCS codes based on the screening score from the PEARLS tool or a qualifying ACEs questionnaire

Providers should document the tool used in the screening, the results of the screen and the interpretation discussed with the member and/or family along with any appropriate actions taken.

Other Provider Obligations under Medi-Cal

- Member Visitation – Provider agrees to permit a member to be visited or accompanied to treatment by their domestic partner, the children of the member's domestic partner, and the domestic partner of the member's parent or child.
- Covered Contraceptive Methods – Providers ensure that members are informed of the full array of covered contraceptive methods when appropriate and the provider makes reasonable efforts to ensure that informed consent is obtained by the treating provider, from members, for sterilization consistent with the requirements of applicable law.
- Medi-Cal Consent Services Program – Provider complies with the Medi-Cal Minor Consent Services program which stipulates that minors do not need parental consent in order to access services related to sexual assault, including rape, drug or alcohol abuse (for children 12 years of age or older), pregnancy, family planning, sexually transmitted diseases, and HIV/AIDS (in children 12 years of age or older).
- Emergency Services Requiring the Use of Drugs – Providers agree that when providing emergency Services to a Medi-Cal member and such member's treatment requires the use of drugs, the provider will provide to the member at least a 72-hour supply of medically necessary drugs, which may include an initial dose and a prescription for additional drugs.
- Testing and Examination of Materials Derived from the Human Body – Providers agree that any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed meet the requirements of 42 USC Section 263a (CLIA) and the regulations thereto.

For more information about billing basics, policies, procedures, new initiatives and upcoming changes to the Medi-Cal program, Medi-Cal offers a learning portal that makes available self-paced online training at https://learn.medi-cal.ca.gov/

Medi-Cal Appeals Process

Expedited Clinical Appeals	Standard Clinical Appeals	External Appeals
1. The member, or their authorized representative, has 60 days (or 10 days to ensure continuation of currently authorized services) from receipt of the notice of action or the intended effective date of the proposed action. The provider may act as the member's appeal representative – Authorized Member Representative (AMR) without completing the *Designation of Appeal Representative Form*. The provider can request an expedited appeal on behalf of the member regardless of the services. 2. A Physician Advisor, who was not involved in the initial decision, reviews all available information and attempts to speak with member's clinical team. 3. A decision is made within 72 hours of the initial request. 4. Throughout the course of an	1. The members, their legal guardian, or AMR have up to 60 days to file an appeal after notification of an adverse determination. 2. A Physician Advisor, not involved in the initial decision, reviews available information and attempts to contact the member's clinical team. 3. Resolution and notification is provided within 30 calendar days of the appeal request and within 2 business days of the decision. 4. If the appeal requires review of medical records (post service situations), the member's or AMR's signature is required on an *Authorization to Release Medical Information Form*, authorizing the release of medical and treatment information relevant to the appeal. If the medical record with *Authorization to Release Medical Information Form* is not received prior to the deadline for resolving the appeal, a resolution is rendered based on the	1. Members have the right to file a fair hearing request with the California Department of Social Services (CDSS) upon receipt of an issued adverse action. 2. The member may represent themself at the fair hearing, or name someone else to be their representative. 3. Members have the right to request an expedited fair hearing if the member meets the definition of urgent care defined above. 4. The request must be filed within 120 calendar days from the date on the adverse action letter. 5. If the appeal goes to state fair hearing, a Carelon Behavioral Health of California representative presents the action taken and basis or reason for the action. 6. The member or their representative then responds with the reason they feel the decision was not correct, and why they need the type and level of

Expedited Clinical Appeals	Standard Clinical Appeals	External Appeals
appeal for services previously authorized by Carelon Behavioral Health of California, the member may continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed within 10 calendar days after the date on the adverse determination notice, or the intended effective date of the proposed Adverse Benefit Determination.	information available. 5. Throughout the course of an appeal for services previously authorized, the member may continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis.	service in dispute, or why Carelon Behavioral Health of California should pay for a service already received. 7. The decision is made by CDSS, and the order is sent to Carelon Behavioral Health of California. Carelon Behavioral Health of California will comply with the final decision in the state fair hearing promptly and as expeditiously as the member's health condition requires.
Contact Information: Appeals requests can be made by calling Carelon Behavioral Health of California at 855765-9700.	Contact Information: Appeals requests can be made by calling Carelon Behavioral Health of California at 855765-9700 or in writing to: Carelon Behavioral Health of California P.O. Box 6065 Cypress, CA 90630	Contact Information: Members or their AMR should contact CDSS at 800-952-5253 (TDD 800-952-8349) or write to: California Department of Social Services, State Hearing Division P.O. Box 944243, MS 9-17-37 Sacramento, CA 94244-2430

Medicare

Medicare is the federal health insurance program for:

- People who are 65 or older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

The Centers for Medicare and Medicaid Services (CMS) is the agency within the Department of Health and Human Services that administers the Medicare program.

Providers are expected to comply with Medicare laws, regulations, and CMS instructions.

Federally Qualified Health Centers (FQHC)

A Federally Qualified Health Center (FQHC) is an outpatient clinic that qualifies for specific reimbursement under Medicare and Medi-Cal. FQHCs include Health Center Program awardees and look-alikes as well as certain outpatient clinics associated with tribal organizations. Different rules may apply to outpatient clinics associated with tribal organizations who enroll in Medicare or Medi-Cal as FQHCs.

To qualify as an FQHC, an entity must meet one of these requirements:

- Obtain a grant under Section 330 of the Public Health Service (PHS) Act (42 USC Section 254a) or funded by the same grant contracted to the recipient
- Not getting a grant under Section 330 of the PHS Act but the HHS Secretary allows such a grant, which qualifies the entity as an "FQHC look-alike" based on a Health Resources and Services Administration (HRSA) recommendation
- Treated by the HHS Secretary as a comprehensive federally funded health center since January 1, 1990, for Medicare Part B purposes
- Operating as an outpatient health program or tribe or tribal organization facility under the Indian Self-Determination Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act FQHC certification requires the entity meet all these requirements:
- Provide comprehensive services including an ongoing quality assurance program and annual review
- Meet all health and safety requirements
- Not approved as a Rural Health Clinic
- Meet all Section 330 of the PHS requirements, including:
- Serve a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP)
- Offer people with incomes below 200% of the federal poverty guidelines a sliding fee scale
- Governed by a board of directors, where most members get care at the FQHC

Disclosure of Ownership and Control

In addition to the other Carelon Behavioral Health of California credentialing requirements, providers participating in the Medicare and/or Medi-Cal networks must also provide a disclosure of ownership form. If an individual practitioner providing direct-care discloses ownership and representation of a group or corporation for which they are responsible for its operations must provide a Disclosure of Ownership Form. Any persons defined as disclosing entities with more than 5% ownership or control must be queried for sanctions and exclusions, and then added to the ongoing monitoring list. Owners or individuals with controlling interest must notify Carelon Behavioral Health of California within 35 calendar days of any changes in ownership or controlling interest in the interim of the recredentialing cycle. An individual providing direct care, responsible for their own business or is a member of a group practice providing direct-care is exempt from providing a Disclosure of Ownership form.

False Claims Acts

The California and Federal False Claims Acts make it illegal to submit claims for payment to Medicare or Medicaid that a provider knows or should know are false or fraudulent. Filing false claims may result in fines of up to three times the program's loss plus $11,000 per claim. Under the civil False Claims Acts, no specific intent to defraud is required. The civil False Claims Acts define "knowing" to include not only actual knowledge but also instances in which the person(s) acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil False Claims Acts contain a whistleblower provision that allows private individuals to file a lawsuit on behalf of the United States and entitles whistleblowers to a percentage of any recoveries. There also is a criminal False Claims Act. Criminal penalties for submitting false claims include imprisonment and criminal fines.

Carelon Behavioral Health of California providers, contractors, employees, members and board members have a responsibility to report suspected or actual violations of applicable laws and regulations. Carelon Behavioral Health of California does not retaliate against or intimidate any individual/entity for reporting a known or suspected violation of applicable laws and regulations.

CARELON BEHAVIORAL HEALTH

CALIFORNIA MEDI-CAL ADDENDUM

Any policies contained in this Provider Handbook Addendum will supersede those policies contained in Carelon Behavioral Health's National Provider Handbook. This Addendum is specific to California Medi-Cal.

10. UTILIZATION MANAGEMENT
11. QUALITY MANAGEMENT/QUALITY IMPROVEMENT

Medi-Cal Providers

The following chapters referenced below correspond with the chapters found in the Carelon National Provider Handbook. Information included under each chapter is specific to your Plan.

1. INTRODUCTION
   See Carelon national handbook
2. ELECTRONIC RESOURCES
   See Carelon national handbook
3. PARTICIPATING PROVIDERS
   See Carelon national handbook
4. CREDENTIALING AND RE-CREDENTIALING
   See Carelon national handbook
5. OFFICE PROCEDURES
   See Carelon national handbook
6. SERVICES TO MEMBERS
   See Carelon national handbook
7. MEMBER RIGHTS AND RESPONSIBILITIES
   See Carelon national handbook
8. PARTICIPATING PROVIDER COMPLAINTS AND GRIEVANCES
   See Carelon national handbook
9. CLAIMS PROCEDURES

Time Limits for Filing Claims
Carelon must receive claims for covered services within 180 days of the dates of service on outpatient claims.

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 180-day filing limit will be subject to reduction in payment or denial per Medi-Cal regulations, unless submitted as a waiver or reconsideration request, as described in this chapter. Claims received beyond 365-days will be denied for untimely filing.

How To Send a Provider Dispute to Carelon
Contracted clinician disputes submitted to Carelon must include the information listed above, for each clinician dispute. To facilitate resolution, the clinician may use either the Provider Dispute Resolution Request Form, available on our website at www.chipa.com, or a personalized form to submit the required information.
All provider disputes can be sent via email providerdisputeresolution@carelon.com or by mail to the attention of Provider Disputes at the following:

Carelon Behavioral Health
P.O. Box 1864
Hicksville, NY 11802-1864

Instructions for Filing Substantially Similar Clinical Disputes
Substantially similar multiple claims, billing or contractual disputes, should be filed in batches as a single dispute, and may be submitted using either the Clinician Dispute Resolution Request – Multiple like Claims Form or a personalized form with the required information.
Time Period for Submission of Provider Disputes
Clinician disputes must be received by Carelon within 365 calendar days from Carelon's action that led to the dispute or the most recent action if there are multiple actions that led to the dispute or in the case of inaction, disputes must be

received by CHIPA within 365 calendar days after Carelon's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
Clinician disputes that do not include all required information as set forth above may be returned to the submitter for completion. An amended clinician dispute that includes the missing information may be submitted to Carelon within 45 calendar days of your receipt of a returned clinician dispute.

Acknowledgment of Provider Disputes and Resolution
Carelon will provide a written acknowledgement of a dispute to the submitting provider within 15 days of receipt of the dispute if received by mail and two business days if received electronically. Carelon will issue a written determination stating the pertinent facts and explaining the reasons for its determination within 30 calendar days after the date of receipt of the clinician dispute or the amended clinician dispute.
Past Due Payments to Clinician
If the clinician dispute or amended clinician dispute involves a claim and is determined in whole or in part in favor of the clinician, Carelon will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five calendar days of the issuance of the written determination.
Paper Submission of 180-Day Waiver Form

- See Table 7-1 for an explanation of waivers, when a waiver request is applicable, and procedural guidelines
- Watch for notice of waiver requests becoming available on eServices
- Download the 180-Day Waiver Form
- Complete a 180-Day Waiver Form for each claim that includes the denied claim(s), per the instructions below
- Attach any supporting documentation
- Prepare the claim as an original submission with all required elements
- Send the form, all supporting documentation, claim and brief cover letter to:

Carelon Behavioral Health
P.O. Box 1864
Hicksville, NY 11802-1864

Completion of the 90-Day Waiver Request Form
To ensure proper resolution of your request, complete the 90-Day Waiver Request Form as accurately and legibly as possible.

1. Provider Name
   Enter the name of the provider who provided the service(s)
2. Provider ID Number
   Enter the provider ID number of the provider who provided the service(s)
3. Member Name
   Enter the member's name
4. Central California Alliance for Health Member ID Number
   Enter the plan member ID number
5. Contact Person
   Enter the name of the person whom Carelon should contact if there are any questions regarding this request
6. Telephone Number
   Enter the telephone number of the contact person
7. Reason for Waiver
   Place an "X" on all the line(s) that describe why the waiver is requested
8. Provider Signature
   A 90-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Carelon will not accept "Signature on file".
9. Date
   Indicate the date that the form was signed

10. UTILIZATION MANAGEMENT

Please call the number on the back of the member's ID card. Utilization management (UM) is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and retrospective review.

CHIPA has entered into a management services agreement with Carelon to provide management services in support of CHIPA's UM functions in accordance with URAC Health UM Standards, NCQA Managed Behavioral Health Organization (MBHO) standards, and state and federal regulations.

CHIPA's UM program is administered by licensed, experienced clinicians, who are specifically trained in utilization management techniques and in Carelon's standards and protocols. All CHIPA clinicians with responsibility for making UM decisions have been made aware that:

- All UM decisions are based upon CHIPA's LOCC (medical necessity)
- Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

Please note: The information in this chapter, including definitions, procedures, and determination and notification time frames may vary for different lines of business; such differences are indicated where applicable.

Annual Affirmative Statement

Please be advised that CHIPA's policy (UM 86) regarding Utilization Management (UM) decision making is as follows:

1. All UM and CM decision making are based only on appropriateness of care and services and existence of coverage. The member's healthcare is not compromised at any time. Medical Necessity Criteria are used as a guideline.
2. There are no financial incentives to encourage adherence to utilization targets and discourage under-utilization. Financial incentives based on the number of adverse determination or denials of payment made by any individual involved in UM decision making are prohibited.
3. CHIPA does not make decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual based upon the likelihood that the individual will support the denial of benefits.
4. The prohibition of financial incentives does not apply to financial incentives established between health plans and health plan providers.
5. Utilization Management staff in no way rewards or incentivizes, either financially or otherwise, practitioners, utilization reviewers, clinical care managers, physician advisers, or other individuals involved in conducting utilization/case management review, for issuing denials of coverage or service, or inappropriately restricting or diverting care including staff that engage in contract/network management activities that could potentially influence referrals to specific providers/services.

Medical Necessity

All requests for authorization are reviewed based on the information provided, according to the following definition of medical necessity:

Medically necessary services are health care and services that:

1. Are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap
2. For which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative and less costly
3. Are of a quality that meets generally accepted standards of healthcare

4. Are reasonably expected to benefit the person. This definition applies to all levels of care and all instances of CHIPA's utilization review

This definition applies to all levels of care and all instances of CHIPA's utilization review. In addition, for California Medi-Cal services, medical necessity is defined as reasonable and necessary to protect life; prevent significant illness or significant disability; or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury as specified under Title 22 California Code of Regulations (CCR) Section 51303.

Decision and Notification Time Frames

CHIPA is required by the state, federal government, NCQA, and URAC to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. CHIPA has adopted the strictest time frame for all UM decisions in order to comply with the various requirements.

The time frames below present the internal time frames for rendering a UM determination and notifying members of such determination. All time frames begin at the time of receipt of the request. Please note: the maximum time frames may vary from those on the table below on a case-by-case basis in accordance with state, federal government, NCQA or URAC requirements that have been established for each line of business.

	TYPE OF DECISION	DECISION TIME FRAME	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Pre-Service Review				
Initial Registration for Other Urgent Mental Health Services	Urgent	Within 72 hours	Within 24 hours of making the decision, not to exceed 72 hours	
Initial Registration for Other Urgent Mental Health Services	Standard	Within 5 business days	Within 24 hours of making the decision	Within 2 business days
Concurrent Review (includes non-inpatient treatment)				
Continued Registration for Non-Urgent Mental Health Services	Non-Urgent / Standard	Within 5 business days	Within 24 hours of making the decision	Within 2 business days
Post-Service				
Registration for Mental Health Services Already Rendered	Non-Urgent / Standard	Within 30 business days	Within 30 business days	

Note: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

When the specified time frames for standard and expedited prior authorization requests expire before CHIPA makes a decision, an adverse action notice will go out to the member on the date the time frame expires.

Appeal Process Detail

This section contains detailed information about the appeal process for members. The table below illustrates:

- How to initiate an appeal
- AMR information

EXPEDITED CLINICAL APPEALS	STANDARD CLINICAL APPEALS	EXTERNAL APPEALS
1. The member, or his or her authorized representative, have 90 days (or 10 days to ensure continuation of currently authorized services) from receipt of the notice of action or the intended effective date of the proposed action. The provider may act as the member's appeal representative (AMR) without completing the Designation of Appeal Representative Form. The provider can file an expedited appeal on behalf of the member regardless of the services. 2. A CHIPA Physician Advisor, who has not been involved in initial decision, reviews all available information and attempts to speak with member's attending physician. 3. Decision is made within 72 hours of initial request. 4. Throughout the course of an appeal for services previously authorized by Carelon, the member shall continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis.	1. The members, their legal guardian, or AMR have up to 90 days to file an appeal after notification of CHIPA's adverse determination. 2. A CHIPA physician advisor, not involved in the initial decision, will review available information and attempt to contact the member's attending physician/provider. 3. Resolution and notification will be provided within 30 calendar days of the appeal request. 4. If the appeal requires review of medical records (post service situations), the member's or AMR's signature is required on an Authorization to Release Medical Information Form, authorizing the release of medical and treatment information relevant to the appeal. 5. If the medical record with Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal; a resolution will be rendered based on the information available. 6. Throughout the course of an appeal for services previously authorized by CHIPA, the member shall continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis.	Members have the right to file a fair hearing request with the California Department of Social Services (CDSS) upon receipt of an adverse action issued by CHIPA. 1. The member may represent themselves at the fair hearing, or name someone else to be their representative. 2. Members have the right to request an expedited fair hearing if the member meets the definition of urgent care defined above. 3. The request must be filed within 90 calendar days from the date on the adverse action letter sent by CHIPA. 4. If the appeal goes to state fair hearing, CHIPA and Alliance representatives present the action taken and basis or reason for the action. 5. The member or his/her representative then responds with the reason he/she feels the decision was not correct, and why he/she needs the type and level of service in dispute, or why CHIPA should pay for a service already received. 6. The decision is made by CDSS, and the order is sent to CHIPA. CHIPA will comply with the final decision in the state fair hearing promptly and as expeditiously as the member's health condition requires.
Contact Information: Appeals requests can be made by calling CHIPA's appeals coordinator at 855.765.9700.	Contact Information: Appeals requests can be made by calling CHIPA's appeals coordinator at 855.765.9700 or in writing to: Carelon Behavioral Health P.O. Box 1864 Hicksville, NY 11802-1864	Contact Information: Members or their AMR should contact CDSS at 800.952.5253 (TDD 800.952.8349) or write to:

EXPEDITED CLINICAL APPEALS	STANDARD CLINICAL APPEALS	EXTERNAL APPEALS
		California Department of Social Services State Hearing Division P.O. Box 944243, MS 917-37 Sacramento, CA 94244-2430

11. QUALITY MANAGEMENT/QUALITY IMPROVEMENT

See Carelon national handbook