# Table of Contents

1. Introduction .......................................................................................................................... 7  
   1.1. Document Purpose and Philosophy ............................................................................. 7  
   1.2. Organizational Overview ......................................................................................... 7  
   1.3. Philosophy .................................................................................................................. 8  
   1.4. Nondiscrimination ........................................................................................................ 8  
   1.5. Contact Information .................................................................................................... 9  
2. Credentialing ....................................................................................................................... 11  
   2.1. Purpose ....................................................................................................................... 11  
   2.2. Credentialing Decisions ............................................................................................. 11  
      2.2.1. Credentialing Committee .................................................................................... 11  
      2.2.2. Committee Minutes ............................................................................................ 12  
      2.2.3. Provider Notification of Decisions ....................................................................... 12  
      2.2.4. Confidentiality and Storage of Records ............................................................... 13  
      2.2.5. Nondiscrimination Processes ............................................................................ 13  
      2.2.6. Appeal/Cure Process ........................................................................................... 13  
   2.3. Provider Role in CBH Network Participation ............................................................... 14  
      2.3.1. CBH Policy ......................................................................................................... 14  
      2.3.2. Provider Responsibility ....................................................................................... 14  
      2.3.3. Types of Providers ............................................................................................... 15  
      2.3.4. Practitioner Directories ........................................................................................ 15  
   2.4. Credentialing and Recredentialing Processes ................................................................. 16  
      2.4.1. Philosophy ......................................................................................................... 16  
      2.4.2. Types of Credentialing ....................................................................................... 16  
      2.4.2.1. Initial Credentialing ....................................................................................... 16  
      2.4.2.2. Recredentialing ............................................................................................... 17  
   2.5. Independent Practitioners and Group Practices Initial Credentialing and Recredentialing ................................................................................................................................. 18  
      2.5.1. Provider Responsibilities ..................................................................................... 18  
      2.5.2. Delegation of Credentialing ............................................................................... 18  
      2.5.3. Written Delegation Agreement ......................................................................... 19  
      2.5.4. Initial Credentialing Timeline: 180 Days ............................................................. 19  
      2.5.5. Use of Protected Health Information (PHI) ....................................................... 19  
      2.5.6. Reporting ........................................................................................................... 20  
      2.5.7. Monitoring of Contracted CVO Performance .................................................... 20  
      2.5.8. Review of Delegated Credentialing Process ..................................................... 20  
      2.5.9. Opportunities for Improvement ......................................................................... 21  
      2.5.10. Provider Credentialing Checklist ...................................................................... 21  
      2.5.11. Criteria Utilized for Credentialing and Recredentialing .................................... 21  
      2.5.12. Verification of Credentials ............................................................................... 22  
      2.5.12.1. Licensure ....................................................................................................... 22
2.5.12.2. Drug Enforcement Administration certification (Physicians and Nurse Practitioners Only) ................................................................. 22
2.5.12.3. Education .................................................................................. 22
2.5.12.4. Board Certification ...................................................................... 23
2.5.12.5. Work History/Experience .............................................................. 23
2.5.12.6. Malpractice History ....................................................................... 23
2.5.12.7. Sanctions ..................................................................................... 24
  2.5.12.7.1. Medicare/Medicaid Exclusions ............................................... 24
  2.5.12.7.2. Other State Sanctions .............................................................. 24
2.5.13. Practitioner Rights ........................................................................... 24
  2.5.13.1. Report of Information Obtained from Outside Sources .............. 24
  2.5.13.2. Ability to Correct Erroneous Information or Deficiencies .......... 25
  2.5.13.3. Application Status Updates ....................................................... 25
  2.5.13.4. Dates and Timeframes ............................................................... 25
  2.5.13.5. Monitoring and Quality Assurance Activities ............................. 25
  2.5.13.6. Notification to Authorities ......................................................... 26
  2.5.13.7. Available Actions to Assist Practitioners ................................. 27
  2.5.13.8. Reporting to Oversight and Enforcement Agencies ................ 27
2.6. Facilities: Initial Credentialing and Recredentialing .............................. 28
  2.6.1. Facilities: Initial Credentialing ....................................................... 28
  2.6.2. Network Entry ................................................................................ 28
  2.6.3. Initiation of Initial Credentialing .................................................... 28
  2.6.4. Initial Credentialing Review Process .............................................. 29
  2.6.5. Coordination of the Initial Credentialing Process ......................... 29
  2.6.6. Business Documents ..................................................................... 29
  2.6.7. Staff Files ....................................................................................... 29
  2.6.8. Policies and Procedures .................................................................. 30
  2.6.9. Site Visit ......................................................................................... 30
  2.6.10. Application Status Updates ......................................................... 31
  2.6.11. Credentialing Committee Review ............................................... 31
  2.6.12. Contracting ................................................................................... 32
  2.6.13. Record Keeping ............................................................................. 32
    2.6.14.1. Weighting ............................................................................... 33
    2.6.14.2. Score ranges .......................................................................... 33
2.7. Applicable Documents ......................................................................... 34
2.8. Applicable Appendices ......................................................................... 34
3. Authorizations ......................................................................................... 36
  3.1. Overview ............................................................................................ 36
  3.2. Types of Services ............................................................................... 36
  3.3. Eligibility ............................................................................................. 37
  3.4. Types of Authorizations and Related Processes ............................... 37
6. Secure File Transfer

6.1. Overview

6.2. Reference Guide

6.3. Claims Testing

5.3. Methods in Billing CBH

5.3.1. Electronic Claims

5.3.2. Filing Manual Claims

5.3.2.1. Inpatient Claims, UB-04 Claim forms

5.3.2.2. Outpatient Claims, CMS-1500 (02-12) Claim form

5.3.2.3. Completion of the UB-04 Claim Form

5.3.2.4. Completion of the CMS-1500 (02-12) Claim Form

5.3.2.5. Multi Claim Form

5.3.2.6. ACT 62 Pennsylvania Mandate for Autism

5.3.2.7. Medicare Inpatient Lifetime Psychiatric Days

5.3.2.8. Medicare Remittance Advice(s)/Other Insurance Carrier Remittance Advice(s)

5.3.2.9. Downloading Claims Responses

5.3.3. Uploading Claims Files

5.3.4. Filing Manual Claims

5.3.5. Submission of Manual Claims

5.3.6. UB-04 Claim Form

5.3.7. CMS-1500 (02-12) Claim Form

5.3.8. Discrepancies Between the EVS and the Claims System

5.3.9. Discrepancies Between the Claims and Payment Recovery System

5.3.10. Discrepancies Between the Remittance Advice and the Payment Recovery System

5.4. CBH Claim Process Cycle and Returned Data

5.4.1. Adjudication Process

5.4.2. Payment of Claims

5.4.3. Returned Claim Data

5.4.4. Payment Recoveries

5.4.5. AP manuscripts

5.5. CBH Provider Follow-up Process

5.5.1. CBH Provider Follow-up Process

5.5.2. Submitting Provider Initiated Voids via the 837I or 837P

5.5.3. Submitting Adjustments Manually

5.5.4. Claims Appeals Process

5.5.4.1. Appealing Rejected Claims for TPL caused by discrepancies

5.5.4.2. Appealing Rejected Claims for "Recipient not Eligible" caused by discrepancies between the EVS and the Claims System

5.5.4.3. Appealing Rejected Claims for “Timely Filing Limit or Late Submission”
1. INTRODUCTION

1.1. Document Purpose and Philosophy

This manual serves as a guide for providers within the Community Behavioral Health (CBH) network. As an extension of the Provider Agreement, this manual describes the policies, procedures, and practices developed by CBH and the Department of Intellectual disAbility Services (DBHIDS).

The content of this manual seeks to ensure that all Philadelphia recipients of mental health and substance use services receive the most appropriate treatment in the least restrictive environment possible. CBH is committed to helping people live successfully in the community. To that end, treatment should be based on principles of recovery, resilience, and self-determination.

Procedures and processes described herein, and the additional documents linked in Chapter 7, are mandatory for all providers in the CBH network.

1.2. Organizational Overview

The City of Philadelphia contracts with the Commonwealth of Pennsylvania Department of Human Services (PA-DHS) for the provision of behavioral health services to Philadelphia’s Medicaid recipients under Pennsylvania’s HealthChoices behavioral health mandatory managed care program. Services are funded on a capitated basis through this contractual agreement. The City of Philadelphia, through (DBHIDS), contracts with CBH to administer the HealthChoices program.

DBHIDS is comprised the Office of Behavioral Health which includes Mental Health and Addictions Services and Intellectual disAbility Services (IDS). DBHIDS contracts with Community Behavioral Health (CBH) to administer behavioral health care services for the City’s approximately 700,000 Medical Assistance recipients under Pennsylvania’s HealthChoices behavioral health mandatory managed care program. CBH manages a full continuum of medically necessary and clinically appropriate behavioral health services. CBH employs more than 450 people and has an annual budget of approximately $800 million.

The Department has a long history of providing innovative and groundbreaking services in Philadelphia for people in recovery, family members, providers and communities and has become a national model for delivering behavioral health care services in the public sector. We envision a Philadelphia where every individual can achieve health, well-being, and self-determination. The mission of DBHIDS is to educate, strengthen and serve individuals and community so that all Philadelphians can thrive. This is accomplished using a population health approach with an emphasis on recovery and resilience-focused behavioral health services and
on self-determination for individuals with intellectual disabilities. Working with an extensive network of providers, DBHIDS provides services to persons recovering from mental health and/or substance use, individuals with intellectual disabilities, and families to ensure that they receive high quality services which are accessible, effective and appropriate.

This program will be administered by and receive oversight from CBH. CBH is committed to offering services to all Philadelphians. The mission of CBH is to meet the behavioral health needs of the Philadelphia community by assuring access, quality, and fiscal accountability through being a high performing, efficient, and nimble organization driven by quality, performance, and outcomes. We envision CBH as a diverse, innovative, and vibrant organization in which we are empowered to support wellness, resiliency, and recovery for all Philadelphians.

1.3. Philosophy

CBH values and cultivates a strength-based, culturally-competent, and recovery-oriented system of care that promotes health, wellness, and achievement of individual goals. CBH grounds services in the principles of recovery, resiliency, and self-determination to facilitate the attainment of a meaningful life in the community for all members.

1.4. Nondiscrimination

CBH maintains a policy of nondiscrimination.

Our credentialing and recredentialing processes, which evaluate and select network providers, does not discriminate based on the applicant’s race, ethnic/national identity, religion, gender, age, sexual orientation, or physical disability.

CBH is committed to developing and implementing recruitment and procurement activities to solicit providers reflective of the diverse membership we serve.
## 1.5. Contact Information

<table>
<thead>
<tr>
<th>Important Contacts</th>
<th>Purpose</th>
<th>Phone Numbers</th>
<th>Hours of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Special Initiative (BHSI)</td>
<td>Providers seeking addictions treatment for uninsured Philadelphia residents should contact.</td>
<td>215-546-1200</td>
<td>Monday—Friday 8:00 a.m.—5:00 p.m.</td>
</tr>
<tr>
<td>CBH</td>
<td>Call with general inquiries and transfers to specific CBH departments.</td>
<td>215-413-3100</td>
<td>Monday—Friday 8:00 a.m.—5:00 p.m.</td>
</tr>
<tr>
<td>CBH Claims Hotline</td>
<td>Providers call with claims questions.</td>
<td>215-413-7125</td>
<td>Monday—Friday 8:00 a.m.—5:00 p.m.</td>
</tr>
<tr>
<td>CBH Clinical Management</td>
<td>Providers call to request non-urgent authorizations.</td>
<td>215-413-3100</td>
<td>Monday—Friday 8:00 a.m.—5:00 p.m.</td>
</tr>
<tr>
<td>CBH Compliance Hotline</td>
<td>Anyone can call to report a concern of fraud, waste, or abuse committed by CBH, a CBH provider, or a CBH member.</td>
<td>1-800-229-3050</td>
<td>Monday—Friday 9:00 a.m.—11:00 a.m., 2:00 p.m.—4:00 p.m.</td>
</tr>
<tr>
<td>CBH Member Services</td>
<td>Members can call for member needs; providers can call with member questions or to assist a member in inquiring about services and rights.</td>
<td>1-888-545-2600</td>
<td>24/7/365</td>
</tr>
<tr>
<td>CBH Operations Support Services</td>
<td>For all services requiring registration, providers call for authorization number for billing.</td>
<td>267-602-8580</td>
<td>Monday—Friday 8:00 a.m.—5:00 p.m.</td>
</tr>
<tr>
<td>CBH Provider Complaint Hotline</td>
<td>Providers call to make a complaint about CBH.</td>
<td>215-413-8581</td>
<td>Monday—Friday 8:00 a.m.—5:00 p.m.</td>
</tr>
<tr>
<td>Important Contacts</td>
<td>Purpose</td>
<td>Phone Numbers</td>
<td>Hours of Operation</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>CBH Provider Relations Hotline</td>
<td>Providers call for provider needs.</td>
<td>215-413-7660</td>
<td>Monday—Friday 9:00 a.m.—5:00 p.m.</td>
</tr>
<tr>
<td>CBH Psychiatric Emergency Services (PES)</td>
<td>Providers call for urgent services. If a provider wishes to request a service that requires prior authorization, they can also contact the PES line for treatment history before making that request.</td>
<td>215-413-7171</td>
<td>24/7/365</td>
</tr>
<tr>
<td>DBHIDS Case Management Unit</td>
<td>Providers call for authorizations for Adult Case Management Services (see section 9.4.)</td>
<td>(215) 599-2150</td>
<td>-</td>
</tr>
<tr>
<td>Intellectual Disability Services (IDS)</td>
<td>Call with general inquiries.</td>
<td>215-685-5900</td>
<td>Monday—Friday 8:00 a.m.—5:00 p.m.</td>
</tr>
<tr>
<td>Mental Health Delegates Hotline(^1)</td>
<td>Call for help arranging crisis services for people with urgent behavioral health needs. After 5 p.m., call to report missing persons with ID needs.</td>
<td>215-685-6440</td>
<td>24/7/365</td>
</tr>
</tbody>
</table>

\(^1\) Also known as the “Philadelphia Crisis Line” and “Acute Services.”
2. CREDENTIALING

2.1. Purpose

This chapter will assist you in navigating the credentialing process. As a contracted network provider, it is your responsibility to be familiar with and adhere to the policies and procedures contained herein.

We hope you find this a helpful tool in working with CBH to provide quality care to members. We welcome your feedback about how we can make this chapter better and more helpful to you. Please email comments to CBH.ComplianceContact@phila.gov.

2.2. Credentialing Decisions

2.2.1. Credentialing Committee

The CBH Board of Directors convenes a Committee to provide oversight to the initial credentialing and recredentialing processes and all decisions made therein. The Credentialing Committee is chaired by the CBH Chief Medical Officer (CMO). The Credentialing Committee Chair is responsible for ensuring that thoughtful consideration is given to all applications presented to the Committee. In addition to responsibilities as Credentialing Committee Chair, the CBH CMO assists the credentialing process by:

- Providing guidance on proposed changes to both this Manual and the Manual for Review of Provider Personnel Files (MRPPF) and its supplement
- Ensuring that relevant actions and activities emanating from the Credentialing Committee are presented to other standing CBH meetings that include but are not limited to:
  - Quality Council
  - Compliance Committee
  - Clinical Review Committee
  - CBH Officers
- Communicating with the Board of Directors and Philadelphia County relating to the potential impact of unfavorable credentialing decisions

As Chair, the CBH CMO reviews and approves all independent practitioner files that have been deemed “clean” (see Definitions in Appendix A). As Chair of the Credentialing Committee, the CMO may designate another senior level CBH physician to approve clean files.

The Credentialing Committee membership includes representatives from CBH’s senior staff and physicians. CBH staff members serve on the Committee as a requirement of their position.
The Committee also includes at least three participating network practitioners who have no other role in CBH’s management activities. The participating network practitioners must be reflective of the practitioners with whom CBH directly contracts. CBH aims to secure both clinicians and physicians from the provider network to ensure a variety of perspectives and experience.

The Credentialing Committee meets in person monthly; however, the Committee may periodically conduct business via conference call to address credentialing decisions requiring more immediate attention.

No practitioner or facility can provide services for CBH reimbursement until they have been successfully credentialled.

The Committee also reviews any recommendation to terminate in-network status for any practitioner or facility based on adverse events or on-going significant concerns.

Examples of adverse events/concerns that may lead to a recommendation for termination include but are not limited to:

- Immediate member safety concerns
- Unresolved quality/compliance concerns
- Inability to effectively and appropriately staff cases
- Failure to meet minimum quality standards as defined by the CBH Provider Agreement

Finally, the Committee reviews proposed changes to the MRPPF. The MRPPF provides detailed requirements for specific clinical staff positions. CBH providers (see Definitions, Appendix A) must meet all requirements in the MRPPF for the specific position.

### 2.2.2. Committee Minutes

The CBH Chief Medical Officer’s staff is responsible for documenting discussions and decisions made in the Committee. Minutes are made available to Committee members for review and approval prior to the next regularly scheduled Committee meeting.

### 2.2.3. Provider Notification of Decisions

Providers are notified, in writing, of the Credentialing Committee decision within 60 days of the Committee meeting date. Notifications are sent for both initial and recredentialing reviews and specify the duration of the credentialing period.
Providers failing to meet standards for credentialing or recredentialing are provided with information related to the factors for which they were found to be deficient. When possible, information on steps needed to cure deficiencies will be provided in the notification letter. The letter will also contain a summary of the appeal rights and process to appeal negative decisions.

2.2.4. Confidentiality and Storage of Records

All members of the Credentialing Committee sign non-discrimination and confidentiality agreements annually. See Appendix B for Confidentiality and Nondiscrimination Agreement.

CBH is committed to ensuring confidentiality of the information collected during the credentialing process. Original documents and copies obtained will be stored on network drives with restricted access. Information obtained will only be shared with outside entities as required by law.

All Committee members attest to respect and maintain the confidentiality of all discussions, records, and information generated in connection with Credentialing Committee activities and to make no disclosure of such information except to persons authorized to receive it.

Credentialing summaries for practitioners and facilities are de-identified during the Committee’s review to facilitate objective discussion and to mitigate against potential conflicts. Additionally, participating network practitioners are required to immediately recuse themselves should the identity of a practitioner or facility become apparent during a discussion.

2.2.5. Nondiscrimination Processes

The Credentialing Committee is responsible for ensuring that the credentialing/recredentialing processes are conducted in a nondiscriminatory manner. All Committee members attest to ensuring that credentialing and recredentialing decisions are made in a non-discriminatory manner and will not be made based on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes.

On an annual basis, CBH Internal Compliance and Risk Management staff will conduct random reviews of procurements and credentialing files/decisions to ensure that discrimination of any kind was not involved in credentialing decisions.

2.2.6. Appeal/Cure Process

CBH affords providers opportunities to register appeals for negative credentialing decisions. Appeals may be made regarding the denial of entry of a prospective provider into the CBH network or the termination of an existing provider or program from the network. Providers are not able to appeal the length of an approved credentialing status.
Appeals must be submitted in writing within 30 days of communication of the decision.

Independent practitioners who cannot be credentialed due to missing elements of the Council for Affordable Quality Healthcare (CAQH) process can submit an appeal to the Credentialing Committee. Appeals must include resolution of any deficiencies identified during the credentialing process, as well as any relevant information related to the request for reconsideration of the credentialing decision. The appeal will be reviewed by the Credentialing Committee during the following meeting cycle, not to exceed 60 days from the appeal date and shall be communicated to the provider in writing within 5 business days of the decision. If a negative decision is made at this stage, a second-level appeal may be made to the City of Philadelphia Commissioner of the Department of Behavioral Health and disAbility Services (DBHIDS) as described below.

Consistent with the (internal) CBH Network Termination Policy and Protocol, appeals regarding a network termination decision must be made by submitting the request, in writing to the City of Philadelphia Commissioner of the Department of Behavioral Health and disAbility Services (DBHIDS). Providers requesting a hearing as part of the appeal process must make this request in the appeal letter. Providers may choose, at their expense, to be represented by an attorney or another person of the provider’s choice.

The decision of the appeals panel is considered final and will be provided via written notification. All appeal decisions shall be made within 10 business days and shall be communicated to the provider within 1 business day of the decision.

Existing in-network providers should reference the CBH Provider Agreement for additional remedies.

2.3. Provider Role in CBH Network Participation

2.3.1. CBH Policy

To be an in-network provider of mental health and substance use services with CBH, you must possess the requisite licensure for the service(s) you wish to provide, become credentialed with CBH, and enter into a Provider Agreement (contract) with CBH.

2.3.2. Provider Responsibility

As a network provider, you must provide medically necessary, covered services to members whose care is managed by CBH. Providers are expected to follow the policies and procedures outlined in the Provider Manual, relevant federal and state regulations, any applicable supplements, and the CBH Provider Agreement. Providers also agree to cooperate and
participate with all care management, quality improvement, outcomes measurement, peer review, and complaint and grievance procedures.

2.3.3. Types of Providers

CBH’s network of providers includes practitioners in private practice (also known as independent practitioners), practitioners in group practices, and provider organizations or facilities.

- **Independent/Individual Practitioner**: A clinician (psychiatrist, psychologist, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist) who provides behavioral healthcare services and bills under their own Taxpayer Identification Number.
- **Group Practice**: A practice contracted with CBH as a group entity and as such bills as a group entity for the services performed by its CBH credentialed clinicians.
- **Facility**: An organization, or program within a parent organization, licensed by the state of Pennsylvania to provide behavioral health services. Examples of facilities include, but are not limited to, psychiatric hospitals, partial hospital programs, mental health clinics, residential treatment facilities, substance use disorder clinics, and rehabilitation providers.
- **Federally Qualified Health Center (FQHC)**: A community-based health care provider that receives funds from the Health Resources and Service Administration (HRSA). Behavioral health services are provided by a **Behavioral Health Consultant (BHC)** (psychologist, licensed clinical social worker, licensed professional counselor, or licensed marriage and family therapist).

Staff employed by a facility are not considered individual practitioners as previously defined. Provider organizations are solely responsible for ensuring that the staff they employ, or contract with, meet all educational and experiential requirements for the positions held as well as possess all the appropriate certifications and clearances. Provider organizations must utilize the CBH MRPPF to ensure that facility staff meets the requisite standards to provide treatment to CBH members. This provider organization responsibility is a component of the provider’s contractual obligation as outlined in the CBH Provider Agreement.

2.3.4. Practitioner Directories

All information obtained during credentialing and recredentialing processes is utilized to accurately populate the CBH Provider Directory. If the information obtained during these processes varies from existing information in the Provider Directory, both the provider and their assigned CBH Provider Relations Representative will be made aware in order to resolve and correct the discrepancy.
2.4. Credentialing and Recredentialing Processes

2.4.1. Philosophy

CBH is committed to promoting quality care for its members. In support of this commitment, providers must meet and maintain a minimum set of credentials to provide services to CBH members.

CBH utilizes the services of a National Committee for Quality Assurance (NCQA) Certified Credentials Verification Organization (CVO) to collect and complete primary source verification on credentials for individual practitioners and group practice members for both initial credentialing and recredentialing. Initial reviews for facilities are conducted solely by CBH staff. Recredentialing reviews for facilities are conducted by the DBHIDS Network Improvement and Accountability Collaborative (NIAC).

2.4.2. Types of Credentialing

2.4.2.1. Initial Credentialing

A practitioner or facility that is not an in-network, contracted provider at the time of application must undergo an initial credentialing review. Practitioners and facilities that have previously participated in the network, but who do not currently have an active contract, will also require an initial credentialing review. New programs proposed by an existing in-network provider will undergo a modified initial credentialing process, with some of the requirements having already been met through the credentialing of the parent organization.

The chart below illustrates the provider type and CBH department responsible for initial credentialing activities.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Responsible Department</th>
<th>Review &amp; Approval</th>
</tr>
</thead>
</table>
| Individual Practitioner | CBH Compliance                  | • Clean Files: CBH CMO  
• Files not meeting full threshold criteria: Credentialing Committee |
| Group Practice | CBH Compliance                  | • Clean Files: CBH CMO  
• Files not meeting full threshold criteria: Credentialing Committee |
<p>| Facility      | CBH Provider Operations         | Credentialing Committee                                                          |</p>
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Responsible Department</th>
<th>Review &amp; Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>FQHC</td>
<td>CBH Provider Operations</td>
<td>Credentialing Committee</td>
</tr>
<tr>
<td>BHC</td>
<td>CBH Compliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clean Files: CBH CMO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Files not meeting full threshold criteria: Credentialing Committee</td>
</tr>
</tbody>
</table>

**2.4.2.2. Recredentialing**

Existing in-network, contracted practitioners and facilities must be recredentialed at intervals not to exceed three years.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Responsible Department</th>
<th>Review &amp; Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Practitioner</td>
<td>CBH Compliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clean Files: CBH CMO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Files not meeting full threshold criteria: Credentialing Committee</td>
</tr>
<tr>
<td>Group Practice</td>
<td>CBH Compliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clean Files: CBH CMO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Files not meeting full threshold criteria: Credentialing Committee</td>
</tr>
<tr>
<td>Facility</td>
<td>NIAC</td>
<td>Credentialing Committee</td>
</tr>
<tr>
<td>FQHC</td>
<td>CBH Compliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clean Files: CBH CMO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Files not meeting full threshold criteria: Credentialing Committee</td>
</tr>
<tr>
<td>BHC</td>
<td>CBH Compliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clean Files: CBH CMO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Files not meeting full threshold criteria: Credentialing Committee</td>
</tr>
</tbody>
</table>

A facility can be subject to an announced, routine recredentialing review, at any time, within the recredentialing calendar year as determined by the Network Inclusion Status awarded at Credentialing Committee and at more frequent intervals as determined by emergent issues related to member quality of care.
BHCs are credentialed and recredentialed in a parallel manner to independent practitioners and group practice members. When hiring a new BHC, the FQHC must submit all credentialing materials to CBH prior to hire. The BHC may work on a provisional basis during the initial credentialing process.

The recredentialing of FQHCs involves the review of documentation including the PROMISe enrollment for each FQHC service location, appropriate and active licensure for each FQHC, and presence of approved status as an FQHC via review of the Notice of Grant Award and/or listing on HRSA.gov. When these elements have been verified, CBH Compliance staff visits each site location to ensure that the location is still active and accurately listed on the contract. FQHCs must be recredentialed on a cycle of no more than three years.

2.5. Independent Practitioners and Group Practices Initial Credentialing and Recredentialing

This section of the Manual applies to independent practitioners and group practices for which the initial and recredentialing review process will be conducted by CBH’s Compliance Department.

As previously stated, CBH contracts with an NCQA certified CVO to complete the primary source verification of credentials for independent practitioners and group practice members.

2.5.1. Provider Responsibilities

Each new independent and group practitioner will be required to complete an on-line application prior to entering the CBH network of providers. See the Initial Credentialing Application for Independent and Group Practitioners.

Individual practitioners and members of group practices are required to submit information to the Council for Affordable Quality Healthcare (CAQH), Inc., CBH’s contracted CVO. Additional information may be required to complete contracting for individual practitioners and/or group practices.

CBH-contracted group practices must notify CBH within 5 business days if any credentialed practitioner leaves the practice.

2.5.2. Delegation of Credentialing

As previously stated, CBH has contracted with an NCQA certified CVO (CAQH) to assist in the primary source verification required to complete the credentialing of independent practitioners and group practice members and to complete primary source verification of the information
obtained. Specific information that is required and the methods that may be used to verify the information are provided later in this guide.

2.5.3. Written Delegation Agreement

CBH has a signed agreement with the CVO specifying the services to be provided, costs, and terms. This agreement defines those areas for which the contracted CVO is responsible. Any functions not specifically identified in the agreement will be completed by CBH.

The written delegation agreement provides for renewal terms and the ability to terminate the agreement both for cause and for convenience. The written delegation agreement also provides for remedies and consequences for failure to meet required timeframes and performance standards. These remedies may include, but are not limited to, discounted fees for the period being reviewed and/or termination of the written delegation agreement.

The written delegation agreement requires that the contracted CVO maintain its NCQA certification.

2.5.4. Initial Credentialing Timeline: 180 Days

CBH is committed to ensuring that credentialing decisions are made in a timely manner consistent with NCQA standards and industry best practices. To that end, CBH has adopted a timeline of 180 days for the course of the initial credentialing process.

Upon receipt of a provider request to enter the CBH Network, the Compliance Department will send an initial credentialing letter and CBH attestation form to the provider via email. Per the letter, the provider will have two weeks from the date of the email to do the following:

- Complete an application and attest or re-attest with CAQH
- Return the signed CBH attestation to CBH

The 180-day timeline for the initial credentialing process begins when a scan of the signed and completed CBH attestation is received at CBH (mail to CBH.ComplianceContact@phila.gov) and is completed with the Committee decision. Upon receipt of the attestation, CBH will submit the provider’s CAQH number to CAQH for primary source verification (PSV). A summary of CAQH’s PSV process will be presented to the CBH Credentialing Committee for a decision regarding the provider’s application for network entry.

2.5.5. Use of Protected Health Information (PHI)

CBH does not expect the contracted CVO to encounter PHI. In the rare event when the contracted CVO does review or encounter PHI, the written delegation agreement stipulates
that the contracted CVO will abide by the protections provided under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

2.5.6. Reporting

The contracted CVO will report to CBH, on an ongoing basis, the results of initial credentialing and recredentialing requests. The written agreements detail the timeframes for the CVO to submit reports to CBH based on priority requests for credentialing and recredentialing.

Aggregate reporting is not completed per the written delegation agreement.

2.5.7. Monitoring of Contracted CVO Performance

CBH Compliance will monitor the performance of the CVO annually and report on overall performance to the CBH Credentialing Committee. Monitoring will be completed by utilizing the following methods:

- **CBH provider feedback**: CBH conducts an annual provider satisfaction survey. This survey contains questions specific to compliance and provider credentialing. Feedback will be solicited regarding the experience of individual practitioners and group practice members in working with the contracted CVO.

- **Annual review of the delegated credentialing process** (see below)

- **Feedback from CBH Compliance staff**: CBH Compliance staff responsible for credentialing and recredentialing independent practitioners and group practice members will be surveyed to gauge their experience with the contracted CVO, including any concerns about the practices of the contracted CVO.

2.5.8. Review of Delegated Credentialing Process

CBH Compliance will annually, at least one month prior to the renewal term of the written delegation agreement with the CVO, audit a sample of credentialing and recredentialing files completed by the CVO. The audit will be completed to ensure that all CBH, State, and NCQA standards are met. The review will also include a review of the CVO’s NCQA status. The written agreement with the CVO clearly states that the CVO must maintain NCQA certification as a CVO for the agreement to remain valid.

CBH Compliance staff will review a sample of 5 percent or 50 files (whichever is less) completed by the CVO. CBH Compliance will randomly select the files to be reviewed. CBH Compliance will continue to randomly select files, in excess of the minimum stated above if necessary, to ensure that the sample contains at least 10 credentialing and 10 recredentialing files in the sample.

When fewer than 10 practitioners or group practice members were credentialied or recredentialied, the entire universe of that review type will be audited.
The audit will also include a review of any changes to the CVO’s policies and practices to ensure that all required elements continue to be verified appropriately.

The audit will be summarized in a report to the CBH Credentialing Committee and benchmarked against the current NCQA standards.

2.5.9. Opportunities for Improvement

Annually, CBH will report to the CBH Credentialing Committee on any potential opportunities to improve the credentialing and recredentialing process for independent and group practitioners. Information will be reviewed that will include feedback from providers based on their experience, CBH Compliance staff, and results from the annual report of the review of the delegation process described earlier.

2.5.10. Provider Credentialing Checklist

A practitioner credentialing summary is prepared for presentation to Credentialing Committee. The second page of the summary includes a credentialing checklist of all required primary source verification elements (See Appendix C). The CBH Compliance reviewer will ensure that all required elements have been verified by the contracted CVO.

When complete, the reviewer signs off by affixing dates and initials to the checklist. The document is then included with copies of relevant credentialing information and the report(s) from the contracted CVO.

2.5.11. Criteria Utilized for Credentialing and Recredentialing

An application will be considered clean and thus presented to the CBH Chief Medical Officer for signature if the following threshold criteria are met:

- A completed CAQH application and attestation
- Valid and active license
- Verified educational and work history meeting minimum requirements for the position
- Not excluded from participating in federally funded healthcare programs
- No malpractice claims and/or settlements
- No adverse license actions
- A signed CBH attestation reporting the applicant is/has:
  - Free of illegal drug use
  - Able to perform essential functions
  - Free of previous adverse licensure actions
  - No previous felony convictions
  - No prior loss of admission privileges or any other disciplinary actions
o Appropriate malpractice coverage
  o Attested to the completeness and correctness of the application

• Physicians only:
  o Has a valid DEA certification
  o Has completed an appropriate residency
  o Is eligible for or holds an appropriate board certification

An application that fails to meet any of the above threshold criteria is not rejected automatically but is presented to the CBH Credentialing Committee for discussion and credentialing decision.

2.5.12. Verification of Credentials

2.5.12.1. Licensure

All practitioners must hold an active and valid license appropriate for their specialty. This verification will be completed by the contracted CVO. The license verification is valid for 180 days or until the license expiration date, whichever occurs first.

2.5.12.2. Drug Enforcement Administration certification (Physicians and Nurse Practitioners Only)

Physicians and Nurse Practitioners must hold active and valid Drug Enforcement Administration (DEA) certification in each state where the physician or nurse practitioner provides care to CBH members. This will be verified by the contracted CVO. The DEA review is valid until the expiration date noted on the certificate and must be completed prior to a successful credentialing decision.

2.5.12.3. Education

All staff must meet the minimum acceptable education requirements for their respective positions. CBH will review the highest of the following three levels of education, as appropriate:

• Board Certification
• Residency
• Diploma/Transcript (for physicians, this must be from a medical school)

The contracted CVO will verify the appropriate level of education or training. The contracted CVO may utilize the following sources in verifying educational requirements:

• American Medical Association (AMA) Physician Masterfile
• American Osteopathic Association (AOA) Physician Profile Report/Masterfile
• Educational Commission for Foreign Medical Graduates (ECFMG) for internationally trained physicians licensed after 1986

While the verification of appropriate training and education has no expiration date, the verification must occur prior to a successful credentialing decision.

2.5.12.4. Board Certification

CBH requires that all physicians be board certified or board eligible (i.e. residency has been completed). Verification of active board certification or residency will be done by the contracted CVO. The contracted CVO may complete the verification via direct confirmation with the applicable specialty board and/or the state licensing body. When this is not possible, the contracted CVO may also utilize one of the following options:

• American Board of Medical Specialties (ABMS) or its member boards
• AMA Physician Masterfile
• AOA Physician Profile Report/Masterfile
• The institution where the residency was completed

Board certification verifications are valid for 180 days.

2.5.12.5. Work History/Experience

Each practitioner must submit a resume or a curriculum vitae (CV) that shows the minimum work experience required for their position as defined in the MRPPF. This must reflect the most recent 5 years of relevant work experience.

CBH Compliance staff will review the CV to ensure that minimum experience requirements have been met for the position. In addition, if the resume or CV shows a gap in employment of 6 months or greater, CBH Compliance requires a clarification of the gap, in writing, directly from the practitioner.

Clean applications must have verified experience meeting the minimum standards for the position as defined in the MRPPF and be free of gaps in employment of 6 months or longer.

Verification of work history and experience is valid for one calendar year (365 days).

2.5.12.6. Malpractice History

The contracted CVO, acting on CBH’s behalf, will directly query the National Practitioner Data Bank (NPDB) for any history of malpractice claims and/or settlements made against the practitioner. Clean applications must be free of any malpractice claims and/or settlements. The NPDB query related to malpractice history is valid for 180 days.
2.5.12.7. Sanctions

2.5.12.7.1. Medicare/Medicaid Exclusions

CBH Compliance will query the sources identified below monthly for current sanctions against the practitioner that would preclude their participation in a federally funded health care program: Federal System for Award Management (SAM), List of Excluded Individuals and Entities (LEIE), Pennsylvania Medcheck List, Social Security Death Master File (SSDMF), and National Plan and Provider Enumeration System (NPPES).

2.5.12.7.2. Other State Sanctions

The contracted CVO will obtain verification directly from the National Practitioner Data Bank (NPDB) and/or the State licensing board that the practitioner has no current or past restrictions on their license or state-imposed sanctions. The NPDB State licensing board query is valid for 180 days.

2.5.13. Practitioner Rights

2.5.13.1. Report of Information Obtained from Outside Sources

Providers are entitled to be informed of any information obtained from the following sources as it relates to their application/credentialing decisions:

- Federal or State Exclusion lists
- Licensing bodies
- Drug Enforcement Agency status verification
- Education entities/sources (schools, residency sites, universities, etc.)
- Board certification verification
- NPDB queries
- Insurance carriers (related to required coverage)

Applicants are not entitled to information:

- That may be involved in an ongoing law enforcement referral/investigation
- From personal references/recommendations
- That is protected by peer-review stipulations
2.5.13.2. Ability to Correct Erroneous Information or Deficiencies

When able, CBH will notify practitioners of excluding information. The practitioner may correct any information believed to be erroneous, or deficient. The credentialing process timeline will not be extended to allow for correction of erroneous information.

If erroneous information or deficiencies are discovered in CAQH or other credentialing materials in advance of their presentation to the Credentialing Committee, providers will be notified by phone and/or e-mail to address the discrepancies within 5 business days of the findings. Providers will then have 5 business days to correct the erroneous information or deficiency by providing the correct information to CAQH via CAQH ProView and/or by PDF scan via email to CBH (CBH.ComplianceContact@phila.gov), as indicated by CBH. Unresolved discrepancies will be presented to the Credentialing Committee for discussion and decision-making.

2.5.13.3. Application Status Updates

Practitioners may request, at any point in the credentialing process, an update on the status of their application. CBH will respond to the provider within 5 business days with an update of what stage the credentialing application is in. The stages are as follows: additional information needed from provider, awaiting rostering to CAQH, rostered to CAQH, or PSV returned from CAQH is awaiting review and Committee and/or CMO approval.

Clean applications (see Definitions, Appendix A) are reviewed and approved by the CBH CMO or designee. The Credentialing Committee is made aware of approvals, granted by the CMO, since the last Committee meeting.

2.5.13.4. Dates and Timeframes

The date on which the CBH CMO signs off on a credentialing decision either for clean or after Committee review, is the effective date of the decision. This date will be reflected on a decision signature sheet which will be retained by the CBH CMO. The standard credentialing duration for independent practitioners and group practices is 2 years.

2.5.13.5. Monitoring and Quality Assurance Activities

CBH monitors in-network independent practitioners using the following criteria and time frames:

- Exclusion from Medicare/Medicaid programs (every 30 days)
- Request information from CBH Quality Management regarding complaints and significant incidents (semi-annually)
CBH Compliance staff will ensure that exclusion list reviews are completed on all contracted practitioners at least every 30 days to meet requirements related to screening for exclusions.

Practitioner complaints will be triaged through CBH Quality Management (QM). QM will notify CBH Compliance of any complaints made against a contracted practitioner or member(s) of a group practice. Any practitioner who receives 6 or more complaints in a 6-month timeframe will be subject to an internal Provider Teaming consistent with CBH’s Oversight and Monitoring policy. The teaming group will decide on appropriate next steps that could include, but are not limited to, the following:

- Practitioner meeting with leadership team
- Closure to new admissions
- On-site monitoring or compliance audit

Adverse events will also be reported through CBH QM via the Procedures for Response, Reporting, and Monitoring of Significant Incident Policy. Adverse event checks will be limited to high-volume providers. A high-volume provider is defined as any practitioner or group practice providing services to 500 or more unique CBH members per calendar year. Any high-volume practitioner with a confirmed adverse event occurring with a CBH member is also subject to a provider teaming as described above.

In the absence of reported adverse events and/or complaints, CBH Compliance will request confirmation from CBH QM at least every 6 months.

Adverse events and complaints and confirmation requests will be tracked by CBH Quality Management as described in the CBH Procedures for Response, Reporting, and Monitoring of Significant Incident Policy.

When a teaming or recredentialing visit reveals evidence of substandard quality of care that could potentially impact the health and safety of our members, sanctions and interventions will be utilized to correct the behavior(s) and to ensure the safety of our members. These sanctions and interventions can range from provider meetings to the termination of the provider agreement.

2.5.13.6. Notification to Authorities

CBH Compliance is responsible for notification of concerns related to overall quality of care and for potential instances of fraud, waste, and abuse (FWA) within our contracted providers. In addition to the notification of appropriate oversight and enforcement agencies, CBH has a range of actions available to assist providers in improving their performance.
2.5.13.7. Available Actions to Assist Practitioners

When a practitioner is identified as having problematic practices that could impact clinical services, many interventions may be utilized to improve the provider’s performance and to ensure the health and safety of our members. These include, but are not limited to:

- Participation in trainings offered by CBH Network Development
- Participation in training offered by CBH Compliance (related to FWA)
- Corrective action or quality improvement plan
- Directed corrective action plan
- On site monitoring by CBH staff
- Clinical chart audits
- Admission closures

2.5.13.8. Reporting to Oversight and Enforcement Agencies

CBH Compliance will report any potential instances of fraud, waste, and/or abuse to both the Pennsylvania Bureau of Program Integrity (BPI) and the Pennsylvania Office of Attorney General Medicaid Fraud Control Section (OAG MFCS). Reporting is completed by the CBH Compliance Special Investigation Unit (SIU).

In addition, should CBH Compliance become aware of any of the following actions, not previously reflected in the National Practitioner Data Bank (NPDB), CBH Compliance will make a direct report to the NPDB and/or other entities. Actions include:

- Medical malpractice payments
- Federal and state licensure and certification actions
- Adverse clinical privileges actions
- Adverse professional society membership actions
- Negative actions or findings by private accreditation organizations and peer review organizations
- Health care-related criminal convictions and civil judgments where CBH is a party
- Exclusions from participation in a federal or state health care program (including Medicare and Medicaid exclusions)
- Other adjudicated actions or decisions

In instances when a practitioner’s provision of care raises immediate safety concerns for members and the provider is not willing or able to participate in remedial activities to improve the provision of care, the practitioner’s licensing body will be notified. The CBH CMO will be responsible for designating staff to complete these referrals. Examples could include, but are not limited to:

- Engaging in dangerous prescribing practices
• Engaging in inappropriate relationships with members
• Practicing without appropriate training or education
• Practicing with an expired or suspended license
• Providing treatment outside of the appropriate scope of practice for the individual

2.6. Facilities: Initial Credentialing and Recredentialing

2.6.1. Facilities: Initial Credentialing

This section of the Manual applies to parent organization and facilities for which the review process is conducted by the CBH Provider Operations Department. See examples of facility types in the Definition section, Appendix A.

2.6.2. Network Entry

Parent organizations will be invited to join the CBH Provider Network consistent with the CBH Network Entry policy (link forthcoming). Parent organizations currently contracted with CBH may expand the scope of their services (to include the addition of new facilities) per the process outlined in the Network Adequacy and Access Policy. An organization or facility will be considered a network provider after the successful completion of the initial credentialing process, approval by the CBH Credentialing Committee, and contracting of the facility (i.e. signing of a Provider Agreement and/or issuance of a Schedule A).

2.6.3. Initiation of Initial Credentialing

The initial credentialing review process is initiated when a facility is licensed/approved and enrolled in the Pennsylvania Medicaid program (or is eligible for enrollment). For new programs, CBH may provide technical assistance regarding the initial credentialing process prior to licensure. This may include a review of credentialing requirements with providers in advance of formal initiation of the credentialing process. The provision of technical assistance will typically occur for new programs that are entering the CBH Network via a procurement process.

CBH will convene a meeting with a facility to initiate the initial credentialing process. At a minimum, provider agency representatives and the CBH Provider Operations initial credentialing team will participate in the meeting. Other CBH departments (e.g. Clinical Management, Quality Management, Compliance) will be invited to participate as ad hoc members of the credentialing team. The facility meeting will be used to review the CBH credentialing and contracting process and will include a discussion of all required documentation necessary for facility credentialing.

Following the provider meeting, CBH Provider Contracting will send the facility written correspondence summarizing the initial credentialing process. Included in the correspondence will be a list of documents required for initial credentialing. The correspondence will also
include a timeline for the initial credentialing process, identify the CBH initial credentialing team leader, and will explicitly state that the credentialing process must be completed within 180 days of the date of the letter. See Initial Credentialing Letter in Appendix D.

2.6.4. Initial Credentialing Review Process

There are four components of the initial credentialing review process: review of business documents, review of staff files, review of policies and procedures, and a facility site visit.

2.6.5. Coordination of the Initial Credentialing Process

The CBH Provider Operations Department is responsible for the initial credentialing of facilities. Each initial credentialing request will be assigned to a team of Provider Operations staff to include representatives from the Provider Contracting, Network Development, and/or Provider Relations units. Provider Operations representation will vary depending on the avenue of network entry as defined by the Network Entry Policy and the Network Adequacy and Access Policy.

A CBH Provider Operations staff will be identified as the team lead for both internal and external coordination related to initial credentialing of facilities. The team lead will be the primary point of contact for the agency/facility and will be responsible for coordinating internal review. The CBH team lead will be noted on the correspondence sent to the provider at the initiation of the initial credentialing process as noted above.

2.6.6. Business Documents

Required business documents are outlined in the Appendices of the Manual. For parent organizations new to the CBH Network, all documents on the list are required. For existing network parent organizations, only documents listed in the Facility-related Appendices are required. Submission of all documents is required to complete the initial credentialing process.

CBH Provider Contracting staff will complete the review of the business documents.

2.6.7. Staff Files

All facilities must complete and submit a completed staff roster and job descriptions for each position listed on the roster. For new facilities, all staff positions must be listed on the staff roster regardless of whether they are filled at the time of the initial credentialing review. Additionally, facilities must maintain staff files for each staff person on the roster with the documents outlined in the Appendices.

Individual staff files do not need to be submitted to CBH for the initial credentialing review. Facilities will be required to sign an attestation confirming that all staff files are complete and
maintained consistent with the parameters outlined in the CBH Manual for Review of Provider Personnel Files (MRPPF). However, CBH reserves the right to request and review staff files as part of the initial credentialing review.

Facilities requesting waivers of any staff requirements must do so during the initial credentialing process. State and federal requirements cannot be waived by CBH.

CBH Provider Contracting staff will complete the review of the provider staff file submissions.

2.6.8. Policies and Procedures

Parent organizations and facilities are required to submit the policies and procedures outlined in the Appendices. Policies will be reviewed consistent with the standards specified in the Appendices. All policies must be reviewed and approved by CBH in order for a provider to complete the initial credentialing process.

Some policy requirements for facility credentialing may be waived if a required policy has been approved for the agency/parent organization or if the required policy is not applicable to the facility program type. For example, submission of medication management policies may not be required for programs that do not offer medication prescription and medication management.

Required policies and procedures will be reviewed with the provider agency representatives at the initial credentialing meeting. The correspondence sent to the provider following the meeting will document all required policies.

CBH Network Management staff will complete the review of the facility policies and procedures.

2.6.9. Site Visit

A site visit will be conducted at the facility as a component part of the initial credentialing process. Visits will occur for both accredited and non-accredited organizations. All CBH Provider Operations staff involved in the initial credentialing process will be invited to participate. Staff from other CBH departments will be invited to participate as indicated or requested.

The primary focus of the site visit will be to tour the facility to ensure there is an adequate treatment/service environment for CBH members (see Appendices for Site Visit Tool). Visits will not include an extensive physical plant inspection; however, site visits may coincide with the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) or the Pennsylvania Department of Drug and Alcohol Programs (DDAP) licensing visits for new programs or facilities. If the visit is not held in conjunction with the licensing visit, any observed
physical plant issues that may impact member health and safety will be reported to the responsible licensing entity.

If providers have not submitted comprehensive initial credentialing documentation prior to the time of the site visit, CBH will request that any missing documentation be available for on-site review during the visits. Additionally, CBH may utilize the site visit as an exit meeting for the initial credentialing process, including discussion of any pending items related to the credentialing process.

The date and outcome of the site visit will be documented in the initial credentialing exit letter and the Credentialing Committee Summary.

2.6.10. Application Status Updates

The CBH Provider Contracting unit is responsible for tracking all initial credentialing requests. For each credentialing request, Provider Contracting will track the date of initiation of the initial credentialing process, the completion date of each phase of the process (i.e. business document, staff file and policy review, site visit), and the scheduled date of the Credentialing Committee presentation. Providers and DBH and CBH stakeholders may request a status update for any pending initial credentialing review.

2.6.11. Credentialing Committee Review

If a facility has not met initial credentialing threshold requirements 60 days in advance of the end of the 180-day review period, Provider Contracting will forward the agency a letter outlining the areas of deficiency. The letter will state that all missing documentation will need to be submitted by the 180-day deadline. If the initial credentialing process is still incomplete at the end of the 180-day review period, the facility application will be considered to not meet threshold requirements and will be presented at the next scheduled Credentialing Committee for review. The provider will be notified of the decision of the Committee in writing within 60 days of the meeting date. For negative decisions, providers will have the right to register an appeal consistent with the Appeal/Cure process outlined in this chapter.

Once a facility has met the initial credentialing thresholds outlined in the Initial Credentialing Review section, Provider Contracting will forward the provider an initial credentialing exit letter. The letter will summarize the outcome of the initial credentialing process and will specify the date the facility will be presented at the Credentialing Committee meeting for review. At this juncture, the facility’s request to enter the Network will be considered a clean application.

Provider Contracting will be responsible for preparing a Credentialing Committee Summary for each clean facility application which will be presented to the Credentialing Committee for review. Information outlined in the initial credentialing exit letter may be included in the
Credentialing Committee Summary. All facilities presented to the Credentialing Committee for initial credentialing will be recommended for a one-year credentialing status.

### 2.6.12. Contracting

Following approval by the CBH Credentialing Committee, CBH Provider Contracting will be responsible for generating a contract for the credentialed facility. The contract will include a Provider Agreement (for new agencies/organizations entering the Network) and a CBH Schedule A (see Definitions, Appendix A), which will allow the provider to submit claims for the services provided at the newly credentialed facility.

For parent organizations new to the CBH Provider Network, a CBH Provider Agreement must be signed by both the organization and CBH prior to a contract being issued for the facility. Once the signed CBH Provider Agreement has been received, Provider Contracting will generate a Schedule A for the facility effective the date of the Credentialing Committee approval.

For existing parent organizations, CBH Provider Contracting will generate a Schedule A for the service(s) effective the date of the Credentialing Committee approval. The CBH Provider Relations Representative will mail an original copy of the Schedule A to the agency/parent organization with a cover letter specifying the credentialing status.

Contracting correspondence will be sent to an agency within 30 days of the Credentialing Committee decisions.

### 2.6.13. Record Keeping

The initial credentialing file will consist of all documents reviewed during the initial credentialing review process (i.e. business documents, staff records, and policies and procedures) as well as the initial credentialing exit letter, the Credentialing Committee summary, and the letter notifying the provider of the Credentialing Committee status. If the Credentialing Committee issues a negative decision, documentation of the Committee decision will also be included in the file. A tracking spreadsheet, as outlined in Appendix N, will be used to capture provider’s license status, accreditation status, the date of CBH visit, and the date of approval from the Credentialing Committee.

Initial credentialing files will be maintained consistent with the parameters outlined in the Confidentiality and Storage of Records section of this chapter.

### 2.6.14. Facilities: Recredentialing Process

The recredentialing of facilities is completed by the Network Improvement and Accountability Collaborative (NIAC). Once a provider has entered the network through the initial credentialing process, NIAC is responsible for the continued assessment of CBH contracted facilities. As the
integrated oversight body for DBHIDS (which includes CBH), NIAC serves as the primary mechanism to achieve a single, consistent approach to oversight in the form of evaluative monitoring across various funding streams. NIAC seeks to reduce the cumulative number of site visits for providers. Recredentialing visits occur for all facilities, regardless of accreditation status, at intervals not to exceed three years.

To ensure all aspects of a site review are scored in a standardized manner, NIAC utilizes an objective scoring instrument based on DBHIDS Practice Guidelines, referred to as the Network Inclusion Criteria (NIC) and located here online. The Appendices outline details about the NIAC Recredentialing process and includes tools related the process, including the NIAC Recredentialing Tracking Log, Site Review Activities Listing, the Network Inclusion Criteria (NIC), and the Practice Guidelines.

The NIC allows the NIAC team to obtain both qualitative and quantitative data to critically assess an organization’s practices. The NIC scores within the components of the Practice Guidelines, which comprise the Foundations of Service Delivery (including policy, supervision, and training) and four practice domains. The sections are weighted as follows:

### 2.6.14.1. Weighting

Organizational Focus Weighting Foundations of Excellence in Service Delivery: 20%
Domain 1: Assertive Outreach and Initial Engagement: 15%
Domain 2: Screening, Assessment, Service Planning and Delivery: 30%
Domain 3: Continuing Support and Early Re-Intervention: 15%
Domain 4: Community Connection and Mobilization: 20%
Total Level of Care Score: 100%

The 5 weighted scores are summed to create a Level of Care score.

NIAC uses the NIC tool to arrive at a quantitative value for each of the 10 activities performed at each site visit. Recredentialing scores range in value from 50% to 100% with the following status breakdown.

### 2.6.14.2. Score ranges

- 6 months 60-69%
- 1 year 70-79%
- 2 years 80-89 %
- 3 years 90-100%

For more information, see the final score sheet example in the Appendices.

---

2 See the most recent version of the NIC on the DBHIDS website for any updates to these score ranges.
The frequency of a NIAC review is determined by the status that a provider receives as a result of the Credentialing Committee process. Each level of care is scored separately and may have different review dates depending on the previous visit score. For more information, see the Tracking Log example in the Appendices.

After NIAC status recommendations are reviewed and approved by the Credentialing Committee, a letter is sent to the provider indicating the network status determination, by level of care, for the organization.

2.7. Applicable Documents

Please see the following linked documents:

- Initial Credentialing Application for Independent and Group Practitioners
- Manual for Review of Provider Personnel Files (MRPPF) 2.2

2.8. Applicable Appendices

Please see the following appendices; these sections are companions to this chapter of the Provider Manual:

- Appendix A: Definitions
- Appendix B: Nondiscrimination and Confidentiality Agreement (Signed by Members of the CBH Credentialing Committee)
- Appendix C: Initial and Recredentialing Summary Template for Independent and Group Practitioners
- Appendix D: Initial Credentialing Letter: Independent and Group Practitioners
- Appendix E: Recredentialing Letter: Independent and Group Practitioners
- Appendix F: Provider Types and Specialty Codes: Independent and Group Practitioners
- Appendix G: Business Documents for Initial Credentialing: Facilities
- Appendix H: Staff Documents for Initial Credentialing: Facilities
- Appendix I: Initial Credentialing Introduction Letter: Facilities
- Appendix J: Initial Credentialing Requirements for Staff Files – Attestation: Facilities
- Appendix K: Initial Credentialing Approval Letter: Facilities
- Appendix L: Initial Credentialing Exit Letter: Facilities
- Appendix M: Credentialing Committee Summary Template: Initial Credentialing: Facilities
- Appendix N: Tracking Spreadsheet for Initial Credentialing: Facilities
- Appendix O: Initial Credentialing Site Visit Checklist: Facilities
• Appendix P: Network Inclusion and Accountability Collaborative (NIAC) Credentialing Process (Recredentialing: Facilities)
• Appendix Q: Provider Preparations for the Network Improvement & Accountability Collaborative Site Review (Recredentialing: Facilities)
• Appendix R: Policies and Procedures for Initial and Recredentialing: Facilities
• Appendix U: Policy Requirements Checklist: Initial and Recredentialing: Facilities
3. AUTHORIZATIONS

3.1. Overview

This chapter describes the procedures providers must follow to obtain authorizations for treatment of CBH members. Coordinating member care is at the core of the managed care concept. Authorizing services enables the managed care organization to have knowledge of the needs of its members, the capacities of its provider network, and the extent of its fiscal responsibilities.

The authorization process involves the following steps:

- Verifying the individual is eligible for the services requested
- Assessing the needs of members using medical necessity criteria (MNC)
- Presenting request for authorization based on MNC
- Obtaining the initial authorization to begin treatment
- Assessing progress or service utilization through concurrent reviews as needed for continued authorization

CBH follows Appendix AA (Department of Human Services Prior Authorization Requirements for Participating Behavioral Health Managed Care Organizations [BH-MCO] in the HealthChoices Program) of the HealthChoices Program Standards and Requirements (PS&R) when determining services that require prior authorization. CBH reserves the right to require prior authorizations for levels of care not outlined in Appendix AA and will seek approval from the Pennsylvania Department of Human Services (PA-DHS).

CBH utilizes the Commonwealth of Pennsylvania’s Medical Necessity Criteria (Appendices S and T), American Society of Addiction Medicine (ASAM), and State-approved MNC (for services not outlined in the PS&R as noted above) in determining service authorizations. These criteria ensure that:

- Treatment services are based upon medical necessity and member need
- Care is provided in the most appropriate and least restrictive setting
- Authorizations are standardized, coordinated, and expedited
- Costs are controlled

All MNC can be found here on the CBH website.

3.2. Types of Services

Emergencies are situations that are so severe that a reasonable person with no medical training would believe that there is an immediate risk to a person’s life or long-term health. An urgent
condition is an illness or condition which, if not treated within 24 hours, could rapidly become a crisis or emergency. CBH providers must provide services within one hour for emergencies, within 24 hours for urgent situations, and within 7 days for routine appointments and specialty referrals.

3.3. Eligibility

To ensure appropriate payment for services, providers should establish protocols for determining eligibility before providing services. Providers can determine an individual’s eligibility for CBH-funded behavioral health services through the DPW PROMISer™ Eligibility Verification System (EVS) by calling 1-800-766-5387 or visiting this online portal. For uninsured members or members whose primary insurance is not CBH, please see 3.4 and below.

3.4. Types of Authorizations and Related Processes

Authorization numbers are required for payment. There are three types of authorization categories and related processes as listed below.

3.4.1. Blanket Authorization Number (BAN)

BAN services can begin without prior authorization and may be emergency or non-urgent services. Providers should refer to the Schedule A corresponding to the service when filing claims using the appropriate BAN.

3.4.2. Registration

Registration authorizations are provided for some non-urgent services. Registration services below can begin without prior authorization but require a member-specific authorization number for payment. Providers obtain this authorization number by faxing a Service Request Form (see Appendix V of this document) to the CBH Operational Support Services (OSS) unit at 215-413-7983 within 90 days of the start of service delivery.

3.4.3. Prior Authorizations

Prior authorizations are required for all urgent and some non-urgent services. They are services that cannot be rendered without being approved ahead of time and apply to requests for initial and continued treatment. Prior authorizations for urgent services are completed telephonically using the PES template (see Appendix W), and CBH issues prior authorizations in these cases within 24 hours. Authorization is time-limited, thus necessitating a concurrent review to continue treatment. Providers request prior authorizations through the PES line (when no other service is in place or the service is requested outside of normal business hours) or the assigned clinical care manager (CCM) (for all concurrent reviews and/or when another service is already in place). Providers request prior authorizations telephonically using the PES template, via
packets including comprehensive biopsychosocial evaluations/re-evaluations (CBE/R—see Appendices W and X), or through submission of a Service Request form to OSS (see authorization guidelines below). The requesting provider shall make good faith efforts to inform the member of the outcome of the prior authorization process. The provider shall document all attempts to inform the member, and documented failure by the provider to inform the member shall not be grounds for sanctions.

3.4.3.1. Approvals

If the member meets MNC, the CCM will authorize the level of care and length of time (i.e. number of days/units). If the requesting provider is not the admitting provider, the admitting facility must contact CBH to obtain the authorization number. When a member is prior authorized for an urgent level of care, the admitting provider has 24 hours to notify CBH of a member’s admission. If CBH is not contacted within 24 hours, the authorization will begin the date CBH is notified and authorization will be generated to match the last covered day anticipated at the time of precertification. See service-specific exceptions below.

3.4.3.2. Denials

3.4.3.2.1. Peer-to-Peer Review

When CBH makes the decision to deny a request for any service requiring prior authorization, the CCM will verbally or electronically notify providers of the denial and offer an opportunity for a peer-to-peer review (between attending or licensed evaluating psychologist and the attending CBH physician or licensed psychologist reviewer) within 24 hours of the notification for levels of care requested telephonically or by 2:00 p.m. the next business day for levels of care requested via packet review (e.g., BHRS, RTF). See service-specific exceptions below.

3.4.3.2.2. Insufficient Information

3.4.3.2.2.1. Bed-Based Services

If the CCM does not have all of the components necessary to make a medical necessity decision (approval or denial), the CCM will notify the provider verbally, detailing which components are missing and allow the provider 24 hours to respond with missing information. The request is marked insufficient until the end of the 24-hour decision-making period from the time of the request or the missing information is received, whichever comes first.

If the provider submits the missing documents within the requested time frame, the CCM will review the request for medical necessity. If the provider fails to submit the missing documents, CBH will deny the request.
3.4.3.2.2. Community-Based Services

If the CCM does not have all components necessary to make a medical necessity decision (approval or denial), the CCM must notify the provider within 48 hours of the request for service(s) and relay which components are missing or deficient. The CCM will also generate an Insufficient Notice for member and provider detailing which components are missing and allow the provider 14 calendar days to send missing documents.

If the provider submits the missing documents within the requested time frame, the CCM will review the request for medical necessity. If the provider fails to submit the missing documents, CBH will deny the request.

3.4.3.3. Authorization Errors

For authorization errors, the provider must submit a CBH Authorization Correction Form (found here as an Excel spreadsheet) to the Operations Support Services Coordinator within 30 days of the date of service. Providers will receive the corrected authorization number via an Authorization Letter or Report within four weeks of the date of submission. In the event that an authorization number cannot be corrected as requested, the provider will receive a CBH Outpatient Feedback Form notifying the provider of such.

Requests for authorizations that are submitted more than 30 days after the date of service will be referred to the Claims department and are not guaranteed for payment. The request must contain the CBH Authorization Correction Form and a cover letter that details the nature of the authorization error, the attempts made to get the authorization corrected and the reason the request is being submitted past 30 days. The provider will receive a written decision within four weeks of the date of submission of request. Any Authorization Correction Forms that are incorrectly completed or illegible will be sent back to the provider without review.

3.5. Authorizations for Philadelphia Residents Who are Uninsured or Have CBH Secondary

Philadelphia County/OMH/BHSI are responsible for ensuring that individuals in Philadelphia County who are uninsured receive mental health and substance use services. CBH assists providers in obtaining prior authorization for acute psychiatric services. Providers should contact BHSI and OMH for authorization requests for other levels of care.

3.5.1. Uninsured Philadelphia Residents – Acute Psychiatric Services

Providers seeking acute psychiatric services for uninsured individuals should follow the process below:
Verify Philadelphia residency through review of one or more of the following: utility bill, social security card, photo identification, etc. in anticipation of CBH requesting this information.

- If an individual is not a Philadelphia resident and is presenting for voluntary admission, refer to the respective office of mental health for funding.
- If an individual is not a Philadelphia resident and is presenting for involuntary admission, contact PES for prior authorization.
- If an individual is a Philadelphia resident, the provider physician must assess for MNC for the acute inpatient psychiatric services.
  - If the assessing psychiatrist believes MNC is met, contact PES for prior authorization.

The Office of Behavioral Health (OBH) expects the provider to take primary responsibility for assisting the member with the Medical Assistance application process and retaining the following documentation:

- Member liability determination standards as outlined by DBHIDS
- Medical Assistance application
- Documentation of approval or rejection.
  - To be approved for county funding, the individual must be rejected for reasons other than excessive income, insufficient information, or other non-medical reasons.

If an individual is determined to be financially liable, the hospital must make collection arrangements with the individual. Collected funds must be deducted from any request for county reimbursement. Verification of an exhaustive collection effort must include proof that the delinquent payment was submitted to a collector and credit bureau for credit reference. Please note that county funding will not be available to reimburse inpatient stays for individuals who have used their annual or lifetime benefits from other third parties.

### 3.5.2. Authorizations When CBH is Not Primary

For services requiring prior authorization, the following procedure applies:

- If a member presents with primary insurance and an approval for services, CBH will request a copy of the approval letter.
- CBH will match any authorized services at the same frequency and duration as the primary insurer, for which CBH is secondary payor.
  - CBH will not render a separate decision of medical necessity, nor is an authorization packet necessary when services are authorized through TPL.
- CBH will only review cases as primary payor for medical necessity if:
- The member has exhausted their straight Medicare days.
- The member’s primary insurer denies services.
  - Provider must complete denial process prior to contacting CBH for a medical necessity determination.
- The service being requested is not a covered benefit under the member’s primary insurance coverage as evidenced by the Explanation of Benefits (EOB).
- The member has exhausted their annual benefit limit and the provider has received a denial or non-authorization due to meeting the “cap.”
- As soon as the provider is aware that an annual benefit limit has been exhausted and the provider wishes for CBH to become primary payor, the provider should follow standard prior authorization procedures.
- If none of the three scenarios described are applicable, CBH will not review for medical necessity.
  - The treating provider will contact CBH only to inform that the member has been admitted and how many straight Medicare days the member has remaining.
  - If the number of straight Medicare days cannot be confirmed by a provider due to it being a weekend or holiday, the provider will verify the number of days remaining on the next business day and contact CBH with this information.
  - Clinical management will document this in CBH’s clinical information system, but no authorization will be generated, no clinical information is required, and no concurrent reviews are completed.
  - Discharge information is provided to Clinical management and the information will be entered within one business day.
    - Clinical management will then generate an authorization to cover the member’s stay in treatment as long as the member’s primary insurance coverage remains active.
    - If any dates are not covered by the member’s primary insurer, Clinical management will ask the provider to submit the member’s chart for a retroactive appeal.
- If a member’s primary insurance coverage is active and a provider wishes to request a service that is not a part of the primary benefit plan, the provider may contact CBH to review for medical necessity.
- When a provider requests that CBH become the primary funder for a member’s treatment, CBH makes a medical necessity determination on the date the request is made.

Also see the CBH Provider Notice dated December 6, 2018 (amended December 20, 2018), “CBH as Primary Insurance for Select Drug and Alcohol Services.”
3.6. Out-of-Network and Out-of-Area Services

CBH will consider authorization of medically necessary in-plan services for CBH members with out-of-network providers when the service is:

- Not available within the CBH provider network
- Not geographically accessible to the member

CBH must provide prior authorization for all services provided by an out-of-network provider. **CBH may refuse to pay for any out-of-network treatment services that have not been prior authorized.**

The CBH member must be evaluated by qualified staff (e.g. physician) to determine whether MNC is met. For requests for urgent services, out-of-network providers must contact the PES line. If the service is approved, a CCM will determine the number of units authorized. The CCM conducts concurrent reviews and assists with care coordination and discharge planning. For requests for non-urgent services, out-of-network providers must contact CBH Member Services.

The following are examples of out-of-network placements:

- In an emergency, members who are out of the CBH provider area may be authorized for hospitalization with providers who are not part of the CBH network.
- Children and adolescents being placed in substitute care may require treatment outside of the CBH provider network.

3.7. Request for Continued Service/Extended Authorization

Requests for continued RTF and CRR-HH must be submitted no earlier than 21 calendar days before the end of the current authorization period.

Requests for continued services for all other levels of care should be made no later than the last covered day in the current authorization period. If a request for continued authorization is received after the last covered day in the current authorization period and services are approved as requested, a new authorization number is generated on the date the approval is made.

Providers should consult Packet Exemption Bulletin 19-04 and the September 11, 2018 Notice on the CBH website for guidance on continued authorizations for children’s community-based services.

For providers seeking continued authorized for community-based services, if caregiver(s) miss more than three consecutive evaluation appointments, providers should contact CBH Member Services.
Services, who will provide outreach to the respective families. Contact to CBH Member Services must occur before the provider considers terminating services to the child/family. All attempts to engage parents in this process must be documented in the clinical record.

3.8. Reporting Discharges/Leaves

3.8.1. Planned Discharges

For services reviewed telephonically, discharge reviews are completed with the CCM within one business day of discharge. For services reviewed by packet, discharge summaries are submitted to the care manager within five business days of discharge.

3.8.2. Against Medical Advice, Administrative Discharge, and AWOL

If the member is not in a facility overnight for any reason other than clinical, planned discharge, or leave, for all services providing 24-hour monitoring and treatment, the facility must:

- Verbally inform CBH within 24 hours, providing any known contacts for the members (family, significant other, etc.).
- Fax a completed copy of the Significant Incident Report (SIR) Form within 72 hours (within 24 hours in the event of death or abuse) CBH Quality Management at (215) 413-7132. See this webpage for details on SIR.

3.9. Service-Specific Guidelines

3.9.1. Children's Community-Based Services

3.9.1.1. Packet Exemptions

Some service requests for several children’s community-based services are authorized via packet exemption.

Requests that qualify for packet exemption are:

- Initial requests for STS Level 2 or Level 3
- Continued requests for STS Level 2 or Level 3 for members with an overall STS length of stay under 12 months
- Continued requests for BHRS for professional services only (i.e. Behavioral Specialist Consultant [BSC], Behavioral Specialist Consultant-Autism Spectrum Disorder [BSC-ASD], and/or Mobile Therapy [MT]) for members with an overall BHRS length of stay under 12 months
- Initial requests for FBS or FFT as a stand-alone service
• FBS Extension requests made following the completion of an extension review with a CBH Clinical Care Manager (CCM) in which the extension was telephonically approved
• FFT Extension requests under four (4) weeks
• MST-PSB recommendation approved following the completion of an Interagency Service Planning Team (ISPT) Meeting in conjunction with the designated MST-PSB provider and a CBH Clinical Department representative

Instead of submitting a packet to request services, providers may submit a list of members meeting MNC for the levels of care outlined above to their CCM using the Authorization Request Form provided by CBH. All elements of the form must be completed, which include:

• Member’s name and medical assistance identification number
• School name
• Previous services authorized and dates (for continued requests only)
• Evaluation date
• Prescriber/evaluator (name and credentials)
• Requested/prescribed services (including level/hours and dates)
• Provider agency name
• Provider agency point of contact (name and contact Information)

Authorization Request Forms must be submitted via the secure website. The Authorization Request Form must be appropriately labeled as: ProviderID#_Auth_Req_Form.

Please note:

“Initial requests” will be defined as requests pertaining to members with no history of any level of care or as members who are not currently authorized for any level of care.

Second authorization periods will take into consideration lapses in services over the summer months. If a member received services in the spring, a request received in the fall will be considered a second authorization.

This exemption includes members who had STS Level 1 for 6 months and now meet medical necessity criteria for STS Level 2 or 3. In this case, only one authorization period could be requested through packet exemption.

While CBH will not require a packet submission, providers must continue to maintain essential documentation to verify medical necessity criteria and to meet requirements of the Office of Mental Health and Substance Abuse Services (OMHSAS).

Providers assume the responsibility to coordinate care. It is the receiving provider’s responsibility to contact the referral source to obtain the prescription for the authorized level
of care. If the request made of the referral source has not been submitted, the provider should contact the assigned CCM or Behavioral Health Liaison (BHL) for further assistance.

3.9.1.2. Requesting Changes to Services During a Current Authorization Period

This section clarifies the use of CBRs, addendums, service authorization grids, and updated mental status examination (MSE) requirements to request service changes within an already determined authorization period for children and adolescents.

3.9.1.2.1. Comprehensive Biopsychosocial Re-evaluations (CBRs)

Within an established authorization period, the CBR is the preferred means to request changes to services for youth receiving prior authorized treatment. A CBR is preferable to integrate changes in the member’s presentation or situation into a comprehensive formulation that best supports the diagnosis and resulting request for services. A CBR can be used at any time to continue or revise services for a child, as long as the clinical reason(s) for the CBR are clearly documented in the Reason for Re-Evaluation section. Reasons for a CBR may include:

- Significant changes in clinical presentation and/or psychosocial context that warrant a comprehensive and updated evaluation
- Lack of progress or worsening of symptoms despite treatment
- A need for further information to contribute to comprehensive treatment planning

CBRs may be billed. See the relevant Guidance for details.

3.9.1.2.2. Addendums

Addendum requests may also be used to request changes in services during an existing authorization period. If an addendum is used, the MSE from the CBE or CBR which the Addendum is modifying can be no older than 60 days. If the MSE is older than 60 days, the Addendum must include a new MSE and be submitted within 60 days of the new MSE. In addition, there are certain times designated by CBH when the MSE requirement is waived for Addendums, such as at the start or end of the school year. Reasons for an Addendum may include:

- No significant changes in clinical presentation and/or psychosocial context, but a recommendation was inadvertently omitted from the prior evaluation

As a reminder, Addendums are not a billable service for CBH members. Time spent preparing the Addendum, including record reviews, may not be billed.
3.9.1.2.3. Service Authorization Grids

Service Authorization Grids can be used to request services at times designated by CBH. Such grids are utilized to support treatment continuity for members during known points of transition for all youth in the city, such as at the end of the school year to support continued treatment over the summer or at the beginning of the school year to support continued treatment needs. Providers will receive notification from CBH that Service Authorization Grids can be submitted. When service request grids are used, there is no need for an updated MSE. However, the Grids must be requesting services within the current authorization period.

Time spent completing Service Authorization Grids is not a billable service for CBH members.

3.9.2. Residential Treatment Facilities (RTF)

At the time of PRTF or RTF referral, CBH may request that an interview be performed before a facility issues a denial for admission. CBH will not request interviews with every referral, but CBH will request interviews when the youth clearly fits the program outlined in the facility’s service description and stated inclusionary and exclusionary criteria. In these instances, CBH requests that an in-person, pre-admission interview be performed prior to determining that the youth is not a clinical fit for the program. For providers that are located more than 50 miles from the youth’s current location, HIPAA-compliant video conferencing is permissible. Upon completion of the pre-admission interview, the RTF should notify CBH of the outcome. Please note that children referred to PRTF and RTF have already been determined to meet medical necessity for this LOC, and any denials following the interview should reflect that any contributing areas of clinical concern were fully explored and assessed. To support these pre-admission assessments, providers may seek reimbursement for LOC 500-24, “RTF Accredited – Pre-Admission Assessment.” LOC 500-24 will be reimbursed at a rate of $115 per event. This rate includes costs related to travel and videoconference. The interview must be completed by a clinician credentialed as a Mental Health Professional, psychologist, or psychiatrist. Providers continue to be able to accept referred youth based on the written referral alone; in these cases, no interview is required. In instances where CBH has requested an interview and the provider is not able to accept—based on the written referral—the provider will reach out to the CBH RTF Referral Behavioral Health Liaison with the time and date of the interview; an authorization will then be issued for LOC 500-24. Please note that requested interviews are mandatory and must take place whether the provider seeks payment or not.

3.9.2.1. Discharge and Re-entry

If the residential treatment services continue to be clinically appropriate for the child upon discharge from the hospital, the residential treatment program must accept the child back into treatment immediately upon discharge from the hospital.
The discharging facility's treating physician or psychiatrist must provide the residential treatment program with a comprehensive evaluation that includes a recommendation that the child return to the residential treatment program for the balance of the originally approved period.

CBH will review the clinical information during the hospital stay. If it is determined that the child's return to the residential treatment program is unlikely, the residential treatment program will be notified, and an end date will be determined.

3.9.2.2. Medical/Psychiatric Leave

In order to reserve a child's place in a residential treatment program when the child leaves for either a general inpatient hospital or a psychiatric facility, CBH will reimburse at one-third of the facility's negotiated per diem rate for up to 15 days per calendar year. For this period, the residential treatment program may not accept reimbursement from any other source on behalf of the child. The days during a hospital leave can be billed electronically or on paper and separately from the residential treatment billing. The residential treatment program should calculate the units to be one-third of the unit (not one-third of the rate) for each day in the hospital. The residential treatment program will be reimbursed for less than 15 days if, during the hospital leave, CBH determines that it would not be clinically beneficial for the child to return to the residential treatment program.

3.9.2.3. Therapeutic Leave

Members in RTFs often receive therapeutic leave passes which provide opportunities for them to return briefly to their home/community while continuing treatment at the RTF. Therapeutic leave passes allow members to practice skills acquired in RTF outside of the residential setting.

Providers must follow all MA regulations regarding leave in the MA Bulletins 01-95-12 (found here) and 01-95-13 (found here) for JCAHO and Non-JCAHO facilities.

3.9.3. Residential Addictions Treatment

3.9.3.1. Discharge and Re-entry

If the residential treatment services continue to be clinically appropriate for the member upon discharge from a medical or psychiatric hospital, the residential treatment program must accept the member back into treatment immediately upon discharge.

CBH will review the clinical information during the psychiatric hospital stay. If it is determined that the member's return to the residential treatment program is unlikely, the residential treatment program will be notified and an end date will be determined.
When the member is readmitted to the residential rehabilitation facility, the facility must revise the treatment plan to reflect the hospitalization and to identify any changes in goals and objectives. The CCM will record this as part of the continued stay review with the respective addiction treatment program.

3.9.3.2. Reduction of Prior Authorization Criteria Requirements

3.9.3.2.1. UDS

CBH no longer requires urine drug screens (UDS) and vital signs for prior authorization for a member for residential and inpatient substance use treatment. This change was made to further increase access to treatment. While UDS and vital signs are not required for prior authorization for substance use treatment, CBH will continue to ask providers with capability to collect UDS and vital signs to provide this information to inform clinically optimal treatment authorizations.

This change means assessment sites (for example CRCs) currently capable of collecting UDS and vital signs should continue to do so. Assessment sites without this capability will now be able to request prior authorizations and make referrals for substance use treatment without UDS and vital signs. Therefore, substance use treatment providers will need to accept the minority of members who will receive prior authorization and be referred for treatment without UDS and vital signs. Providers will need to factor this into acceptance criteria, admission protocols, and treatment decisions and should continue to follow clinical best practices and state regulatory standards related to obtaining vitals and UDS results as part of their assessment and treatment planning process.

3.9.3.2.2. ASAM Partial Hospitalization (Level 2.5) and ASAM Clinically Managed High Intensity Residential Services (Level 3.5)

Providers admitting CBH members to 2.5 or 3.5 should notify the CBH Psychiatric Emergency Services (PES) line (215-413-7171) at the time the member is admitted, and an initial authorization for 15 days for 3.5/45 days for 2.5 will be provided. Concurrent reviews will begin on day 15 for 3.5, and subsequent reviews will occur as necessary.

As historically required, providers admitting members to 2.5 or 3.5 units must complete an assessment within 72 hours of admission, including American Society of Addiction Medicine (ASAM) criteria, documenting that the member meets medical necessity for this level of care. Discharge planning must begin upon intake; if it is determined upon the initial concurrent review that the individual does not meet medical necessity criteria for 2.5 or 3.5, the member must be sufficiently ready for discharge. Additionally, when questions regarding medical necessity arise during concurrent review, retrospective chart reviews may occur through the CBH Compliance Department.
3.9.3.2.3. Mobile Psychiatric Rehabilitation and Peer Specialist Services

Effective October 13, 2019, CBH no longer requires prior authorization for Mobile Psychiatric Rehabilitation (level of care 900-5) and Peer Specialist Services (level of care 800-17). This change only impacts providers who do not already use blanket authorization numbers for Mobile Psychiatric Rehabilitation and Peer Specialist Service Providers. These providers will notify CBH’s Community Support Services via secure email (cbhcss@phila.gov) upon admitting CBH members to Mobile Psychiatric Rehabilitation and Peer Specialist Services. Once this information is received, a CBH Clinical Care Manager will generate an authorization number for six months. If additional Mobile Psychiatric Rehabilitation or Peer Specialist Services are required after this period, additional requests should be made to the assigned CBH Clinical Care Manager. As historically required, providers admitting members to Mobile Psychiatric Rehabilitation and/or Peer Specialist Services must have appropriate documentation supporting medical necessity for this level of care, including a completed Licensed Practitioner of the Healing Arts (LPHA) form.

3.9.4. Psychological Testing

Psychological testing is a prior authorized service and can be requested via a Psychological Testing Pre-Authorization Request Form. Once completed, the request and a copy of the CBE can be faxed to 215-413-7184 (ATTN: Director of Psychology). Upon receipt by CBH, the request will be date stamped.

Requests will be considered for authorization:

- When the request meets MNC and clearly indicates how testing will inform the behavioral health treatment plan.
- When the request indicates why the CBE was insufficient to determine an initial case formulation and treatment plan.
- The member or appropriate representative has provided informed consent for psychological testing.
- The request is for behavioral health services other than establishing risk for fire setting.
- The request is not primarily for medical/physical treatment/rehabilitation or educational/vocational services in the absence of a specific anticipated impact on the behavioral health treatment plan.
- The request indicates, by name, what tests will be administered, the questions that each test will address, and estimated administration time for each test. Note that estimated testing times that differ significantly from test publisher recommendations should be accompanied by a rationale.
- The request is signed by a licensed psychologist and the PA license number is indicated.
Testing authorization is provided in one-hour units including administration, scoring, interpretation, and report preparation time. Testing typically includes a battery of instruments administered during a concentrated time period. Thus, testing is typically authorized in 30-day increments. A longer duration can be considered for medical necessity provided there is documentation of a rationale regarding the purpose. Verbal requests for extensions can be made to the CBH Director of Psychology.

Determination of testing authorization or denial will be made within two business days from receipt of the request. A CBH-designated Administrative Assistant will provide notification of approval or denial via fax to the provider and will issue an authorization number. A notification letter regarding testing denial and grievance process will be mailed to the CBH member within 2 business days of receipt of the request. This letter is completed by a designated CBH Clinical Care Manager using the electronic record Denial Module.

The psychological testing must be completed within one month of authorization. Upon completion of the psychological testing report, the provider agency should fax a copy of that report to the CBH Director of Psychology.

A Psychological Testing Pre-Authorization Request Form does not need to be completed on behalf of members who are receiving treatment in a residential, inpatient, or juvenile justice setting. In such settings, psychological testing is part of the provider’s per diem rate and is included in the provider agreement.

If a provider identifies an individual member who requires psychological testing, but that provider does not have a contract with CBH to provide psychological testing services, it is preferable for that provider to obtain a release of information from the member and collaborate directly with a provider who is under contract with CBH to provide psychological testing services. A CBH Provider Relations or Member Services Representative can assist with a list of agencies that provide psychological testing. The identified agency that will be completing the testing can submit the Testing Preauthorization Request Form to CBH for review. A CBH Provider Relations Representative or Member Services Representative can provide testing referral support when needed.

Psychological testing may also be indicated to address questions that are not primarily related to behavioral health services. Such requests should be directed to the appropriate payer. For example:

- Requests for neuropsychological testing to determine organic contributions to behavior should be directed to the member’s Physical Health Managed Care Organization.
- Requests for testing for educational services should be directed to the member’s School District.
• Requests for testing for vocational services should be directed to the PA Office of Vocational Rehabilitation at 215-560-1900.
• Requests for testing for intellectual disability case management or services should be directed to Intellectual disAbility Services at 215-685-5900.

3.9.5. Behavioral Health Case Management Continuum

The behavioral health case management services listed below are authorized and coordinated by the DBHIDS Behavioral Health Case Management Unit using MNC found in Appendix T. To obtain information on prior authorization, call (215) 599-2150. Each referral must be accompanied by a completed DBHIDS integrated intake form available here.

Based on the PA DHS Office of Mental Health and Substance Abuse (OMHSAS) definition, Targeted Case Management is a primary, non-clinical, direct service provided to individuals with serious and persistent mental illness who live in the community. It is designed to ensure individual access to community agencies, services, and people whose functions are to provide the support, training, and assistance required for a stable, safe, and healthy community life. It is a time-limited, voluntary service.

Behavioral Health Case Management includes:

• **Resource Coordination:** A short-term service for individuals with a serious and persistent mental illness who may also have minor substance use issues and mild to moderate difficulty in accessing mental health treatment, social, job-related, or daily living skills. Resource Coordinators will meet with individuals on a regular basis as dictated by their Personal Goal Plan. Frequency of contact may range from daily to every 30 days. Services are available Monday-Friday, 9-5.

• **Intensive Case Management (ICM):** ICM is for persons with a severe and persistent mental illness who may also have significant substance use problems. ICM is recommended for persons who experience chronic homelessness and frequent times of crisis. These individuals may be unable to obtain or maintain a safe place to live, or to identify, reach, and maintain personal goals. The service is accessible 24/7 and supported with active street outreach efforts. Frequency of contact can range from multiple times in a day to once every 14 days.

• **Blended Case Management (BCM):** BCM is for persons with a severe and persistent mental illness who may also have significant substance use problems. BCM is recommended for persons who experience frequent hospitalizations or times of crisis. These individuals may be unable to obtain or maintain community-based MH treatment or to identify, reach, and maintain personal goals. The service is accessible 24/7.
Frequency of contact can range from daily to once every 30 days based on individual need and their Personal Goal Plan.

- **Non-Fidelity Assertive Community Treatment Non-Fidelity ACT**: Non-fidelity ACT is for individuals with a severe and persistent mental illness who may also have serious substance use problems and/or additional issues. Non-fidelity ACT is recommended for individuals who experience frequent hospitalizations, CRC visits, and mobile emergency service use. These programs are enhanced with a full-time psychiatrist, nurse, and Alcohol and Other Drugs (AOD) specialist to support the needs of certain individuals on the caseload. These teams have extended office hours during the week and limited active work hours over the weekends. The service is accessible 24/7. Frequency of contact can range from multiple times a day to every 14 days depending on the individual's Personal Goal Plan.

- **Assertive Community Treatment (ACT)**: ACT is a service delivery model for providing comprehensive community-based treatment to persons with serious mental illness who may also have serious substance use and/or other co-morbid issues. It is a level of care that is used when other types of community-based treatment have been tried but not been effective and there have been several inpatient admissions. It is a self-contained mental health program comprised of a multidisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services individuals need to achieve their goals.

3.9.6. **Authorization Guidelines for Psychiatric Consultations in Medical Facilities**

Providers are reimbursed for one initial and one follow-up consultation. CBH reserves the right to retroactively deny payment if a consultation is not deemed medically necessary. The following constitutes MNC:

- Suicidal ideation, intent, or plan
- Homicidal ideation or plan
- Acute agitation
- Chronic and persistent mental illness with concomitant medical illness
- Substance use and dependence, including withdrawal management
- Constant observation needed
- Differential diagnosis and treatment recommendations are requested
- Competency assessment
- Any psychiatric disorder or disturbance that interferes with a patient’s care in a medical setting

CBH provides payment for one initial consultation and one follow-up visit.
If a service recipient has been in a Nursing Facility for 30 consecutive days or longer, they are no longer CBH eligible.

Psychiatric consultations are to be performed ONLY by licensed psychiatrists or groups of psychiatrists who are independently credentialed by CBH.

Each type of consultation has a distinct BAN which must be used in billing. CPT codes are time specific and therefore must contain a start and end time for the consultation.
3.10. Authorization Guidelines

3.10.1. Child Services Authorization Requirements

Finalized authorization information about Intensive Behavioral Health Services (IBHS) is forthcoming. For updates, please see the CBH Provider Bulletins page. As of the publication of this document, the following Bulletins discuss IBHS authorization:

- Bulletin 19-24: Accessing Intensive Behavioral Health Services (IBHS)
- Bulletin 20-03: BHRS Assessment and Initial Treatment Authorization During the Transition to IBHS
- Bulletin 20-10: Updated Written Order Letter and Authorization Timeframes

<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Service</th>
<th>How to access service</th>
<th>Type of auth</th>
<th>Who provides auth</th>
<th>MNC</th>
<th>What must requester submit to obtain auth?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency (No Prior Auth)</td>
<td>Children’s Mobile Crisis Team (CMCT)</td>
<td>Mental Health Delegates 215-685-6440</td>
<td>BAN</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Crisis Response Center (CRC)</td>
<td>Walk in/ Mental Health Delegates 215-685-6440 for help with 302</td>
<td>BAN</td>
<td>N/A – Schedule A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Level of Urgency</td>
<td>Service</td>
<td>How to access service</td>
<td>Type of auth</td>
<td>Who provides auth</td>
<td>MNC</td>
<td>What must requester submit to obtain auth?</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>-----------------------</td>
<td>--------------</td>
<td>------------------</td>
<td>-----</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Urgent (Prior Auth is usually provided in 24 hours)</td>
<td>Adolescent Drug and Alcohol Residential Rehabilitation [200-2, 200-7]</td>
<td>Substance use assessment</td>
<td>Prior Auth</td>
<td>PES line or Assigned CCM</td>
<td>ASAM</td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call.</td>
</tr>
<tr>
<td></td>
<td>Children’s Mobile Intervention Services [800-30]</td>
<td>Children’s crisis providers recommend; cannot have other prior authorized services in place</td>
<td>Prior Auth</td>
<td>PES line</td>
<td>State-approved on the CBH website</td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call.</td>
</tr>
<tr>
<td></td>
<td>Acute Psychiatric Inpatient [100-1, 100-4]</td>
<td>Physician at a children’s crisis provider recommends</td>
<td>Prior Auth</td>
<td>PES line or Assigned CCM</td>
<td>Appendix T</td>
<td>Physician MSE for initial and concurrent</td>
</tr>
</tbody>
</table>

---

3 When an authorization is being requested by the inpatient provider for members who are already on the inpatient unit (in cases when CBH coverage is initiated during inpatient stay, i.e. county or Medicare coverage exhausts and individual becomes CBH eligible), the care manager assigned to the provider provides the prior authorization.


5 When an authorization is being requested by the inpatient provider for members who are already on the inpatient unit (in cases when CBH coverage is initiated during inpatient stay, i.e. county or Medicare coverage exhausts and individual becomes CBH eligible), the care manager assigned to the provider provides the prior authorization.
<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Service</th>
<th>How to access service</th>
<th>Type of auth</th>
<th>Who provides auth</th>
<th>MNC</th>
<th>What must requester submit to obtain auth?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent</td>
<td>Autism After School Services [300-37]</td>
<td>Contact Member Services or the provider</td>
<td>Registration</td>
<td>OSS</td>
<td>Appendix T (Same as BHRS) <a href="#">on the CBH website</a></td>
<td>Submit Service Request Form (Appendix V).</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health Rehabilitative Services (BHRS)⁶</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>Appendix T <a href="#">on the CBH website</a></td>
<td>Submit CBE/R no older than 60 days; BHRS Cover Sheet; Plan of Care; Interagency Service Planning Team (ISPT) Meeting Sign-In/Concurrence Form and ISPT Meeting Summary; Comprehensive Treatment Plan; Therapeutic Staff Support (TSS) Scheduler, if TSS is requested. See section 3.8.</td>
</tr>
<tr>
<td></td>
<td>BHRS-ABA⁷</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>Appendix S <a href="#">on the CBH website</a></td>
<td>Submit CBE/R no older than 60 days; BHRS Cover Sheet; Plan of Care; Interagency Service Planning Team (ISPT) Meeting Sign-In/Concurrence Form and ISPT Meeting Summary and Signature Form; Comprehensive Treatment Plan; Therapeutic Staff Support (TSS) Scheduler, if TSS is requested.</td>
</tr>
</tbody>
</table>

---

⁶ Providers should consult Packet Exception Bulletin 19-04 and the September 11, 2019 Notice on the CBH website for guidance on continued authorizations for children’s community-based services. Please also see note about IBHS at the beginning of this section.

⁷ Please see note about IBHS at the beginning of this section.
<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Service</th>
<th>How to access service</th>
<th>Type of auth</th>
<th>Who provides auth</th>
<th>MNC</th>
<th>What must requester submit to obtain auth?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blended Case Management</td>
<td>Contact DBHIDS Case Management (BHCMU) 215-599-2150</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>Appendix T on the CBH website (use MNC for TCM)</td>
<td>Submit <a href="#">Case Management Referral Form</a>.</td>
</tr>
<tr>
<td></td>
<td>Clinical Transition and Stabilization Services (CTSS)</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>State-approved on the CBH website</td>
<td>Submit CBE/R no older than 60 days; BHRS Cover Sheet; Plan of Care; Interagency Service Planning Team (ISPT) Meeting Sign-In/Concurrence Form and ISPT Meeting Summary and Signature Form; Comprehensive Treatment Plan.</td>
</tr>
<tr>
<td></td>
<td>Community Residential Rehabilitation (CRR) Host Home</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>State-approved on the CBH website</td>
<td>Submit CBE/R no older than 60 days; MA 97 or MA 325 Form; Treatment Plan; ISPT Meeting Form and Signature Page.</td>
</tr>
<tr>
<td></td>
<td>Drug and Alcohol Intensive Outpatient</td>
<td>Contact Member Services or the provider</td>
<td>Registration</td>
<td>OSS</td>
<td>ASAM</td>
<td>Submit Service Request Form (Appendix V).</td>
</tr>
<tr>
<td></td>
<td>Drug and Alcohol Outpatient</td>
<td>Contact Member Services or the provider</td>
<td>BAN</td>
<td>N/A</td>
<td>ASAM</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Family-Based Services (FBS)</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>Appendix T on the CBH website</td>
<td>Submit CBE/R no older than 60 days and FBS Form. See section 3.8.</td>
</tr>
<tr>
<td>Level of Urgency</td>
<td>Service</td>
<td>How to access service</td>
<td>Type of auth</td>
<td>Who provides auth</td>
<td>MNC</td>
<td>What must requester submit to obtain auth?</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>-----------------------</td>
<td>--------------</td>
<td>-------------------</td>
<td>-----</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Functional Family Therapy (FFT)</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>Appendix T on the CBH website</td>
<td>Submit CBE/R no older than 60 days and FFT Referral Form. See section 3.8.</td>
</tr>
<tr>
<td></td>
<td>Mental Health Outpatient</td>
<td>Contact Member Services or the provider</td>
<td>BAN</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Multi-systemic Therapy for Problem-Sexual Behaviors (MST-PSB)</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>Appendix T on the CBH website (use MNC for FBMHS)</td>
<td>Submit CBE/R no older than 60 days and MST-PSB Referral Form. See section 3.8.</td>
</tr>
<tr>
<td></td>
<td>Parents And Children Together (PACT)</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>Appendix T on the CBH website (use MNC for Therapeutic Preschool)</td>
<td>Submit CBE/R no older than 60 days; BHRS Cover Sheet; Plan of Care; Interagency Service Planning Team (ISPT) Meeting Sign-In/Concurrence Form and ISPT Meeting Summary; Comprehensive Treatment Plan</td>
</tr>
<tr>
<td>Partial Hospitalization [325-6]</td>
<td>Contact Member Services or the provider</td>
<td>Registration</td>
<td>OSS</td>
<td>Appendix T on the CBH website</td>
<td>Submit Service Request Form (Appendix V).</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization After School [325-7]</td>
<td>Contact Member Services or the provider</td>
<td>Registration</td>
<td>OSS</td>
<td>Appendix T on the CBH website (same as BHRS)</td>
<td>Submit Service Request Form (Appendix V).</td>
<td></td>
</tr>
<tr>
<td>Level of Urgency</td>
<td>Service</td>
<td>How to access service</td>
<td>Type of auth</td>
<td>Who provides auth</td>
<td>MNC</td>
<td>What must requester submit to obtain auth?</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------</td>
<td>-----------------------</td>
<td>--------------</td>
<td>------------------</td>
<td>-----</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Preschool Family Intervention (PFI)</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>Appendix T on the CBH website (use MNC for Therapeutic Preschool)</td>
<td>Submit CBE/R no older than 60 days; BHRS Cover Sheet; Plan of Care; Interagency Service Planning Team (ISPT) Meeting Sign-In/Concurrence Form and ISPT Meeting Summary; Comprehensive Treatment Plan</td>
</tr>
<tr>
<td></td>
<td>Psychiatric Consult in Medical Facility</td>
<td>Administered at medical facility</td>
<td>BAN</td>
<td>N/A</td>
<td>See section 3.8</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Psychological Testing - Outpatient [300-7]</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CBH Director of Psychology</td>
<td>State-approved on the CBH website</td>
<td>Psychological Testing Pre-Authorization Request Form faxed to 215-413-7184. See section 3.8.</td>
</tr>
<tr>
<td></td>
<td>Psychosexual Evaluation</td>
<td>Contact Member Services or the provider</td>
<td>Registration</td>
<td>OSS</td>
<td>N/A</td>
<td>Submit Service Request Form (Appendix V).</td>
</tr>
<tr>
<td></td>
<td>Residential Treatment Facility (JCAHO and Non-JCAHO certified) [500-1, 500-2, 500-5, 500-6, 500-7, 500-10]</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>Appendix T on the CBH website</td>
<td>Submit MA 97 (non-accredited programs) or MA 325 form (accredited programs) CBE/CBR completed within the last 60 days of receipt Treatment plan ISPT meeting form and signature page</td>
</tr>
</tbody>
</table>
## CHILD SERVICES AUTHORIZATION REQUIREMENTS

<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Service</th>
<th>How to access service</th>
<th>Type of auth</th>
<th>Who provides auth</th>
<th>MNC</th>
<th>What must requester submit to obtain auth?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>School Therapeutic Services (STS)(^8)</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td></td>
<td>BHRS Cover Sheet; Plan of Care; Interagency Service Planning Team (ISPT) Meeting Sign-In/Concurrence Form and ISPT Meeting Summary; Psychological/Psychiatric Evaluation; Comprehensive Treatment Plan. See section 3.8.</td>
</tr>
<tr>
<td></td>
<td>Summer Therapeutic Activities Program (STAP)(^9)</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td></td>
<td>BHRS Cover Sheet; Plan of Care; Interagency Service Planning Team (ISPT) Meeting Sign-In/Concurrence Form and ISPT Meeting Summary; Psychological/Psychiatric Evaluation; Comprehensive Treatment Plan</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Emotional Support Classroom (TESC)(^10)</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>CCM</td>
<td></td>
<td>BHRS Cover Sheet; Plan of Care; Interagency Service Planning Team (ISPT) Meeting Sign-In/Concurrence Form and ISPT Meeting Summary; Psychological/Psychiatric Evaluation; Comprehensive Treatment Plan</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Preschool [325-6]</td>
<td>Contact Member Services or the provider</td>
<td>Registration</td>
<td>OSS</td>
<td></td>
<td>Submit Service Request Form (Appendix V).</td>
</tr>
</tbody>
</table>

---

\(^8\) Please see note about IBHS at the beginning of this section.
\(^9\) Please see note about IBHS at the beginning of this section.
\(^10\) Please see note about IBHS at the beginning of this section.
### 3.10.2. Adult Services Authorization Requirements

<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Service</th>
<th>How to access service</th>
<th>Auth required</th>
<th>Who provides auth</th>
<th>MNC</th>
<th>What must requester submit to obtain auth?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Crisis Response Center (CRC)</td>
<td>Walk in/ Mental Health Delegates 215-685-6440 for help with 302</td>
<td>BAN</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Acute Psychiatric Inpatient Hospitalization</td>
<td>Evaluating physician recommends</td>
<td>Prior Auth</td>
<td>PES or CCM</td>
<td>Appendix T on the CBH website</td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call.</td>
</tr>
<tr>
<td></td>
<td>[100-1, 100-4]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ASAM Clinically Managed High Intensity</td>
<td>Substance use assessment, or contact provider or Member Services</td>
<td>No Prior Auth</td>
<td>CCM</td>
<td>ASAM</td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call. See section 3.8.</td>
</tr>
<tr>
<td></td>
<td>Residential Services (Level 3.5)</td>
<td></td>
<td>For Initial; Prior Auth for Concurrent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ASAM Medically Monitored</td>
<td>Substance use assessment, or</td>
<td>Prior Auth</td>
<td>PES or CCM</td>
<td>ASAM</td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call. See section 3.8.</td>
</tr>
</tbody>
</table>

---

11 When an authorization is being requested by the inpatient provider for members who are already on the inpatient unit (in cases when CBH coverage is initiated during inpatient stay, i.e. county or Medicare coverage exhausts and individual becomes CBH eligible), the care manager assigned to the provider provides the prior authorization.
<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Service</th>
<th>How to access service</th>
<th>Auth required</th>
<th>Who provides auth</th>
<th>MNC</th>
<th>What must requester submit to obtain auth?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Inpatient Services (Level 3.7)</td>
<td>contact provider or Member Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASAM Medically Managed Intensive Inpatient Services (Level 4)</td>
<td>Substance use assessment, or contact provider or Member Services</td>
<td>Prior Auth</td>
<td>CCM or PES</td>
<td>ASAM</td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call. See section 3.8.</td>
<td></td>
</tr>
<tr>
<td>Non-urgent</td>
<td>ASAM Clinically Managed Low Intensity Residential</td>
<td>Substance use assessment, or contact provider or Member Services</td>
<td>Prior Auth</td>
<td>PES or CCM</td>
<td>ASAM</td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call.</td>
</tr>
</tbody>
</table>

12 When an authorization is being requested by the inpatient provider for members who are already on the inpatient unit (in cases when CBH coverage is initiated during inpatient stay, i.e. county or Medicare coverage exhausts and individual becomes CBH eligible), the care manager assigned to the provider provides the prior authorization.
## ADULT SERVICES AUTHORIZATION REQUIREMENTS

<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Service</th>
<th>How to access service</th>
<th>Auth required</th>
<th>Who provides auth</th>
<th>MNC</th>
<th>What must requester submit to obtain auth?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services (3.1) (formerly known as Halfway House)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASAM Partial Hospitalization (2.5)</td>
<td>Substance use assessment, or contact provider or Member Services</td>
<td>No Prior Auth for Initial; Prior Auth for Concurrent</td>
<td>CCM</td>
<td>ASAM</td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call. See section 3.8.</td>
<td></td>
</tr>
<tr>
<td>ASAM Intensive Outpatient (2.1) [375-11]</td>
<td>Contact provider or Member Services</td>
<td>Registration</td>
<td>OSS</td>
<td>ASAM</td>
<td>Submit Service Request Form (Appendix V).</td>
<td></td>
</tr>
<tr>
<td>ASAM Outpatient (1.0) [375-11]</td>
<td>Contact provider or Member Services</td>
<td>Registration</td>
<td>OSS</td>
<td>ASAM</td>
<td>Submit Service Request Form (Appendix V).</td>
<td></td>
</tr>
<tr>
<td>CASE MANAGEMENT: Intensive Case Management; Targeted Case Management; Non-fidelity ACT;</td>
<td>Contact DBHIDS Case Management (BHCMU) 215-599-2150</td>
<td>Prior Auth</td>
<td>Contact DBHIDS Case Management (BHCMU) 215-599-2150</td>
<td>Appendix T on the CBH website</td>
<td>Use DBHIDS Referral Form.</td>
<td></td>
</tr>
</tbody>
</table>

---

13 MNC determined by whether the member requires alcohol testing in order to establish or exclude a diagnosis of alcohol intoxication, use or dependence in order to guide treatment; and whether the member’s current clinical status prevents the use of a breath alcohol test.
<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Service</th>
<th>How to access service</th>
<th>Auth required</th>
<th>Who provides auth</th>
<th>MNC</th>
<th>What must requester submit to obtain auth?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Resource Coordination; ACT</td>
<td>Contact provider or Member Services</td>
<td>BAN</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Community Integrated Recovery Centers (CIRC)</td>
<td>BAN</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clozapine</td>
<td>Contact provider or Member Services</td>
<td>BAN</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Drug and Alcohol Intensive Case Management [800-16]</td>
<td>Contact DBHIDS Case Management (BHCMU) 215-599-2150</td>
<td>Registration</td>
<td>OSS</td>
<td>Must have a SUD diagnosis and 2 or more services in place</td>
<td>Submit Service Request Form (Appendix V).</td>
</tr>
<tr>
<td></td>
<td>Electroconvulsive Therapy (ECT)</td>
<td>Contact provider or Member Services</td>
<td>Prior Auth</td>
<td>PES or CCM</td>
<td>State-approved <a href="#">on the CBH website</a></td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call.</td>
</tr>
<tr>
<td></td>
<td>Medication-Assisted Treatment (MAT)</td>
<td>Contact provider or Member Services</td>
<td>BAN</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Mental Health Outpatient</td>
<td>Contact provider or Member Services</td>
<td>BAN</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Level of Urgency</td>
<td>Service</td>
<td>How to access service</td>
<td>Auth required</td>
<td>Who provides auth</td>
<td>MNC</td>
<td>What must requester submit to obtain auth?</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------</td>
<td>-----------------------</td>
<td>---------------</td>
<td>------------------</td>
<td>-----</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Mental Health Residential (Project Transition)</td>
<td>Physician recommends</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>State-approved on the CBH website</td>
<td>Referral form and requirements listed in MNC</td>
<td></td>
</tr>
<tr>
<td>Mobile Psychiatric Rehabilitation Services [900-5]</td>
<td>Contact provider or Member Services</td>
<td>BAN or CCM</td>
<td>N/A or CCM</td>
<td>State-approved on the CBH website</td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call.</td>
<td></td>
</tr>
<tr>
<td>Psychological Testing (Outpatient) [300-7]</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>Director of Psychology</td>
<td>State-approved on the CBH website</td>
<td>Psychological Testing Pre-Authorization Request Form. See section 3.8.</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Consult in Medical Facility</td>
<td>Administered at medical facility</td>
<td>BAN</td>
<td>N/A</td>
<td>See section 3.8</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

14 When an authorization is being requested by the inpatient provider for members who are already on the inpatient unit (in cases when CBH coverage is initiated during inpatient stay, i.e. county or Medicare coverage exhausts and individual becomes CBH eligible), the care manager assigned to the provider provides the prior authorization.
## ADULT SERVICES AUTHORIZATION REQUIREMENTS

<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Service</th>
<th>How to access service</th>
<th>Auth required</th>
<th>Who provides auth</th>
<th>MNC</th>
<th>What must requester submit to obtain auth?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Residential Treatment for Adults (RTFA) [900-15]</td>
<td>Physician recommends</td>
<td>Prior Auth</td>
<td>CCM</td>
<td>State-approved on the CBH website</td>
<td>CBE/R Court eval submitted for Forensic RTFA</td>
</tr>
<tr>
<td></td>
<td>Tricyclic Antidepressant (TCA) Screening</td>
<td>Contact Member Services or the provider</td>
<td>Prior Auth</td>
<td>PES or CCM</td>
<td>CBH MNC on the CBH website</td>
<td>Use PES Prior Authorization Template (Appendix W) during phone call.</td>
</tr>
</tbody>
</table>
3.11. Applicable Documents

- Medical Necessity Criteria

3.12. Applicable Appendices

- Appendix A: Definitions
- Appendix W: PES Prior Authorization Template
- Appendix X: Comprehensive Biopsychosocial Evaluation (CBE) Required Elements
4. QUALITY

4.1. Quality Goals

CBH defines, evaluates, and reviews all aspects behavioral health service delivery to everyone covered under HealthChoices for Philadelphia County. CBH’s goal is to ensure that appropriate treatment options are provided to individuals in a culturally sensitive, quality-driven, and supportive environment.

The Quality Management Department provides education about quality-of-service standards to participating providers and people in recovery. CBH requires that a provider develop internal quality improvement processes that enhance and support the quality of care delivered. The Quality Management Department works closely with other CBH and DBHIDS departments to monitor the service delivery of providers. The Quality Management Department is responsible for monitoring the activities outlined in this chapter.

4.2. Provider Participation in Quality Improvement Activities

CBH requires that providers cooperate in activities that improve the quality of care and services and member experience. This includes the collection and evaluation of data and participation in the CBH’s quality improvement (QI) programs. Such activities may include, but are not limited to:

- Providing information requested through Provider Bulletins and Provider Notices
- Adhering to Clinical Practice Guidelines and Performance Standards
- Participating in Quality Management activities, including chart reviews, root cause analysis, action plans, and quality improvement plans
- Reporting on Performance Metrics requested through the P4P, VBP, and the performance evaluation processes
- Engaging in credentialing, recredentialing, and compliance activities, including providing information required for credentialing/recredentialing, auditing, and NIAC site visits

4.3. Complaint Procedure (Member-Driven)

Providers should be aware that members have a right to complain and appeal. This process is detailed in the CBH Member Handbook that is issued to all members.15 A complaint is a dispute or objection filed with CBH about a participating healthcare provider or about the coverage, operations, or management policies of CBH. Complaints include, but are not limited to:

- A member’s dissatisfaction with CBH or a provider

---

15 See here, pages 45-64 (as of June 30, 2020, English edition).
• A service denial because the requested service is not a covered benefit
• Failure of CBH to meet the required timeframes for providing a service, which includes provider failure to deliver all services as authorized
• Failure of CBH to decide a complaint or grievance within the specified timeframes
• A denial of payment after a service(s) has been delivered because the service was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program
• A denial of payment after a service(s) has been delivered because the service is not a covered benefit
• When the term does not include a grievance (the term/process for a complaint is not related to those service approval items that are included under the grievance process)

Anyone can file a complaint. A member may designate a personal representative through written authorization. Should CBH not receive a representative form, the information will be shared with the member only. The member has the right to withdraw any filed complaint at any point in the process by contacting CBH at 1-888-545-2600.

CBH has established and maintains an internal complaint process with two levels of review. Complaints can also be expedited. For CBH to process an expedited request, CBH must receive certification from the provider indicating that the member’s life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy if the complaint is resolved in the standard timeframe of 30 days. If certification is accepted by CBH, a decision will be made within 48 hours of receiving the provider’s certification or 72 hours of receiving a request for an expedited review, whichever is shorter.

Complaints can be called in to CBH Member Services (1-888-545-2600) or received via mail. Complaints can also be received from individuals with disabilities using alternative formats.

4.3.1. First-Level Review Process

This process includes:

• A first level review committee consisting of
  1. one or more CBH employees who have not been involved in the subject of the complaint, and
  2. a CBH physician or psychologist for clinically-related complaints

• Allowance of a written or oral complaint

• Allowance of participation in the complaint process by providing testimony or evidence to the review committee
- The allowance of written data or other supporting information
- An investigation of the complaint
- Written notification to the member regarding the decision of the initial review committee within 30 days from the date the complaint was filed (includes the basis for the decision and the procedure to file a second-level review of the decision of the initial review committee)

4.3.2. Second-Level Review Process

This process includes:

- A review of the first-level decision by a second-level committee, which will consist of
  1. three or more individuals who did not participate in the initial review,
  2. consumer representation (comprising one-third of the committee), and
  3. an alternate CBH physician or psychologist (if one participated in the first level review)
- Notification to the member of the right to appear before the review committee 10 days prior to the scheduled date
- Allowance of a written or oral complaint
- Allowance of written data or other supporting information
- A review of the first-level review, which will be completed within 45 days of the receipt of the second-level complaint
- Written notification to the member regarding the decision of the second-level review committee will occur within 45 days from when the complaint was filed, including the basis for the decision

4.3.3. Expectations for Providers During First-Level Process

In compliance with Pennsylvania Act 68 of 1998, CBH is required to investigate and respond to all complaints brought to our attention by CBH members or, in the case of children, by parents/guardians. A CBH investigator will determine what is necessary to resolve the complaint, including but not limited to citing policies/procedures, touring provider sites, interviewing staff, interviewing the member and support system (when indicated), and reviewing medical records. If a member or legal guardian requests a copy of any correspondence received from the provider related to the complaint response, CBH is required
to forward it to them at no cost to the member. Provider cooperation is essential and is documented in every complaint.

4.3.4. Expectations for Providers During Second-Level Hearings

CBH is compelled by Pennsylvania Act 68 of 1998 to hold hearings for all second level complaints upon request by CBH members; the scheduling and execution of these hearings often requires a great investment of time for CBH, the provider, and our members. CBH expects providers to participate in second level complaint hearings if the member requests provider participation; providers should be prepared to address the questions and concerns of both the hearing panel and the CBH member(s) involved.

4.4. Complaint Procedure (Provider-Driven)

A provider can file a complaint at 215-413-8581 regarding any CBH employee or CBH practice. The Director of Quality Management will contact the provider’s Chief Executive Officer (CEO) to verify they want to proceed with the complaint. If the CEO wishes to proceed, the complaint will be resolved within 30 days, and a decision letter will be issued within 5 business days of the decision. The complaint committee will be comprised of the Medical Director of Quality Management (MDQM), the Chief Administrative Officer (CAO) or the CAO’s designee, the Manager of Internal Compliance or their designee (when relevant), and the director (or officer, when the complaint is made against a director) or designee of the department for which the complaint was filed.

4.5. Grievances

A grievance is a request for CBH to reconsider a decision solely concerning the Medical Necessity Criteria (MNC) and appropriateness of a healthcare service. A grievance may be filed regarding a CBH decision to:

- Deny, in whole or in part, payment for a service if based on lack of medical necessity
- Deny or issue a limited authorization of a requested service, including the type of level of service
- Reduce, suspend, or terminate a previously authorized service
- Deny the requested service but approve an alternative service

CBH has established and maintains an internal grievance process with one level of review. A grievance can also be expedited, or CBH may determine it meets the grievance timeline criteria laid out by the National Committee for Quality Assurance (NCQA), which will take precedence. For CBH to process an expedited request, CBH must receive certification from the provider indicating the member’s life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy if the grievance is resolved in the standard timeframe of 30 days. If
certification is accepted by CBH, a decision will be made within 48 hours of receiving the provider’s certification or 72 hours of receiving the request for an expedited review, whichever is shorter. The member may designate a personal representative through written authorization. Should CBH not receive a representative form, the information will be shared with the member only. Regarding NCQA, CBH will make its determination about response time based in NCQA criteria; these criteria concern initial or continued requests, urgent or non-urgent requests, and level of care. If specific NCQA criteria are met, CBH will make a determination within 72 hours of grievance filing.

4.5.1. Grievance Process

This process includes:

- Review of the denial decision by a review committee consisting of
  1. three or more persons who did not previously participate in any decision to deny payment for the health care service and,
  2. consumer representation (comprising one-third of the committee)

- Notification to the member or the healthcare provider of the right to appear before the review committee 10 days prior to the scheduled date

- Complete review and written notification sent to the member and healthcare provider regarding the decision of the review committee within 30 days of the file date, including the basis and clinical rationale for the decision and the procedure for appealing the decision

CBH has established and maintains an external grievance process by which a member, personal representative with the written consent of the member, or a healthcare provider with the written consent of the member can appeal the denial of a grievance following the completion of the internal grievance process. The external grievance process will be conducted by a certified review entity not directly affiliated with CBH. To file an external grievance with CBH, Member Services must be contacted. Additionally, when a denial is issued, a Fair Hearing can be filed by a member, personal representative with written consent of the member, or healthcare provider with the written consent of the member. A Fair Hearing can be filed at the conclusion of the grievance process by contacting Pennsylvania Department of Human Services.

4.6. Provider Teamings

An interdepartmental provider teaming is convened when CBH becomes aware of a significant provider-related issue. This may include quality concerns, significant member incidents, a Provisional Licensing status by the Office of Mental Health and Substance Abuse Services (OMHSAS) or the Department of Drug and Alcohol Program (DDAP), or a request initiated by
the CBH Board of Directors. Any CBH Officer or staff person in consultation with the Director of Quality Management can convene a Provider Teaming. Depending on the nature of the concern, staff representing Quality Management, Compliance, Medical Affairs, Network Development, Clinical Management, Provider Relations, Network Improvement and Accountability Collaborative (NIAC), Member Services, Data Informatics, Consumer Satisfaction Team (CST), Behavioral Health Special Initiative (BHSI), and/or other DBHIDS staff may be included in the provider teaming. During the teaming, a review of all issues occurs, and a plan of action is determined. A plan of action may include but not be limited to: a request for a Quality Improvement Plan or action plan, chart reviews, or site visit.

4.7. Quality Concerns

Quality of care issues are typically generated by Clinical Management and/or Medical Affairs as a result of clinical and service request reviews, NIAC post-site visits, or by Member Services regarding incidents and member concerns when members do not wish to file a formal complaint.

4.8. Clinical Appeals Procedure

In accordance with Act 68, Quality Health Care Accountability, providers may submit a clinical appeal in writing to request retrospective reimbursement for days of service not authorized. Appeals can occur at two levels.

4.8.1. First Level Appeals

4.8.1.1. Step One

All first level appeal requests must be submitted no more than 90 days after the last day of the episode of care in question. The appeal packet must include:

- A cover letter with the following information:
  - Name/contact information of the person submitting the appeal
  - Member’s name and an identifier such as SSN, DOB, or MA#
  - Exact level of care being requested
  - Exact dates of service in question
  - Brief explanation of the reason for the appeal

Address the cover letter to:

Community Behavioral Health
ATTN: Clinical Appeals Specialist
801 Market Street, 7th Floor
Philadelphia, PA 19107
AND

- All documentation related to the dates in question, including evaluations, assessments, progress notes, laboratory tests, discharge summary, etc.

4.8.1.2. Step Two

The Appeals Specialist will review the case. The Appeals Specialist will determine if the case warrants:

- An Administrative Review (meaning the provider did not adhere to CBH protocols or the case involves a clerical or procedural error)

OR

- A Physician Review (meaning the dates in question were denied by a CBH physician and the case needs to be reviewed by another CBH physician)

4.8.1.3. Step Three

CBH will notify providers of the result of their appeal verbally and in writing. CBH will comply with the timeframes set forth in 28 Pa. Code. 9.753(c). If the dates in question are denied after a Physician Review, the provider may submit a Second Level Appeal. Instructions for submitting the Second Level Appeal will be provided in the response letter. Please keep in mind that a provider cannot seek a Second Level Appeal if the First Level Appeal was denied due to an Administrative Review.

4.8.2. Second Level Appeals

If the provider disagrees with the First Level Physician Review Appeal decision, the provider may request a Second Level Appeal.

4.8.2.1. Step One

All second level appeals must be submitted in writing no more than 30 days from receipt of the First Level Appeal response letter. Providers do not need to resubmit clinical information.

All second level appeals should be addressed to:

Community Behavioral Health
ATTN: Clinical Appeals Specialist
801 Market Street, 7th Floor
Philadelphia, PA 19107
4.8.2.2. Step Two

A CBH physician who did not previously participate in any decision to deny payment for the service will review the clinical information and notify providers of the result of their appeal in writing. CBH will comply with the timeframes set forth in 28 Pa. Code. 9.753. (c).

The decision of the Second Level Appeal is final.

4.9. Documentation and Significant Incident Reporting

DBHIDS and CBH have instituted a centralized process for reporting all Significant Incidents. CBH serves as a clearinghouse for this process. The policy applies whenever a provider reports a significant incident involving adult and child members of mental health and drug and alcohol services, whether they are CBH members receiving in-plan services or county-funded individuals receiving supplemental funding through the Office of Addiction Services, including those served by the Behavioral Health Special Initiative (BHSI). Please also see Bulletin 18-13.

A Significant Incident is any occurrence of a non-routine event which is inconsistent with standards or practice and has or has the potential to jeopardize the health and/or wellbeing of an individual receiving services. Reportable Significant Incidents include, but are not limited to, the following:

- Death of a member
- Restraints (physical, mechanical, and chemical)
- Seclusion
- Homicide committed by a member who is receiving services or has been discharged within 90 days
- Suicide attempt (with or without medical intervention)
- Act of violence requiring medical intervention (includes intervention provided by staff nurse/physician), by or to a member
- Alleged or suspected abuse (physical, sexual, verbal, financial) of or by a member
- Adverse reaction to medication and/or medication error administered by a provider (includes Medication Assisted Treatment dispensing errors)
- Any physical ailment or injury that requires non-routine medical attention at a hospital on an emergency, outpatient, or inpatient basis (includes visits to urgent care)
- Neglect which results in injury or hospital treatment (committed by provider)
- Elopement from facility:
  - Adults
    - An adult who is out of contact with staff without prior arrangement or who may be in “immediate jeopardy” based on their personal history
• Any time the police are contacted about a missing person or the police independently find and return the member regardless of the time the member was missing
  o Children/adolescents
    • A child/adolescent who is absent from the facility premises without the approval of staff
    • Any time the police are contacted about a missing person
  • Police involvement or arrest (excludes involuntary commitments [302s])
  • Fire, flood, or serious property damage at a site where behavioral health services are delivered or a facility where members reside
  • Infectious disease outbreak at a provider site
  • All non-routine discharges from inpatient, residential rehabilitation (drug and alcohol), children’s residential treatment, detoxification, or methadone maintenance treatment (i.e., administrative/involuntary discharges or leaving a facility against medical or facility advice [AMA, AFA])
  • Any sexual contact involving a minor, non-coerced or otherwise, that occurs at a provider site
  • Presence of contraband (illicit substances and synthetic cannabinoids) at a bed-based facility

4.9.1. Reporting Process

• Any death which occurs at a provider facility must be immediately reported to CBH’s Psychiatric Emergency Services (PES) line. The PES line can be contacted at (215) 413-7171.

• A copy of all reportable incidents must be faxed to the Quality Management Department at (215) 413-7132 on the attached Significant Incident Report form within 24 hours of an incident or upon notification of an incident. All Significant Incident Report forms must indicate the Provider Number in Section 7 if applicable.

  o Exceptions:
    • Reports of children who have not returned home or to the facility within 4 hours must be reported immediately.
    • All Long-Term Structured Facilities (LTSR) and Community Residential Rehabilitation programs (CRR) will only enter the reportable incident into the Enterprise Incident Management (EIM) system within 24 hours of the occurrence.

• When an internal investigation is warranted, the provider must submit a copy of the investigative report to CBH within 14 days of the incident. Investigative reports must clearly document how the incident was investigated and the findings of the
investigation, including any corrective actions taken to prevent further occurrence. Investigative reports may be faxed to the Quality Management Department at (215) 413-7132 or mailed to:

Community Behavioral Health
Quality Management Department
801 Market Street, 7th Floor
Philadelphia, PA 19107

NOTE: If an investigation is not completed within the designated 14 days, the provider must notify the Quality Management Department of the investigation status, including preliminary findings, and a projected investigation completion date.

- Incidents involving alleged physical abuse, sexual abuse, and/or neglect of children must be reported to the Pennsylvania Department of Human Services (PA DHS). Providers are mandated by the PA DHS to report incidents directly by calling the Commonwealth’s Childline at (800) 932-0313 or by submitting the information via the online portal here.
  
  o For incidents involving alleged abuse or neglect, providers must submit the PA DHS notification letter (indicated/unfounded) to the Quality Management Department upon receipt. If the provider has not received a notification letter, but has received verbal communication from the PA DHS, the provider must notify the Quality Management Department of the date the verbal determination was provided and the name of the investigator providing the verbal determination. If an allegation is deemed indicated or a Licensing/Approval/Registration Inspection Summary Violation is issued, the provider must submit a copy of the Licensing/Approval/Registration Inspection Summary Violation and the corresponding Corrective Action Plan submitted to the PA DHS.

- Incidents involving alleged physical abuse, sexual abuse, and/or neglect of an adult between 18 and 59 years old, who has a physical or mental impairment that substantially limits one or more major life activities, must be reported to the PA DHS. Providers are mandated by the PA DHS to report incidents directly by calling the Commonwealth’s Protective Services Hotline at (800) 490-8505.

- A missing person who may be at-risk should be reported to the Acute Services Mental Health Delegates by calling 215-685-6440, and a police report should be filed. The Acute Services Mental Health Delegate will notify the Crisis Response Center (CRC), so that they can notify the provider if the member presents at a CRC.
### 4.9.2. Where to Send Significant Incident Reports

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>All reportable incidents must be faxed to CBH Quality Management</td>
<td>Fax: (215) 413-7132</td>
</tr>
<tr>
<td>Investigative reports may be faxed or mailed to CBH Quality Management</td>
<td>Fax: (215) 413-7132&lt;br&gt;Mail: Community Behavioral Health Quality Management Department 801 Market Street, 7th Floor Philadelphia PA, 19017</td>
</tr>
<tr>
<td>Incidents involving the suspected abuse/neglect of children must be reported to the Commonwealth’s Childline.</td>
<td>Childline phone number: (800) 932-0313&lt;br&gt;Online: <a href="https://www.compass.state.pa.us/cwis/public/home">https://www.compass.state.pa.us/cwis/public/home</a></td>
</tr>
<tr>
<td>An at-risk missing person should be reported to the Acute Services Mental Health Delegates.</td>
<td>Mental Health Delegate phone number (215) 685-6440</td>
</tr>
<tr>
<td>Death of a member at a provider facility must be reported to the CBH PES Line.</td>
<td>PES Line phone number (215) 413-7185</td>
</tr>
<tr>
<td>Incidents involving the suspected abuse/neglect of an adult between 18 and 59 years old, who has a physical or mental impairment that substantially limits one or more major life activities, must be reported to the Commonwealth’s Protective Services.</td>
<td>Protective Services Hotline at (800) 490-8505</td>
</tr>
</tbody>
</table>

### 4.10. “Provider Preventable Conditions” Reporting

In accordance with the PA Department of Human Services’ (DHS) Medical Assistance Bulletin, titled "Provider Preventable Conditions" (July 1, 2012), providers must submit a Self-Report Form to Community Behavioral Health upon the identification of a Provider Preventable Condition, to include HealthCare-Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC’s). Please see the Bulletin, available here. The DPW Bulletin clearly defines...
PPC, HCACs, OPPCs, and the self-reporting requirement in more detail and includes a direct link to the Self Report Form.
5. CLAIMS

5.1. Submission Policies and Procedures

Local, state, and federal governments seek clinical and cost data to carefully monitor the use of public health care funds. In order to comply with governmental mandates for information, CBH must obtain detailed claims data from providers.

Timely submission of accurate claims information is an essential part of the provider’s role in delivering care, tracking clinical activity, and maintaining fiscal stability. CBH is committed to working with providers to help the process go as smoothly and efficiently as possible. Providers may contact the Claims Hotline at (215) 413-7125 with specific questions about claims. All in-network providers are assigned a claims analyst who can assist in navigating the claims processing system.

This chapter explains the procedure for providers to bill CBH for services rendered.

5.1.1. Claims Categories and Timeframes

A Clean Claim is a claim submitted with all essential provider or third-party details; it can therefore be processed “as is.” A provider must submit a clean claim no more than 90 days after the date of service.

Unclean Rejected Claims are claims returned to the provider or third party with requests for additional information. Unclean Rejected Claims must be resubmitted as clean claims, still within the 90-day timeframe that starts with the date of service.

Clean Rejected Claims are claims returned to the provider or third party due to ineligible recipient or service.

Coordination of Benefits refers to the process a provider pursues to obtain a final determination from the primary payer (when members have a primary insurance and CBH is secondary). The final determination must be dated no more than 180 days following the date of service, and providers must submit a clean claim within 90 days after receipt of determination from the primary payer.

CBH reserves the right to make no payments for claims received beyond the time requirements stated herein.
5.1.2. Claims Process

Verify Member Eligibility here

Is CBH the only coverage?

Yes

Obtain authorization number via:
- BAN from Schedule A, or
- Authorization number from OSS, or
- Authorization number from CCM

Inpatient

Electronic

Paper

837 Institutional

UB-04

No

Pursue Coordination of Benefits, i.e. bill primary payer for services.

After the benefits have been coordinated, the claims should be submitted to CBH along with the EOB and/or final determination letter.

Outpatient/Community Based

Electronic

Paper

837 Professional

CMS 1500 (02-12)
5.1.3. Before You Bill CBH

5.1.3.1. Verify Eligibility

In order to receive payment for services rendered, providers must check member eligibility. Providers can access the DHS daily eligibility file by phone by calling 800-766-5387. Providers may also use the various methods described on the DHS website under Eligibility Verification Information here.

5.1.3.2. Obtain Authorization Number

All claims must include the appropriate authorization number for services rendered. For services requiring a prior authorization, providers will obtain the authorization number from the CBH Clinical Care Manager (CCM). For services that can begin without a prior authorization but require a specific authorization number for payment, providers will obtain this number from the CBH Operations Support Services Coordinator (OSS). For all other services, providers will obtain a Blanket Authorization Number (BAN) corresponding to the service as per the Schedule A. For a complete list of types of authorizations and related processes, see Section 3.0, “Authorizations.” A claim form without a required authorization number will be rejected (if filed manually, the claim will be returned to the provider to be corrected).

5.1.3.3. Determine Claim Form to be Submitted

Providers can choose to submit electronic or manual claims. Filing claims electronically helps providers minimize data entry errors after submission, ensure information is legible, and expedite the processing of their claims. In order to submit claims electronically, the provider must have the appropriate software and complete a claims test process. The four types of claims forms are:

- 837I Institutional (electronic claims form for inpatient levels of care)
- 837P Professional (electronic claims form for community-based levels of care)
- UB-04 (paper claims form for inpatient levels of care)
- CMS-1500 (paper claims for community-based levels of care)

Companion Guides for electronic claims submissions can be found here.

5.1.3.4. Ensure Pricing and Information Modifiers are added as needed

Certain services (both authorized and non-authorized) require pricing and/or information modifiers. Please refer to Schedule A to identify the services that require modifiers. When completing the claim form, place the pricing modifier in the first modifier field and the information modifier in the second modifier field. There are sample claim forms at the end of this chapter for reference.
5.1.3.5. Enter Date Information Correctly

One of the most common causes of claims rejection is entering date information incorrectly. When entering inpatient treatment days, please enter the date of admission as the "begin date" and the day of discharge as the "service end" date, but count the length of the stay according to the number of "nights" of stay. The day of discharge is not counted as a day of treatment.

When completing the UB-04 or CMS-1500 (02-12) claim forms, the provider must use the complete four-digit year. For example, enter the full year as “2017” rather than “’17.” Any manual claims submitted without the full-year date format will be returned.

5.1.3.6. Ensure Appropriate Billing for Consecutive Days (Span Billing)

When billing for per diem services that were provided on consecutive days, the provider does not need to enter each individual date of service on the claim form. Instead, a provider may “span bill” the entire period of service. “Span billing” means that the provider notes on the claim the dates that treatment began and ended and the number of units of service provided. Both the "service begin" date and the "service end" date must be within the authorized period. The day of discharge from inpatient treatment does not count for units of service.

5.1.3.7. Ensure Appropriate Billing for Non-Consecutive Days

When billing for non-consecutive days within a particular authorization period, the provider must note each date of service individually. Do not span date for non-consecutive days of service or non-per diem services. Such claims will be rejected.

5.1.3.8. Follow Requirements for Provider Signature

The provider rendering the service must sign all invoices for claims, whether they are submitted electronically or manually. The signature certifies that the service has been rendered according to the Medical Assistance (MA) Billing Guide. All claims received that do not meet the provider signature requirements will not be processed. These claims will be returned to the provider for correction.

The following are acceptable methods of signing claims:

- *For claims submitted via secured file transfer:*
  
  An electronic certification is incorporated into the submission process.
• **For paper claims:**

   An actual handwritten authorization signature of the provider directly on the signature line of the invoice. The provider’s initials or printed name are not acceptable signatures.

   Signature stamp of the provider placed directly over the signature line of the invoice is acceptable, if the provider authorizes its use and assumes responsibility for the information in the invoice.

   An actual handwritten authorization signature of the provider directly on the MA-307 Invoice Transmittal Form, a form used to certify that treatment services have been delivered by the provider for the attached claim(s).

   [See the form here.](#)

5.2. Overview of Special Circumstances

5.2.1. Third Party Liability (TPL) Billing

Third Party Liability (TPL) refers to entities other than CBH, such as Medicare and Blue Cross, that may be liable for all or part of a member’s healthcare expenses. When third-party resources are available to cover behavioral health, services provided to Medicaid recipients, CBH is the “payor of last resort.”

Once the provider determines that a member has other insurance, the bill should be sent first to the primary insurance carrier(s) for payment consideration. CBH will consider for payment all balances for behavioral health services that are unpaid by the other insurance carriers.

Before CBH can consider a TPL claim for payment, the provider must submit the completed claim form, the Explanation of Benefits (EOB), and/or the denial letter(s) sent to the provider by any and all other carriers.

The claim must be fully considered and resolved with the primary carrier before it is billed to CBH. If the services are rejected by the primary carrier due to missing, incomplete, or incorrect information, the service must be re-billed to the primary carrier before CBH will consider payment. The EOB and/or the denial letter(s) must be the final determination. If the primary carrier rejects the claim, the primary carrier’s internal appeals process must be exhausted before CBH will consider the claim for payment.

It is important that the provider’s claim matches the EOB information. This applies to the billed amount, beginning and ending dates, Medicare approved amount, other insurance paid
amount, Medicare deductible, and the Medicare co-insurance amount. Primary Insurance Company proprietary codes for coordination of benefits are no longer accepted by CBH. EOB data sent electronically and/or on paper must contain the Claim Adjustment Group Codes, Claim Adjustment Reason Code (CARC), and/or the Remittance Advice Remark Code (RARC) if the CARC code requires it. This information must be submitted for each claim line on the EOB billed to CBH. See Bulletin 15-02 and the forms below.

If the EOB form is larger than letter size, please reduce the EOB to 8-1/2” by 11” in size. Please include a copy of the EOB with each claim. Do not attach several claims to one EOB.

5.2.2. TPL Medicare Inpatient Claims

When submitting Medicare and other insurance carriers’ third-party liability claims for one inpatient stay, CBH requires separate claim(s) for each authorization number issued for the various levels of care during the stay. Be sure to use the appropriate authorization number on each claim for the authorized period.

Once a provider receives the Medicare or other insurance EOB, complete the 837I or UB-04 Claim Form for each authorized period. The billed charges must be for the authorized period. The UB-04 Claim Form requires that you attach a copy of the EOB with the Claim Adjustment Group Codes, CARC, and the RARC if the CARC code requires it. This information should be included with each claim prior to submitting to CBH. It is essential to submit these claim(s) together to ensure proper processing. If there is a deductible, coinsurance, lifetime reserve day, or copay that applies to all of the claim, it must be prorated accordingly on each claim.

5.2.3. Post-Payment Recoveries

According to the City of Philadelphia’s contract with the Pennsylvania Department of Human Services, CBH is required to take all reasonable measures to ensure that CBH is the payor of last resort when other third-party resources are available to cover the cost of medical services.

When CBH becomes aware of payments made on behalf of a CBH member who has valid third-party resources, post-payment recoveries will be pursued. If a provider is identified as having received an inappropriate payment, a post-payment recovery letter will be sent to the provider. Providers who receive such letters are required to bill the primary carrier(s) and resubmit the claim along with a copy of the recovery letter and the final determination for CBH review and processing. These should not be submitted as regular adjustments. They should be sent to the attention of the CBH staff member that is handling the recovery. If CBH does not receive a response within 60 days from the date of the letter on the status of the recovery, CBH will automatically back out the claims. The provider has 90 days from the date the payment has been retracted to submit the claims and EOB and/or final determination letter with Claim Adjustment Group Codes, CARC, and the RARC (if required by the CARC) to CBH for processing.
The Pennsylvania Department of Human Services (DHS)) will pursue all cases that CBH is unable to recover.

5.2.4. Exhausted Medicare Inpatient Lifetime Psychiatric Days

If the member’s lifetime psychiatric days have been exhausted, submit both the Medicare Part A and Part B EOBs with the Claim Adjustment Group Codes, CARC, and the RARC if the CARC code requires it on the claim.

The Medicare Part A EOB must show the Medicare Lifetime Exhaustion rejection code (i.e. PR119 or PR35). If the provider does not have the Medicare Part A EOB, the provider must submit the Health Insurance Query Access (HIQA) Inquiry Form from the Medicare system. However, the Medicare HIQA Inquiry Form will only be accepted if the inquiry date is the admission date or the date on which the benefits were exhausted during the stay, or it should be covered in the Date of Earliest Billing (DOEBA) or Date of Last Billing (DOLBA) time period.

For Medicare Part B, the provider must use the appropriate value code in the 837I or Field 39 on the UB-04 claim form to indicate the Medicare Part B payment. The Part B value amount on each claim must reflect only the portion that applies to the dates of services on each claim.

5.2.5. Medicare Remittance Advice(s)/Other Insurance Carrier Remittance Advice(s)

For CBH to process Medicare claims correctly, the following information is needed on the remittance advice(s):

1. From and Through Date
2. Total Days (Cost Days)
3. Covered Days
4. Non-Covered Days
5. Total Charges
6. Covered Charges
7. Non-Covered Charges
8. Claim Adjustment Group Codes, CARC, and the RARC if the CARC requires it.

For CBH to process Commercial Insurance Carriers and Medicare Advantage Plans claims, the following information is needed on the remittance advice(s):

1. From and Through Date
2. Total Days
3. Covered Days
4. Non-Covered Days
5. Claim Adjustment Group Codes, CARC, and the RARC if the CARC requires it.

If you or your vendor are unable to include the CARC and the RARC data on your remittance advice(s), please add the information to your EOB. This will help to ensure that your claim(s) are processed and paid correctly. Otherwise, CBH will reject your claim to allow the provider to correct and resubmit the claim(s) with all of the necessary requirements. The Committee on Operating Rules for Information Exchange has developed different business scenarios for the usage of CARCs and RARCs, which can be found online here.

5.2.6. ACT 62 Pennsylvania Mandate for Autism

As of 7/1/2009, the PA DHS requires many private health insurance companies to cover the cost of diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for children under the age of 21. The amount is adjusted annually, and the cap is currently $38,276, with coverage subject to copayment, deductible, coinsurance, and other exclusions of limitations to the same extent as other medical services covered by the policy; however, some plans do not impose any cap. Be sure to check with the health plan first. The Act 62 coverage mandate applies to employer group health insurance policies (including HMO’s and PPOs) issued in Pennsylvania to groups of 51 or more employees. Act 62 does not apply to policies that are issued outside of Pennsylvania or that are “self-funded” and therefore subject to the Employer Retirement Income Security Act of 1974 (ERISA).

It is the responsibility of the provider to contact the parents and the primary carrier of each member with an Autism Spectrum Disorder to determine whether or not they have the Pennsylvania Mandate for Autism, ACT 62. If the member has the ACT 62 mandate, the benefits must be coordinated with the primary carrier for all levels of care, except the ones noted below, which CBH will continue to pay as the primary. Once the EOB with the CARC, RARC, and/or Final Determination letter is obtained, the claims must be submitted electronically or manually with a copy of an EOB/Final Determination letter attached to each claim.

If a member is being seen, and CBH does not have a record of the ACT 62 benefit, and CBH finds the member does have the ACT 62 benefits, then all the claims will be identified for which CBH should not have paid as the primary carrier and the claim(s) will be backed out as noted in the Post Payment Recovery section.

CBH will continue to pay as the primary for the following levels of care:

- 450
- 550
- 700 All except for LOC 700-22,700-23,700-30 and 700-31 (These LOC should be coordinated with the primary).
• 800 All except for LOC 800-32 (These LOC should be coordinated with the primary).
• 900

All other levels of care must be coordinated with the primary carrier before they can be considered for payment by CBH.

5.3. Methods in Billing CBH

5.3.1. Electronic Claims

CBH prefers all claims be submitted via Electronic Data Interchange. Filing claims electronically helps providers minimize data entry errors after submission, ensure information is legible, and expedite the processing of their claims. CBH has issued Companion Guides to assist with billing EDI.

5.3.2. Filing Manual Claims

Providers filing manual claims must use one of two printed claim forms designated for that purpose. Please refer to Schedule A of your CBH Provider Agreement for all contractual services and the appropriate CPT codes, pricing and information modifiers, and BANs. This section provides specific information about which forms are to be submitted for the specific types of treatment. It also provides examples of each form.

All manual claims must be sent via the U.S. Postal System or delivery service to:

CBH, Claims Department
801 Market Street, 7th Floor
Philadelphia, PA 19107

Hand-deliveries will not be accepted.

5.3.2.1. Inpatient Claims, UB-04 Claim forms

All inpatient hospital or RTF-Accredited claims must be submitted using the UB-04 Claim Form.

5.3.2.2. Outpatient Claims, CMS-1500 (02-12) Claim form

All other claims must be submitted using the CMS-1500 (02-12) Claim Form.
5.3.2.3. Completion of the UB-04 Claim Form

The UB-04 Claim Form is used when an inpatient (hospital inpatient or RTF Accredited) stay has been provided. **Revenue codes** are used **exclusively** on the UB-04 claim form. Please see the UB-04 example below or **see online here**.

Listed below are the required fields that **must** be completed on the UB-04 Claim Form, which are the same required fields for 837I Institutional. Remember that all services require an authorization number for billing and only one authorization number per claim form is allowed. **When an item is "not applicable," do not use zero. Leave it blank. See the PROMISe desk reference for assistance in the completion of the UB-04 Claim form.** Please see the reference below or **see online here**.

(continued)
<table>
<thead>
<tr>
<th>Form Locator</th>
<th>Description for Paper</th>
<th>USAGE</th>
<th>175 Companion Code for EDI</th>
<th>ASC 8.17 v5010A2 Loop, Segment for EDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Billing Provider, Name, Address and Telephone Number</td>
<td>REQUIRED</td>
<td></td>
<td>Loop 2010AA, NM1, 8503, N3 segment, N4 segment</td>
</tr>
<tr>
<td>02</td>
<td>Pay-to-Name and Address (required when different from form locator 01)</td>
<td>SITUATIONAL</td>
<td></td>
<td>Loop 2010AB, NM1, 8503, N3 segment, N4 segment</td>
</tr>
<tr>
<td>03a</td>
<td>Patient Control Number</td>
<td>REQUIRED</td>
<td>It is a requirement that the value submitted MUST be unique for EACH individual claim.</td>
<td>Loop 2300, CLM01</td>
</tr>
<tr>
<td>03b</td>
<td>Medical Record Number</td>
<td>SITUATIONAL</td>
<td></td>
<td>Loop 2300, REF, EA/02</td>
</tr>
<tr>
<td>04</td>
<td>Type of Bill</td>
<td>REQUIRED</td>
<td>Code values: 0 Non-Payment/Zero, 1 Admit Through Discharge Claim, 2 Interim - First Class, 3 Interim - Continuing Claim, 4 Interim - Last Claim, 5 Void/Cancel of Prior Claim, Recommended value is &quot;1&quot; to indicate an &quot;Original&quot; claim unless one of the other codes is more appropriate. *See notes on declaration of Discharge Time (Loop 2300, DTP03)</td>
<td>Loop 2300, CLM05-1, CLM05-3</td>
</tr>
<tr>
<td>05</td>
<td>Federal Tax ID</td>
<td>REQUIRED</td>
<td></td>
<td>Loop 2010AA, NM108, REF, EII02</td>
</tr>
<tr>
<td>06</td>
<td>Statement Covers Period (MM/DD/YY)</td>
<td>REQUIRED</td>
<td></td>
<td>Loop 2300, DTP434/03</td>
</tr>
<tr>
<td>06b</td>
<td>Patient Name</td>
<td>REQUIRED</td>
<td></td>
<td>Loop 2010BA, NM1, 8503, 04, 05, 07</td>
</tr>
<tr>
<td>06c-d</td>
<td>Patient Address a) State b) City c) State d) ZIP Code</td>
<td>REQUIRED</td>
<td></td>
<td>Loop 2010BA, N001, N401, 02, 03, 04</td>
</tr>
<tr>
<td>10</td>
<td>Patient Birth Date</td>
<td>REQUIRED</td>
<td></td>
<td>Loop 2300, EMG02</td>
</tr>
<tr>
<td>11</td>
<td>Patient's sex</td>
<td>REQUIRED</td>
<td></td>
<td>Loop 2300, EMG02</td>
</tr>
<tr>
<td>12</td>
<td>Admission/Start of Care Date</td>
<td>REQUIRED</td>
<td></td>
<td>Loop 2300, DTP435/03</td>
</tr>
<tr>
<td>13</td>
<td>Admission Hour</td>
<td>SITUATIONAL</td>
<td></td>
<td>Loop 2300, DTP435/03</td>
</tr>
<tr>
<td>14</td>
<td>Admission Type</td>
<td>SITUATIONAL</td>
<td>See UB-04 Desk Reference for Hospitals</td>
<td>Loop 2300, CL101</td>
</tr>
<tr>
<td>15</td>
<td>Source of Admission</td>
<td>REQUIRED</td>
<td>Code Values: 1 Non-Health Care Facility Point of Origin, 2 Clinic or Physician's Office, 3 Transfer from Hospital (Different Facility), 4 Transfer from Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or Assisted Living Facility (ALF), 5 Transfer from Health Care Facility, 6 Court/Law Enforcement, 7 Information Not Available, CBN will ONLY accept numeric values for this data segment.</td>
<td>Loop 2300, CL102</td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour</td>
<td>SITUATIONAL</td>
<td>If Discharge Time is declared then the Type of bill (CLM5-5) value MUST be &quot;1&quot; or &quot;4&quot;</td>
<td>Loop 2300, DTP066/03</td>
</tr>
<tr>
<td>17</td>
<td>Patient Discharge Status</td>
<td>REQUIRED</td>
<td>See UB-04 Desk Reference for Hospitals</td>
<td>Loop 2300, CL103</td>
</tr>
<tr>
<td>Form Locator #</td>
<td>Description for Paper</td>
<td>UDAOF</td>
<td>KNH Component Code for EDI</td>
<td>ASC 837</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------</td>
<td>-------</td>
<td>--------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>16-28</td>
<td>Condition Codes</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>29</td>
<td>Assistant Data</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>31-34</td>
<td>Occurrence Code/Date</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>35-36</td>
<td>Occurrence Span Code/Date</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>39-41</td>
<td>Value Code/Amount</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Value codes must be entered in numeric sequence, starting in Form Locator 39a through 41a, 39b through 41b, 39c through 41c, and 39d through 41d. See UB-04 Desk Reference for Hospitals.</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>42</td>
<td>Revenue Code</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>43</td>
<td>Revenue Description</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>44</td>
<td>HiPCGS/Rate/HPES Code</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>45</td>
<td>Service Date</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>46 (23)</td>
<td>Creation Date</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>46</td>
<td>Service/Units</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>47 (23)</td>
<td>Total Charges</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>50a-c</td>
<td>Payee Name</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td></td>
<td>Identification Code</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>51a-c</td>
<td>Other Payor Identifier</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>52a-c</td>
<td>Release of Information</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>53a-c</td>
<td>Assignment of Benefits Certification</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>54a-c</td>
<td>Prior Payment Amounts</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>55a-c</td>
<td>Estimated Amount Due</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>56</td>
<td>National Provider Identifier (NPI)</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>57c-c</td>
<td>Billing Provider Specialty Information</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>58a-c</td>
<td>Insured's Name</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>58b-c</td>
<td>Other Insured's Name</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>60a-c</td>
<td>Subscriber Identification Code</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Code</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>67a-q</td>
<td>Diagnosis</td>
<td>REQUIRED</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>70a-c</td>
<td>Patient Reason for Visit</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>71</td>
<td>Diagnosis Related Group (DRG) Code</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>72a-c</td>
<td>External Cause of Injury Code</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td>74</td>
<td>Principal Procedure Code</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
<tr>
<td></td>
<td>Principal Procedure Date</td>
<td>SITUATIONAL</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
<td>Loop 2300, H01-2 (H011-1+BG)</td>
</tr>
</tbody>
</table>
### UB-04 Desk Reference for Hospitals

These values are valid for paper claim submission on the UB-04 Claim Form only.

<table>
<thead>
<tr>
<th>Condition Codes (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X3 Hysterectomy Acknowledgment Form (MA 30)</td>
</tr>
<tr>
<td>X4 Medicare Denial on File</td>
</tr>
<tr>
<td>X5 Third Party Payment on File</td>
</tr>
<tr>
<td>X6 Restricted Recipient Referral Form</td>
</tr>
<tr>
<td>X7 Medical Documentation for Hysterectomy</td>
</tr>
<tr>
<td>Y0 Newborn Eligibility</td>
</tr>
<tr>
<td>Y3 Copay Not Collected</td>
</tr>
<tr>
<td>Y6 Third Party Denial on File</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Status Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Form Locator 17)</td>
</tr>
<tr>
<td>01 Discharge to home or self-care – Routine Discharge</td>
</tr>
<tr>
<td>02 Discharged/transferred to another hospital for inpatient care</td>
</tr>
<tr>
<td>03 Discharged/transferred to a skilled nursing facility</td>
</tr>
<tr>
<td>04 Discharged/transferred to an intermediate care facility</td>
</tr>
<tr>
<td>05 Discharged/transferred to another type of institution for inpatient care</td>
</tr>
<tr>
<td>07 Left against medical advice or discontinued care</td>
</tr>
<tr>
<td>20 Expired</td>
</tr>
<tr>
<td>30 Still a patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occurrence Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Form Locators 31–34)</td>
</tr>
<tr>
<td>01 Auto Accident</td>
</tr>
<tr>
<td>02 No Fault Accident</td>
</tr>
<tr>
<td>03 Accident/Tort Liability</td>
</tr>
<tr>
<td>04 Accident/Employment Related</td>
</tr>
<tr>
<td>05 Other Accident</td>
</tr>
<tr>
<td>06 Crime Victim</td>
</tr>
<tr>
<td>24 Date Insurance Denied</td>
</tr>
<tr>
<td>25 Date Benefits Terminated By Primary Payer</td>
</tr>
<tr>
<td>A3 Benefits Exhausted</td>
</tr>
<tr>
<td>B3 Benefits Exhusted</td>
</tr>
<tr>
<td>C3 Benefits Exhausted</td>
</tr>
<tr>
<td>DR Disaster Related</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occurrence Span Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Form Locator 35–36)</td>
</tr>
<tr>
<td>71 Prior Stay Dates</td>
</tr>
<tr>
<td>74 Non-covered Level of Care/Leave of Absence (JCAHO RTF only)</td>
</tr>
<tr>
<td>MR Disaster Related</td>
</tr>
</tbody>
</table>

#### Type of Bill Codes

**INPATIENT ONLY:**

<table>
<thead>
<tr>
<th>First Digit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Type of Facility – Hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Second Digit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Bill Classification – Inpatient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Third Digit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Non Payment/Zero Claim</td>
</tr>
<tr>
<td>1 Admit through Discharge Claim</td>
</tr>
<tr>
<td>2 Interim – First Claim</td>
</tr>
<tr>
<td>7 Replacement of Prior Claim</td>
</tr>
<tr>
<td>8 Void/Cancel of Prior Claim</td>
</tr>
</tbody>
</table>

**OUTPATIENT ONLY:**

<table>
<thead>
<tr>
<th>First Digit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Type of Facility – Hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Second Digit</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Bill Classification – Outpatient</td>
</tr>
<tr>
<td>4 Bill Classification – Hospital Special Treatment Room</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Third Digit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Nonpayment/Zero Claim</td>
</tr>
<tr>
<td>1 Admit through Discharge Claim</td>
</tr>
<tr>
<td>7 Replacement of Prior Claim</td>
</tr>
<tr>
<td>8 Void/Cancel of Prior Claim</td>
</tr>
</tbody>
</table>

#### Admission Type

<table>
<thead>
<tr>
<th>Emergency Admission</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Urgent Admission</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Elective Admission</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Newborn Admission</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Trauma Admission (Emergency Admission)</th>
</tr>
</thead>
</table>

#### Condition Codes

<table>
<thead>
<tr>
<th>Condition Codes (Form Locators 18–28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 Condition is Employment Related</td>
</tr>
<tr>
<td>03 Patient is Covered by Insurance Not Reflected Here</td>
</tr>
<tr>
<td>05 Lien Has Been Filed</td>
</tr>
<tr>
<td>60 Day Outlier</td>
</tr>
<tr>
<td>77 Provider accepts or is obligated/required to a contractual agreement or law to accept payment by primary payer as payment in full</td>
</tr>
</tbody>
</table>

<p>| A1 EPSDT |
| A4 Family Planning Outpatient |
| AA Abortion Consent (MA 3) – Rape |
| AB Abortion Consent (MA 3) – Incest |
| AD Abortion Consent (MA 3) – Danger to Life |
| AI Sterilization Patient Consent Form (MA 31) |
| B3 Pregnancy |
| X2 Medicare EOMB on File |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06</td>
<td>Medicare Blood Deductible (Paper Claims Only)</td>
</tr>
<tr>
<td>14</td>
<td>No Fault, Including Auto/Other</td>
</tr>
<tr>
<td>15</td>
<td>Worker's Compensation</td>
</tr>
<tr>
<td>16</td>
<td>PHS or Other Federal Agency</td>
</tr>
<tr>
<td>38</td>
<td>Medicare Blood Deductible Pints Furnished</td>
</tr>
<tr>
<td>39</td>
<td>Medicare Blood Deductible Pints Replaced</td>
</tr>
<tr>
<td>47</td>
<td>Any Liability Insurance</td>
</tr>
<tr>
<td>66</td>
<td>Patient Pay</td>
</tr>
<tr>
<td>73</td>
<td>Sequestration Adjustment Amount</td>
</tr>
<tr>
<td>80</td>
<td>Covered Days</td>
</tr>
<tr>
<td>81</td>
<td>Non-Covered Days</td>
</tr>
<tr>
<td>82</td>
<td>Co-Insurance Days</td>
</tr>
<tr>
<td>83</td>
<td>Lifetime Reserve Days, Inpatient Only</td>
</tr>
<tr>
<td>A1</td>
<td>Deductible Payer A</td>
</tr>
<tr>
<td>A2</td>
<td>Coinsurance and Lifetime Reserve Payer A</td>
</tr>
<tr>
<td>A7</td>
<td>Copayment, Payer A</td>
</tr>
<tr>
<td>B1</td>
<td>Deductible Payer B</td>
</tr>
<tr>
<td>B2</td>
<td>Coinsurance and Lifetime Reserve Payer B</td>
</tr>
<tr>
<td>B7</td>
<td>Copayment, Payer B</td>
</tr>
<tr>
<td>X0</td>
<td>Medicare Part B</td>
</tr>
</tbody>
</table>

**Patient's Relationship to Insured Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Spouse</td>
</tr>
<tr>
<td>04</td>
<td>Grandparent</td>
</tr>
<tr>
<td>05</td>
<td>Grandchild</td>
</tr>
<tr>
<td>07</td>
<td>Nieco/Nephew</td>
</tr>
<tr>
<td>10</td>
<td>Foster Child</td>
</tr>
<tr>
<td>15</td>
<td>Ward of the Court</td>
</tr>
<tr>
<td>17</td>
<td>Step Child</td>
</tr>
<tr>
<td>18</td>
<td>Patient Is Insured</td>
</tr>
<tr>
<td>19</td>
<td>Natural Child/Insured Financial Responsibility</td>
</tr>
<tr>
<td>20</td>
<td>Employee</td>
</tr>
<tr>
<td>21</td>
<td>Unknown</td>
</tr>
<tr>
<td>22</td>
<td>Handicapped Dependent</td>
</tr>
<tr>
<td>23</td>
<td>Sponsored Dependent</td>
</tr>
<tr>
<td>24</td>
<td>Minor Dependent of a Minor Dependent</td>
</tr>
<tr>
<td>29</td>
<td>Significant Other</td>
</tr>
<tr>
<td>32</td>
<td>Mother</td>
</tr>
<tr>
<td>33</td>
<td>Father</td>
</tr>
<tr>
<td>36</td>
<td>Emancipated Minor</td>
</tr>
<tr>
<td>39</td>
<td>Organ Donor</td>
</tr>
<tr>
<td>40</td>
<td>Cadaver Donor</td>
</tr>
<tr>
<td>41</td>
<td>Injured Plaintiff</td>
</tr>
<tr>
<td>43</td>
<td>Natural Child/Insured does not have Financial</td>
</tr>
<tr>
<td></td>
<td>Responsibility</td>
</tr>
<tr>
<td>53</td>
<td>Life Partner</td>
</tr>
<tr>
<td>58</td>
<td>Other Relationship</td>
</tr>
</tbody>
</table>

*Please note that the Patient's Relationship to Insured Codes are the same codes used electronically in the 837/1.*
5.3.2.4. Completion of the CMS-1500 (02-12) Claim Form

The CMS-1500 (02-12) Claim Form is used when an outpatient service has been provided. Current Procedure Terminology (CPT Codes) or Healthcare Common Procedure Coding System (HCPCS Codes) are only allowed on this claim form. Please see the CMS-1500 (02-12) example below or see online here.

Listed below are the required fields that must be completed on the CMS-1500 (02-12) Claim Form, which are the same required fields for 837P Professional. Remember that all services require an authorization number for billing and only one authorization number per claim form is allowed.
<table>
<thead>
<tr>
<th>Item Number</th>
<th>Description for Paper</th>
<th>Usage</th>
<th>Loop ID for EDI</th>
<th>837P Segment/Data Element Name for EDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other</td>
<td>Required</td>
<td>2000B</td>
<td>SBR09 Claim Filing Indicator Code</td>
</tr>
<tr>
<td>1a</td>
<td>Insured's ID Number</td>
<td>Required</td>
<td>2010BA</td>
<td>NM109 Subscriber Primary Identifier</td>
</tr>
<tr>
<td>2</td>
<td>Patient's Name</td>
<td>Required</td>
<td>2010CA or 2010BA</td>
<td>NM103 Patient Last Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM104 Patient First Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM105 Patient Middle Name or Initial</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM107 Patient Name Suffix</td>
</tr>
<tr>
<td>3</td>
<td>Patient's Birth Date, Sex</td>
<td>Required</td>
<td>2010CA or</td>
<td>DMG02 Subscriber Birth Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DMG03 Subscriber Gender Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N302 Patient Address Line</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N401 Patient City Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N402 Patient State Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N403 Patient Postal Zone or ZIP Code</td>
</tr>
<tr>
<td>5</td>
<td>Patient's Address</td>
<td>Required</td>
<td>2010CA</td>
<td>N401 Patient City Name</td>
</tr>
<tr>
<td>6</td>
<td>Patient Relationship to Insured</td>
<td>Required</td>
<td>2000B</td>
<td>SBR02 Individual Relationship Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PAT01 Individual Relationship Code</td>
</tr>
<tr>
<td>9</td>
<td>Other Insured's Name</td>
<td>Situational, if TPL information present then Required</td>
<td>2330A</td>
<td>NM103 Other Insured Last Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM104 Other Insured First Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM105 Other Insured Middle Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM107 Other Insured Name Suffix</td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured's Policy or Group Number</td>
<td>Situational, if TPL information present then Required</td>
<td>2320</td>
<td>SBR03 Insured Group or Policy Number</td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name</td>
<td>Situational, if TPL information present then Required. You Must use the Carrier Name listed in Appendix A of the CBH Companion Guide</td>
<td>2320</td>
<td>SBR04 Other Insured Group Name</td>
</tr>
<tr>
<td>Item Number</td>
<td>Description for Paper</td>
<td>Usage</td>
<td>Loop ID for EDI</td>
<td>837P Segment / Data Element Name for EDI</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------</td>
<td>------------</td>
<td>-----------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>10a</td>
<td>Is Patient's Condition Related to: Employment</td>
<td>Required</td>
<td>2300</td>
<td>CLM11 Related Cause Code</td>
</tr>
<tr>
<td>10b</td>
<td>Is Patient's Condition Related to: Auto Accident</td>
<td>Required</td>
<td>2300</td>
<td>CLM11 Related Cause Code</td>
</tr>
<tr>
<td>10c</td>
<td>Is Patient's Condition Related to: Other Accident</td>
<td>Required</td>
<td>2300</td>
<td>CLM11 Related Cause Code</td>
</tr>
<tr>
<td>11d</td>
<td>Is there another Health Benefit Plan?</td>
<td>Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient's or Authorized Person's Signature</td>
<td>Required</td>
<td>2300</td>
<td>CLM09 Release of Information Code</td>
</tr>
<tr>
<td>13</td>
<td>Insured's or Authorized Persons Signature</td>
<td>Required</td>
<td>2300</td>
<td>CLM08 Benefits Assignment Certification Indicator</td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Provider or Other Source</td>
<td>Required</td>
<td>2310A (referring)</td>
<td>NM103 Referring Provider Last Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM104 Referring Provider First Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM105 Referring Provider Middle Name or Initial</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM107 Referring Provider Name Suffix</td>
</tr>
<tr>
<td>17b</td>
<td>NPI #</td>
<td>Required</td>
<td>2310A (referring)</td>
<td>NM109 Referring Provider Identifier</td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
<td>Situational</td>
<td>2300</td>
<td>DTP03 Related Hospitalization Admission Date</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>21A = Required 21B-L = Situational</td>
<td>2300</td>
<td>HIO1-2 Diagnosis Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIO2-2 Diagnosis Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIO3-2 Diagnosis Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIO4-2 Diagnosis Code</td>
</tr>
<tr>
<td>22</td>
<td>Medicaid Resubmission and/or Original Reference Number</td>
<td>Situational</td>
<td>2300</td>
<td>CLM05-3 Claim Frequency Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>REFO2 Payer Claim Control Number</td>
</tr>
<tr>
<td>Item Number</td>
<td>Description for Paper</td>
<td>Usage</td>
<td>Loop ID for EDI</td>
<td>837P Segment/ Data Element for EDI</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------</td>
<td>---------------</td>
<td>-----------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization Number</td>
<td>Required</td>
<td>2300</td>
<td>REF02</td>
</tr>
<tr>
<td>24A</td>
<td>Date(s) of Service</td>
<td>Required</td>
<td>2400</td>
<td>DTP03</td>
</tr>
<tr>
<td>24B</td>
<td>Place of Service</td>
<td>Required</td>
<td>2300</td>
<td>CLM05-1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2400</td>
<td>SY105</td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, Services, or Supplies</td>
<td>CPT/HCPCS: Required MODIFIER: Situational</td>
<td>2400</td>
<td>SV101 (2-6)</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Pointer</td>
<td>Required</td>
<td>2400</td>
<td>SV107 (1-4)</td>
</tr>
<tr>
<td>24F</td>
<td>$ Charges</td>
<td>Required</td>
<td>2400</td>
<td>SV102</td>
</tr>
<tr>
<td>24G</td>
<td>Days or Units</td>
<td>Required</td>
<td>2400</td>
<td>SV104</td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax ID Number</td>
<td>Number Field: Required SSN/EIN: Required</td>
<td>2010AA</td>
<td>REF02</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>REF02</td>
</tr>
<tr>
<td>26</td>
<td>Patient’s Account No.</td>
<td>Required</td>
<td>2300</td>
<td>CLM01</td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment?</td>
<td>Required</td>
<td>2300</td>
<td>CLM07</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td>Required</td>
<td>2300</td>
<td>CLM02</td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
<td>Situational, if TPL information present then Required</td>
<td>2300</td>
<td>AMT02</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2320</td>
<td>AMT02</td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician or Supplier Including Degrees or Credentials and Date</td>
<td>Required</td>
<td>2300</td>
<td>CLM06</td>
</tr>
<tr>
<td>32</td>
<td>Service Facility Location Information</td>
<td>Situational, if laboratory services required</td>
<td>2310C</td>
<td>NM103</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N301</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N401</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N402</td>
</tr>
<tr>
<td>Item Number</td>
<td>Description for Paper</td>
<td>Usage</td>
<td>Loop ID for EDI</td>
<td>Loop ID for Data Element for EDI</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------</td>
<td>---------------</td>
<td>----------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>32a</td>
<td>NPI #</td>
<td>Situational, if laboratory services required</td>
<td>2310C</td>
<td>N403</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM109</td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Info &amp; Ph #</td>
<td>Required</td>
<td>2010AA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM104</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM105</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NM107</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N301</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N401</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N402</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N403</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PER04</td>
</tr>
<tr>
<td>33a</td>
<td>NPI #</td>
<td>Required</td>
<td>2010AA</td>
<td>NM109</td>
</tr>
<tr>
<td>33b</td>
<td>Other ID #</td>
<td>Required</td>
<td>2000A 2010AA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>REF01</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>REF02</td>
</tr>
<tr>
<td>MEDICARE</td>
<td>MEDICAID</td>
<td>TRICARE</td>
<td>CHAMPVA</td>
<td>GROUP HEALTH PLAN (GHP)</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>---------</td>
<td>---------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
<td>(d)</td>
<td>(e)</td>
</tr>
</tbody>
</table>

3. PATIENT'S DATE OF BIRTH: 03/21/1945

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
   BROWN LILY

5. PATIENT'S ADDRESS (No., Street)
   625 DAISY STREET

6. PATIENT'S AGENCY/INSURER OR DRG (Coding Information)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO:
    - EMPLOYMENT (Current or Previous)
    - AUTO ACCIDENT?

11. INSURED'S DATE OF BIRTH
    - MM DD YY
    - SEX

12. NAME OF REFERRING PROVIDER OR OTHER SOURCE
    - TREATMENT NOW

13. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    - ICD-9-CM
    - 304.03

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)
    - OLY/06/2015

15. OTHER DATE
    - QUAL

16. DATES PATIENT WAS UNABLE TO WORK IN CURRENT OCCUPATION
    - FROM
    - TO

17. INSURED'S NAME (Last Name, First Name, Middle Initial)

18. OTHER CLAIM ID (Designated by NUCC)

19. INSURANCE PLAN NAME OR PROGRAM NAME

20. IS THERE ANOTHER HEALTH BENEFIT PLAN?
    - YES
    - NO

21. SIGNATURE OF Physician or Supplier (Including Degrees or Credentials)
    - THROUGH
    - THIS BILL

22. BILLING CODE
    - 85014

23. AMOUNT PAID
    - 75.00

24. DATES OF SERVICE
    - FROM
    - TO

25. FEDERAL ID. NO.
    - 01-8765432

26. PATIENT'S ACCOUNT NO.
    - 4747474747478747

27. TOTAL CHARGE
    - 75.00

28. MEDICARE IDENTIFICATION NUMBER
    - 1123457789

29. Federal Tax Id. No.
    - 01-123456789

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

31. DATES OF SERVICE
    - FROM
    - TO

32. BILLING CODE
    - 85014

33. AMOUNT PAID
    - 75.00

34. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

35. BILLING CODE
    - 85014

36. AMOUNT PAID
    - 75.00

37. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

38. BILLING CODE
    - 85014

39. AMOUNT PAID
    - 75.00

40. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

41. BILLING CODE
    - 85014

42. AMOUNT PAID
    - 75.00

43. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

44. BILLING CODE
    - 85014

45. AMOUNT PAID
    - 75.00

46. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

47. BILLING CODE
    - 85014

48. AMOUNT PAID
    - 75.00

49. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

50. BILLING CODE
    - 85014

51. AMOUNT PAID
    - 75.00

52. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

53. BILLING CODE
    - 85014

54. AMOUNT PAID
    - 75.00

55. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

56. BILLING CODE
    - 85014

57. AMOUNT PAID
    - 75.00

58. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

59. BILLING CODE
    - 85014

60. AMOUNT PAID
    - 75.00

61. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

62. BILLING CODE
    - 85014

63. AMOUNT PAID
    - 75.00

64. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

65. BILLING CODE
    - 85014

66. AMOUNT PAID
    - 75.00

67. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

68. BILLING CODE
    - 85014

69. AMOUNT PAID
    - 75.00

70. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

71. BILLING CODE
    - 85014

72. AMOUNT PAID
    - 75.00

73. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)
    - THROUGH
    - THIS BILL

74. BILLING CODE
    - 85014

75. AMOUNT PAID
    - 75.00
5.4. CBH Claim Process Cycle and Returned Data

5.4.1. Adjudication Process

CBH will adjudicate 100% of clean claims within 45 days and adjudicate 100% of all claims within 90 days. Adjudicate means to pay or reject a claim.

5.4.2. Payment of Claims

Payment will be Electronic Funds Transfers to the Bank designated by the provider in the Direct Deposit Form. Changes in Bank must be reported in writing under the signature of the Chief Executive Officer or Chief Financial Officer to the provider’s assigned Provider Relations Representative at:

[Assigned Provider Relations Representative], CBH
801 Market Street, 7th Floor
Philadelphia, PA 19107

5.4.3. Returned Claim Data

Whether a claim is accepted or rejected, claims data will be made available to the provider through the provider portal. The portal can be reached via se.dbhids.org. All data returned to the provider is via EDI, which is detailed usage and understanding is published by Washington Publishing Company and can be reached at wpc-edi.com.

- Returned Claim Acknowledgement:
  - Ta1-Acknowledges the receipt of the EDI File
  - 999- Implementation Acknowledgement
  - 277- Healthcare Claim Acknowledgement
- Returned Remittance Advice:
  - 835RA- Healthcare Claim Payment Advice

5.5. CBH Provider Follow-up Process

5.5.1. CBH Provider Follow-up Process

On occasion, after a payment has been issued, either CBH Claims staff or the provider may detect an error in the processing of the claim that was paid. The void or adjustment process deals with the correction of those claims that have been through the adjudication cycle and been paid. If a claim has been rejected and not yet paid, it is not subject to a “void or adjustment.” Only those claims that have already been paid can be voided or adjusted. Claims voids or adjustments generally occur for the following reasons:
• Claim was submitted and paid twice.
• Claim was paid at an incorrect rate.
• Claim was paid for the incorrect date(s) of service.
• Claim was paid at an incorrect level of care.
• Claim was submitted with excessive units of service within the time period.
• Services were span billed with overlapping days on more than one claim.
• A compliance audit was conducted.
• Post payment recoveries

5.5.2. Submitting Provider Initiated Voids via the 837I or 837P

• Provider must have completed and passed both phases of Provider Initiated Void testing and be able to send claim frequency code 8 at the CLM05-3 segment and the claim number at the REF*F8 for the claim that must be voided first before the new claim
• Await the acknowledgment that the Provider Initiated Void has been accepted and processed correctly before sending the new claim(s) for payment consideration

5.5.3. Submitting Adjustments Manually

Complete and submit the following:

• Claims Adjustment Request Form—note the claim number(s) in the space that is provided or attach a copy of the 835RA clearly indicating the claim number requiring an adjustment
• Corrected Claim(s) Form
• The EOB for TPL Claims

5.5.4. Claims Appeals Process

There are three categories of claims rejections that providers may appeal. The processes for each category are described separately. Providers are required to send a cover letter on company letterhead explaining why the claim(s) were delayed in being billed timely along with supporting documentation. Claims Appeals without a cover letter will not be accepted.

5.5.4.1. Appealing Rejected Claims for TPL caused by discrepancies

If the provider accesses the Eligibility Verification System (EVS) information and it indicates that the client does not have TPL coverage, but while processing the claim, the CBH system detects such coverage and consequently rejects the claim, within 90 days from the date of the rejection the provider must do the following:
• Note the claim number with the specific TPL rejection reason or send a copy of the 277CA or 835RA with the TPL rejection reason.
• Make a copy of the eligibility information that notes the client does not have TPL coverage.
• Make a copy of all outstanding claims along with any other evidence of non-coverage by a third-party.
• Mail the above to the CBH Claims Department, 801 Market Street, 7th Floor, Philadelphia, PA 19107. The envelope must clearly state “TPL Discrepancy.”

CBH will then perform a manual review of the client’s coverage. If it is determined that the client has no TPL coverage, CBH will reprocess the claim and make the necessary system adjustments. If it is found that the client does have TPL coverage, CBH will return the claim to the provider along with the name of the primary carrier and policy number. The provider must obtain a final determination from the primary payor dated no more than 180 days following the date of the TPL Discrepancy continuation letter issued by CBH to the provider. The provider must submit a clean claim to CBH within 90 days after receipt of the EOB and/or final determination letter with Claim Adjustment Group Codes, the CARC, and the RARC, if required by the CARC, from the primary payor.

5.5.4.2. Appealing Rejected Claims for "Recipient not Eligible" caused by discrepancies between the EVS and the Claims System

If the provider accesses the eligibility information and it indicates that the client is eligible for treatment on a particular date, but during the processing of the claim CBH does not show the individual to be eligible and rejects the claim, within 90 days from the date of rejection the provider must do the following:

• Make a copy of the 277CA or 835RA that notes the eligibility rejection.
• Make a copy of the eligibility information that notes the client was CBH eligible to receive service on the date(s) indicated on the claim.
• Prepare a new clean claim for the service(s) performed.
• Mail the above to the CBH Claims Department, 801 Market Street, 7th Floor, Philadelphia, PA 19107. The envelope must clearly state “Eligibility Rejection Appeal.”

5.5.4.3. Appealing Rejected Claims for “Timely Filing Limit or Late Submission”

If CBH receives a claim or Adjustment Request Form beyond the timely submission requirements noted above, the claim or adjustment form will reject or be returned to the provider due to late submission. Claims or adjustments rejected or returned for late submission may be appealed only due to processing errors made by CBH. The following requirements are necessary to be eligible for appeal and must be spelled out in your letter:
• Provider had submitted a clean claim within the required timeframes.
• CBH had improperly processed the clean claim, causing an incorrect payment or a rejection only resulting from CBH's processing error.
• Provider resubmits the clean claim (along with an Adjustment Request Form for incorrect payments) within 90 days from the date of the incorrect payment or rejection.
• A copy of the 277CA or 835RA that notes the rejection reason caused by CBH's error or the incorrect payment made due to CBH's error, and
• A copy of the claim and EOB and/or final determination letter with Claim Adjustment Group Codes, the CARC, and the RARC, if required by CARC, for TPL claims. If the appeal is due to untimely final EOB, documentation is needed. Documentation must be submitted to explain or show why the final determination could not be obtained timely.
• Mail the above to the CBH Claims Department, 801 Market Street, 7th Floor, Philadelphia, PA 19107. The envelope must clearly state “Late Submission Appeal.”
6. SECURE FILE TRANSFER

6.1. Overview

This section outlines reports that are available for exchange to or from Providers via our Secure Managed File Transfer.

The following reports will be sent to providers:
- Weekly Schedule A Report/Contract
- Daily, Weekly, and 90-Day Authorization Reports
- Daily TA1, 999, and 277 Claims Acknowledgement response files for every claim file loaded to CBH
- Weekly 835 Remittance Advice file
- Weekly Claims Rejected/Denied Reports

The following reports are expected from providers:
- E-Packets
- School Census Transfer

(continued)
6.2. Reference Guide

This section is a reference guide for CBH’s secure file transfer system, including information about how to upload and download reports.

6.2.1. Overview

This web-based file transfer portal allows simple and secure uploading and downloading of E-Packets, School Census files, and Claims Files, including 837 Submission files, 277 Response files, 835 Remittance Advise Files, TA1 and 999 response files, Authorization Reports, and Schedule A Contracts.

6.2.2. Gaining Access

To begin, users gain access to the system by obtaining login credentials via an Access Request form sent to providers upon request from CBH through a provider-user’s Provider Relations Representative.

When the Access Request form is completed, usernames and temporary passwords are sent to the email address submitted on the form.

Using the CBH-provided login information, users navigate to se.dbhids.org to begin the login process.

Note: Temporary passwords expire and must be changed within 72 hours.
6.2.3. Login

To begin the log-in process, use an Internet browser to navigate to se.dbhids.org.

Before logging in, please read the Security Notice located under the log-in section carefully. Keep in mind, for security purposes, that you should not share login information with anyone.

To log in, enter the supplied user name and password, and click Sign On.

6.2.4. Changing Temporary Passwords

New users receive temporary passwords via a New User Account email when they are first granted access to the portal.

As noted above: initial passwords are temporary and must be changed within 72 hours. Use the link supplied in the “New User Account” or “Password Reset” email to log in and change a temporary password.

---

From: Community Behavioral Health Notification Service [noreply@moveitscloud.com]
To: CBH FileTransfer
Cc: 
Subject: New User Account for Community Behavioral Health (se.dbhids.org)

Welcome to Community Behavioral Health!

An account has been created for you with the username ‘demo_user@fakeaccount.org’. Your new credentials are:

Username: demo_user@fakeaccount.org
Password: y96e%%

If site policy requires it, at sign on you will be guided through additional steps to secure your account.

Please use the following URL to sign on to the system:

If you need assistance, please contact Community Behavioral Health at CBH_filetransfer@philagov.

Regards,
Community Behavioral Health Notification Service
It is recommended that users copy and paste the temporary password contained in the New User Account email into the Enter Your Old Password box (below), as temporary passwords contain many special characters.

Clicking the link will bring users to a dialog like the one below.

Enter the temporary password into the Enter Your Old Password box. Then create a new password that meets the system password requirements and enter it twice in the appropriate boxes. Finally, click “Change Password” to update an old or temporary password.

Users will receive a reminder to change passwords every 90 days. Account information must be kept secure. Follow your organization’s requirements for managing credentials.
6.2.5. Multi-Factor Authentication

The last step in the login process is called Multi-Factor Authentication. In this process, a six-digit code is sent to users as a second security step.

After a user’s second login, a “Remember this device” checkbox will be visible. Checking this box allows users to “opt out” of Multi-Factor Authentication for the specific device on which they are working.
6.2.6. Navigation

Once logged in, notice the structure of the user portal Home page. There are three main sections:

1. **Navigation and Search**
2. **Announcements**
3. **Upload Files Section**

1. The Navigation Section contains a **Folder** link, a **Find File/Folder** search box, and a **Go To Folder** drop-down selection list that allow users to browse existing folders, search for existing files and folders, or select a folder to “go-to” from a drop-down menu.

2. Announcements placed in Section 2 above allow users to see any relative communications regarding claims file submission or claims file response from CBH.

3. Finally, uploading files is handled quickly from the Home Page using the **Upload** button located in section three.

In the new file transfer system, files are processed as they have been historically.

E-Packet Files are uploaded to the appropriate folder:
School Census Files are uploaded to the appropriate folder:

Folders
- Provider School Census

Go To Folders...

<table>
<thead>
<tr>
<th>Name</th>
<th>Created</th>
<th>Size/Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Folder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[224456] Your Provider Name</td>
<td>10/8/2017 12:35:33 PM</td>
<td></td>
</tr>
<tr>
<td>School Census Application Download</td>
<td>10/8/2017 12:40:16 PM</td>
<td>4</td>
</tr>
</tbody>
</table>

Claims Response Files are returned to providers via the *Download Claims Files* folder and placed in sub-folders by type for provider review and downloading.

Folders
- Provider School Census

Go To Folder...

<table>
<thead>
<tr>
<th>Name</th>
<th>Created</th>
<th>Size/Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Folder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>.pdf</td>
<td>277pce</td>
<td>6/15/2017 2:46:07 PM</td>
</tr>
<tr>
<td>.pdf</td>
<td>835RA Payment Advice</td>
<td>6/15/2017 2:46:07 PM</td>
</tr>
<tr>
<td>.pdf</td>
<td>Authorizations</td>
<td>6/15/2017 2:46:07 PM</td>
</tr>
<tr>
<td>.pdf</td>
<td>Rejected Denied</td>
<td>6/15/2017 2:46:07 PM</td>
</tr>
<tr>
<td>.pdf</td>
<td>Schedule A</td>
<td>6/15/2017 2:46:07 PM</td>
</tr>
</tbody>
</table>

16 In the *Download Claims Files* folder, separate folders exist for 277pce forms, 835RA Payment Advise documents, Authorizations, Rejected Denied Claims, Schedule A forms, and TA1/999 documents. For users with E-Packet or School Census access, separate folders also exist for uploading E-Packets and School Census files (see above images).
6.2.7. Claims Folder Structure

Navigating in the Secure File Transfer System for claims processing begins by knowing what folders are open and where to go for claims file uploading and downloading. To assist in these items, the new system displays what folder a user has open in the upper-center portion of the main screen (1).

The image below shows the main folder areas containing destinations for testing claims processing (Claims TEST), sending claims (Upload Claims Files), and receiving claims responses (Download Claims Files):

2. **Claims TEST**: contains folders for testing initial connectivity and testing changes to existing claims processing.
3. **Download Claims Files**: contains responses to submitted claims, i.e. 277s, 835RAs, Authorizations, Schedule As, TA1s, and 999s.
4. **Upload Claims Files**: the location where 837 claim files are uploaded.
6.2.8. Uploading Claims Files

Navigate to the *Upload Claims Files* folder to begin uploading files for claims processing. The steps are:

1. Navigate to the *Upload Claims Files* folder and click the *Upload Files (1)* button.

2. Select the correct folder in the *Upload To* drop-down menu.
3. Click the *Browse* link to open the file explorer on your local computer system.

4. Select the appropriate file on your local computer system. Once the desired file is selected, click *Open*. 
5. When a file is selected for uploading, both the target location (Upload To) and the file appear in the MOVEit Upload Files window. This allows the user to confirm the file that is being uploaded and that the file will be placed in the correct target location.

6. Now the user simply clicks the Upload button to place the file where they have chosen.
7. The MOVEit *Upload Files* window shows the location of the successful upload and the file that has been uploaded with a green checkmark. This window can now be closed.
6.2.9. Downloading Claims Responses

Downloading Claims Responses is a simple process. For illustration, this section will use the Go To Folder drop-down method, though users may choose to navigate directly through folders to reach the same destination.

1. First, select the *Folders* item in the *Navigation* section of the portal’s main page.

2. In the main window, click the *Providers* folder.
3. Then click the *CBH Claims* folder marked with the Provider Name (here the Provider Name is “Small Provider Services”).

4. Select the desired response folder, i.e. 277pre, 835A Payment Advise, etc.
5. With the desired folder open, click the download icon (highlighted below right) or simply click on the file name to move the file from the portal to your computer.

6. From the File Actions section, click the Download button.
• Clicking the Download button brings up a browser window that asks the user what they would like to do with the file. It is recommended that the file be saved to a predetermined location on the local computer system. In this example, the user would click Save in the Internet Explorer dialogue box and then choose a location in which to save the file.

• Sometimes, browsers automatically save files in a location named “Downloads”. In these cases, go to the “Downloads” folder on your computer to open the file.

A few notes:
• Notice the icon that sits to the left of the file above (8). The icon is blank because the computer does not know with what software opens the file.
• Since all the response files—except Schedule A files—are text files with strange endings like .277pre or .835ra, again, the computer is unsure how to open them.
• Telling the computer how to open a file is a simple but seldom-used process. See the steps below.
• With the downloaded file highlighted, right-click and select *Open with*.

• All of the response files are simple text files; however, they end in uncommon file extensions like .277, .835ra, .999, etc. So, using the *Open with* Windows menu, direct your computer to use Microsoft Word or WordPad.
• A note about assigning a program to open responses:

  • If the Microsoft Word or WordPad icons do not appear in the Open with window, use the Browse button (lower right) to search for a program with which to open the file. Program files can exist in a number of places, though they are normally found in the computer’s “Program Files” or “Program Files (x86)” folders. A simple way to find an appropriate program to use when opening downloaded claims responses is to look in the computer’s C: drive for a program called:
    o Winword.exe – for Microsoft Word
    o Excel.exe – for Microsoft Excel

Again, the location of executable files varies with the operating system. If executables cannot be found in the described folders, use the “Search” function on your computer to locate where files ending in the extension ‘.exe’ are stored.
6.2.10. E-Packet and School Census Folder Structure

1. Click on the *Folders* link to be taken to the parent folders for E-Packet and School Census File submission.

2. Click on the appropriate folder for the type of transfer desired (E-Packets, in this example).

3. Click on the folder titled with the correct six-digit provider number prefix.
4. To upload files to the portal, simply click the *Upload Files* button located in the upper-right section of the main or content window.

5. Verify the correct upload folder is selected in the *Upload to* drop-down list.
6. Click *Browse* to select the desired file on your local computer system.

7. Click *Upload* to upload the desired file to the portal.
8. Verify the correct file has been transferred by checking the uploaded file name next to the check icon.

9. After closing the Upload Files window, check to see that the desired file exists in the correct upload folder.
6.3. Claims Testing

6.3.1. Overview

This section outlines some basic information related to Claims Testing when a user moves to electronic billing or Third-Party Liability testing.

6.3.2. Main Claims Test Folder Structure

Within the portal, in the provider’s folder (a folder named after the provider) a Claims Test folder exists which allows providers to test the claims submission transfer function of the website. Claims Test (1) contains folders for uploading test claims (used only when claims processing is changing and requires testing). It also contains folders for downloading test claim responses and folders for testing initial connectivity before a provider begins using the website.
6.3.3. Testing and More on Claims Test Folder Structure

On the website, the Claims Test folder exists for two purposes:

1. Testing of claims processes that may have changed while providers are using the system (Test Claims)

   The Test Claims folders will always be available to the provider in the event that any type of claims testing is needed.

2. Initial connectivity testing for providers who are beginning to use the system (Test Connectivity)

   This Test Connectivity folder will not be visible once the provider is in production with the new system.
3. For initial connectivity testing, the Test Connectivity folder is used and will not be visible once a provider is moved to Production Status.

4. Inside the Test Connectivity folder, upload and download tests are handled through Upload Claims Files Test and Download Claims Files respectively.
7. ADDITIONAL DOCUMENTS AND LINKS

7.1. Clinical Documentation Guidelines

- Per Diem Drug and Alcohol Treatment Documentation Requirements
- Treatment Planning Guide
- Comprehensive Biopsychosocial Evaluation/Re-evaluation (CBE/R) Guide

7.2. Clinical Guidelines

- Clinical Guidelines for Tapering Benzodiazepines

The following Clinical Guidelines will expire on Monday, September 7, 2020:

- Clinical Guidelines for the Pharmacologic Treatment of Attention Deficit and Hyperactivity Disorder (ADHD) (2018)
- Clinical Guidelines for the Pharmacologic Treatment of Schizophrenia (2018)
- Clinical Guidelines for the Prescribing and Monitoring of Antipsychotic Medications for Youth (2018)
- Clinical Guidelines for the Prescribing and Monitoring of Benzodiazepines and Related Medications (2018)

The following Clinical Guidelines will take effect on Monday, September 7, 2020:

- Clinical Guidelines for Opioid Use Disorder (OUD) (2020, updated)
- Clinical Guidelines for the Pharmacologic Treatment of Attention Deficit and Hyperactivity Disorder (ADHD) in Children and Adolescents (2020, updated)
- Clinical Guidelines for the Pharmacologic Treatment of Schizophrenia (2020, updated)
- Clinical Guidelines for the Prescribing and Monitoring of Antipsychotic Medications for Youth (2020, updated)
- Clinical Guidelines for the Prescribing and Monitoring of Benzodiazepines and Related Medications (2020, updated)
- Clinical Guidelines for the Treatment of Tobacco Use Disorder (2020, new)

7.3. Performance Standards

- ABA Performance Standards
  - ABA Forum FAQ
  - Application for ABA Designation
• Child and Adolescent Inpatient Performance Standards
• Psychiatric Residential Treatment Facility Performance Standards

7.4. Provider Personnel

• Manual for Review of Provider Personnel Files (MRPPF) 2.2
• NPAU Provider Personnel Roster 2019 (.xlsx)

7.5. Exclusion Lists

Neither a provider nor its staff, contractors, subcontractors, or vendors may be on any of the three Excluded Individuals and Entities lists:

• List of Excluded Individuals and Entities (LEIE)
• System for Award Management (SAM) (formerly Excluded Parties List System [EPLS])
• Department of Human Services Medichec List

7.6. Provider Bulletins

• Provider Bulletins

7.7. Provider Notices

• Provider Notices

7.8. Provider Resources

• Medicaid Coverage for Tobacco Treatment

7.9. Miscellaneous

• CBH Initialism & Acronym Guide
## 8. REVISION LOG

<table>
<thead>
<tr>
<th>Date</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 6, 2020</td>
<td>• Added new Clinical Guidelines in Section 7.2.</td>
</tr>
<tr>
<td></td>
<td>• Added expiration for old Clinical Guidelines in Section 7.2.</td>
</tr>
<tr>
<td></td>
<td>• Added language about providers informing members about prior authorization outcomes in 3.4.3.</td>
</tr>
<tr>
<td></td>
<td>• Removed “draft” watermark from PRTF Standards</td>
</tr>
<tr>
<td></td>
<td>• Updated list of exclusion sources in 2.5.12.7.1.</td>
</tr>
<tr>
<td>July 12, 2020</td>
<td>• Updated “Types of Providers” (2.3.3. in this revision), including new FQHC and BHC definitions</td>
</tr>
<tr>
<td></td>
<td>• Updated credentialing tables (1.4.2.1. “Initial Credentialing” and 1.4.2.2. “Recredentialing” in this revision)</td>
</tr>
<tr>
<td></td>
<td>• Added BHC and FQHC language to 1.4.2.2.</td>
</tr>
<tr>
<td></td>
<td>• Updated language in “Drug Enforcement Administration certification (Physicians and Nurse Practitioners Only)” (2.5.12.2. in this revision)</td>
</tr>
<tr>
<td></td>
<td>• Added FQHC and BHC definitions to definitions appendix; updated MRPPF definition (Appendix A in this revision)</td>
</tr>
<tr>
<td></td>
<td>• Updated “PSV by” fields in “Initial and Recredentialing Summary Template for Independent and Group Practitioners” (Appendix C in this revision)</td>
</tr>
<tr>
<td></td>
<td>• Replaced “Initial Credentialing Letter: Independent and Group Practitioners” (Appendix D in this revision)</td>
</tr>
<tr>
<td></td>
<td>• Replaced “Recredentialing Letter: Independent and Group Practitioners” (Appendix E in this revision)</td>
</tr>
<tr>
<td></td>
<td>• Added 09-103, “CRNP – Family and Adult Psychiatric Mental Health,” to “Provider Types and Specialty Codes: Independent and Group Practitioners” (Appendix E in this revision)</td>
</tr>
<tr>
<td></td>
<td>• Corrected formatting in authorization guideline tables</td>
</tr>
<tr>
<td></td>
<td>• Corrected CBH Compliance Hotline hours</td>
</tr>
<tr>
<td></td>
<td>• Added information about IBHS authorization Bulletins</td>
</tr>
<tr>
<td></td>
<td>• Corrected appendices listed Authorization Applicable Appendices</td>
</tr>
<tr>
<td>Date</td>
<td>Updates</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>June 30, 2020</td>
<td>- Added Quality subsection “Provider Participation in Quality Improvement Activities”&lt;br&gt;- Changed Provider Hotline hours&lt;br&gt;- Normalized time format&lt;br&gt;- Updated Member Handbook link</td>
</tr>
<tr>
<td>April 22, 2020</td>
<td>- Updated MRPPF link to 2.2 in Compliance section</td>
</tr>
<tr>
<td>March 5, 2020</td>
<td>- Updated MRPPF link to 2.2 in Additional Documents and Links section</td>
</tr>
<tr>
<td>March 4, 2020</td>
<td>- Updated MRPPF link to 2.1 in Additional Documents and Links section</td>
</tr>
<tr>
<td>February 27, 2020</td>
<td>- Updated Exclusion List links&lt;br&gt;- Updated MRPPF link to 2.0 in Additional Documents and Links section&lt;br&gt;- Updated NPAU Personnel Roster link</td>
</tr>
<tr>
<td>December 20, 2019</td>
<td>- Initial publication of new combined document</td>
</tr>
</tbody>
</table>
APPENDIX A: DEFINITIONS

Active Provider: Any provider who:

- Is contracted with CBH to provide services to CBH members at the time a decision is made

  OR

- Has been contracted with CBH to provide services to CBH members within the last 30 days

Adverse Events: Any event occurring during the course of treatment that may place the safety or wellbeing of a member in jeopardy. All adverse events will be reported and tracked through Quality Management as described in the CBH Procedures for Response, Reporting, and Monitoring of Significant Incident Policy.

Applications Not Meeting Threshold Requirements: Any application missing required documents or having documents that do not reflect good standing. Any applicant appearing on an applicable exclusion or sanction list (see Appendices D and E) will also be considered as not meeting threshold requirements.

Behavioral Health Consultant (BHC): A psychologist, licensed clinical social worker, licensed professional counselor, or licensed marriage and family therapist working in a Federally Qualified Health Center (FQHC).

Blanket Authorization Number (BAN): A provider-specific authorization number assigned to services that do not require a prior authorization, used during claims submission, and found on the Provider Schedule A.

Clean Application: An application that meets full threshold criteria; all applicable documentation and screening requirements have been met.

Concurrent Request: A review conducted by the BH-MCO during a course of treatment to determine whether services should continue as prescribed or should be terminated, changed, or altered.

Emergency Services: Services needed to evaluate or stabilize an emergency psychiatric medical condition delivered by a provider qualified under the Medical Assistance Program. CBH does not require prior authorization for emergency services, which include services through a crisis response center, a substance use assessment center, or mobile crisis teams.
**Facility:** Organizations that employ or contract with staff to provide behavioral health services under an appropriate facility license. Examples of facilities may include, but are not limited to:

- Inpatient Hospitals
- Free Standing Substance Use Treatment Facilities
- Residential Treatment Facilities
- Outpatient Clinics
- Laboratories
- Partial Hospital Programs

**Federally Qualified Health Center (FQHC):** A community-based health care provider that receives funds from the Health Resources and Service Administration (HRSA). Behavioral health services are provided by a Behavioral Health Consultant (BHC).

**Group Practice (Group):** A professional corporation or partnership of individual practitioners of the same discipline and license type. The group is the entity to which payments will be made. A group must be enrolled in PROMISe as a group provider, and each individual practitioner who performs services for which payment will be made via the group must also be enrolled in PROMISe. The group may not bill for services as a rendering provider.

**High-Volume Provider:** Any practitioner or group practice seeing 500 or more unique CBH members in a calendar year.

**Independent Practitioner:** Practitioners who are licensed, certified, or registered by the State to practice independently and have an independent contractual relationship with CBH. An independent practitioner is enrolled in PROMISe under their own Social Security Number (SSN) and/or Federal Employee Identification Number (FEIN).

**Level of Care:** Refers to the services a provider is approved to deliver. Levels of care appear on the Schedule A along with billing codes and rates.

**Manual for Review of Provider Personnel Files (MRPPF):** CBH-published document that provides minimum standards for all clinical staff positions within the CBH Provider Network. The MRPPF is updated at least annually and is available to the public on the CBH Compliance webpage.

**Medical Necessity Criteria (MNC):** Detailed criteria to assist providers and CBH in determining the most clinically appropriate type, amount, extent, duration, and site of behavioral health services for the member’s specific needs. Medical Necessity Criteria for state-wide available mental health services are issued by the State and found in the PS&R Appendices S and T. MNC for CBH-specific services are written by CBH and approved by the State. MNC for all substance use treatment services is found in the ASAM.
**Negative Decision:** A recommendation by the Credentialing Committee for either termination from the network or inability to enter the network.

**Network Improvement and Accountability Collaborative (NIAC):** The Network Improvement and Accountability Collaborative is the primary mechanism to accomplish the creation of a single, consistent approach to site reviews [monitoring] across various funding streams. NIAC promotes ongoing quality of care improvement across DBHIDS providers. NIAC establishes an accountability partnership among people receiving services, DBHIDS, providers, and other stakeholders. DBHIDS (via NIAC) engages in a structured, collaborative review process to assess with providers the degree of such alignment with domains, standards, and associated practices using an objective scoring method.

**Network Inclusion Criteria (NIC):** The Network Inclusion Criteria (NIC) scoring tool is used to quantify the Standards of Excellence and outlines the measurement of standards and practices and scoring. As stated above, NIAC determines the degree of provider practice alignment with the Network Inclusion Criteria. The process and the instrument are designed to capture the relevant scoring of practices as well as narrative information on each practice.

**Non-urgent Services:** Non-acute services when the decision-making timeframe does not adversely impact the health of the member or the member’s ability to regain maximum functioning and would not subject the member to severe distress or decompensation. Non-urgent services do not require a prior authorization.

**Parent Organization:** An “umbrella” organization within the CBH provider network that may operate more than one program or facility. For example, Crest Behavioral Services is a parent organization licensed to provide Behavioral Health Rehabilitative Services and Outpatient Mental Health Services.

**Primary Source Verification:** Verification from the original source of a specific credential (education, training, licensure) to determine the accuracy of the qualifications of an individual healthcare practitioner.

**Prior Authorization:** A determination made by a Primary Contractor or its BH-MCO to approve or deny a provider's request to provide a service for a specific duration and scope to a member *prior* to the provider initiating provision of the requested service.

**Protected Health Information (PHI):** Health data created, received, stored, or transmitted by HIPAA-covered entities and their business associates in relation to the provision of healthcare, healthcare operations, and payment for healthcare services. PHI includes all individually identifiable health information, including demographic data, medical histories, test results,
insurance information, and other information used to identify an individual or provide healthcare services or healthcare coverage.

**Provider**: A term used interchangeably to describe independent practitioners and facilities.

**Registration Number**: A member-specific authorization number assigned to services that do not require a prior authorization but do require submission of a service request form to obtain an authorization number.

**Schedule A**: A document issued by CBH which allows the provider to submit claims for the services provided at the newly credentialed facility. All approved services or levels of care offered by the parent organization or facility are listed on document along with billing codes and rates.

**Urgent Services**: Acute services to address a member’s psychological state, which, without services, could jeopardize the life, health, or safety of the member or others. Under reasonable standards, a determination for care is made within a 24-hour period and, if left untreated, could rapidly become a crisis or emergency. An urgent request also includes when a member’s discharge from a hospital will be delayed until services are approved, or a member’s ability to avoid hospitalization depends upon prompt approval of services.
APPENDIX B: NONDISCRIMINATION AND CONFIDENTIALITY AGREEMENT (SIGNED BY MEMBERS OF THE CBH CREDENTIALING COMMITTEE)

Nondiscrimination and Confidentiality Statement

As a member of the Community Behavioral Health Credentialing Committee, involved in the evaluation and improvement of quality of care and services, I recognize that confidentiality is vital to the credentialing process. Therefore, I agree to respect and maintain the confidentiality of all discussions, records, and information generated in connection with Credentialing Committee activities, and to make no voluntary disclosure of such information except to persons authorized to receive it.

As a member of the Credentialing Committee, I will ensure credentialing and recredentialing decisions will be made in a non-discriminatory manner and will not be made based on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes.

Date: ___________________     Print Name: ____________________________

Signed: ______________________

______________________________
APPENDIX C: INITIAL AND RECREDENTIALING SUMMARY
TEMPLATE FOR INDEPENDENT AND GROUP PRACTITIONERS

<table>
<thead>
<tr>
<th>Provider/Provider Type</th>
<th>CBH Child #</th>
<th>PROMISe #</th>
<th>License #</th>
<th>Practice Location (Child Address)</th>
<th>Recommended Status</th>
</tr>
</thead>
</table>

**Specific Services to be Delivered**

- Specific Levels of Care:

**Credentialing Status:** Complete/Clean or Incomplete/Unclean

<table>
<thead>
<tr>
<th>Deficiency Code</th>
<th>Date of Report</th>
<th>File Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Other Findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCQA Element / Factor</td>
<td>Verification</td>
<td>PSV by</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td>Credentials A.1</td>
<td>License</td>
<td>CAQH</td>
</tr>
<tr>
<td>Credentials A.2</td>
<td>DEA</td>
<td>CAQH</td>
</tr>
<tr>
<td>Credentials A.3</td>
<td>Residency (if no board certification)</td>
<td>CAQH</td>
</tr>
<tr>
<td>Credentials A.3 &amp; 4</td>
<td>Board certification</td>
<td>CAQH</td>
</tr>
<tr>
<td>Credentials A.5</td>
<td>Work history (5 years starting with licensure date)</td>
<td>CAQH</td>
</tr>
<tr>
<td>Credentials A.6</td>
<td>Malpractice history</td>
<td>CAQH</td>
</tr>
<tr>
<td>Sanctions B.1</td>
<td>License</td>
<td>CAQH</td>
</tr>
<tr>
<td>Sanctions B.2</td>
<td>Medicare / Medicaid</td>
<td>CAQH</td>
</tr>
<tr>
<td>Sanctions B.2</td>
<td>Medicare / Medicaid</td>
<td>CBH/Streamline Verify</td>
</tr>
<tr>
<td>Application C.1</td>
<td>Inability to perform essential functions</td>
<td>CAQH</td>
</tr>
<tr>
<td>Application C.2</td>
<td>Illegal drug use</td>
<td>CAQH</td>
</tr>
<tr>
<td>Application C.3</td>
<td>History of loss of license</td>
<td>CAQH</td>
</tr>
<tr>
<td>Application C.3</td>
<td>History of felony convictions</td>
<td>CAQH</td>
</tr>
<tr>
<td>Application C.4</td>
<td>Limitation of privileges, disciplinary actions</td>
<td>CAQH</td>
</tr>
<tr>
<td>Application C.5</td>
<td>Malpractice coverage</td>
<td>CAQH</td>
</tr>
<tr>
<td>Application C.6</td>
<td>Correctness &amp; completeness of application</td>
<td>CAQH</td>
</tr>
<tr>
<td><strong>CBH Attestation</strong></td>
<td>Mandatory Trainings, LOC Requirements, Clearances, Covered Services in the Medicaid or Medicare Program or any other state or federal assistance program, Exclusion List</td>
<td>CBH/Attestation</td>
</tr>
</tbody>
</table>

Medical Director Signature: _______________________________  Date: __________

Medical Director Printed Name: ______________________________________

CBH Reviewer Signature: _______________________________  Date: __________

CBH Reviewer Printed Name: ______________________________________
APPENDIX D: INITIAL CREDENTIALING LETTER: INDEPENDENT AND GROUP PRACTITIONERS

(Date)
(Name and Title)
(Organization Name and Title)
(Organization Address)

Dear Practitioner,

Thank you for your interest in joining the CBH network.

CBH has contracted with the Council for Affordable Quality Healthcare, Inc. (CAQH) to complete primary source verification of key credentialing elements for independent practitioners and group practice members entering the CBH Network. CAQH is a credentialing verification organization, widely known and utilized, and is certified by the National Committee for Quality Assurance (NCQA). *(CBH Bulletin 18-16, October 9, 2018)*

If you are currently enrolled with CAQH you will be contacted by CAQH to advise you that they will be initiating the credentialing process on behalf of CBH.

If you are not currently enrolled with CAQH you will need to enroll as a condition of providing services as a CBH Network provider. You are required to complete your enrollment with CAQH no later than __/__/2020. You can access the CAQH Proview [registration portal here](#).

It is essential that your CAQH application is filled out completely, reflecting all training, residency, and fellowship information. CBH is unable to credential providers with an incomplete CAQH report. Please note that providers who are unable to be credentialed are prohibited from participating in the CBH network.

You are required to sign and date the attached attestation and return to CBH at CBH.ComplianceContact@phila.gov by __/__/2020. You may also be asked to provide additional information to the CBH Contracting department.

Please refer to the CBH Provider Manual at [www.cbhphilly.org](http://www.cbhphilly.org) for further support. Practitioner rights can be found in section 2.5.13 of the Provider Manual.

Please direct any questions to CBH.ComplianceContact@phila.gov.

Sincerely,
COMMUNITY BEHAVIORAL HEALTH PROVIDER CREDENTIALING – ATTESTATION

Practitioner Name:

Individual PROMISe (MAID) Number:

License Number:

NPI:

CAQH Number:

I, (practitioner), attest that I have met each of the following requirements:

- Completed all CBH mandatory trainings (or will complete within 90 days of contracting, and ongoing as required)
- Completed a CPR training and maintain current CPR certification, when required. (All physicians, children’s RTF, and partial hospitalization program staff must be CPR certified. For all other programs, at least 50% of staff must be CPR certified)
- Obtained and maintain a valid PA Criminal History Report
- Obtained and maintain a valid PA Child Abuse Clearance (for staff likely to have contact with children per Commonwealth definition)
- Obtained and maintain a valid FBI Clearance (for staff likely to have contact with children per Commonwealth definition, and for staff who live or have lived outside of Pennsylvania within the past two years)
- Reported directly to CBH any history of arrest or allegation that appears on the PA Criminal History Report, PA Child Abuse Clearance, or FBI Clearance.
- Created a CAQH profile, attested or re-attested to the content, and authorized CBH to access my profile and documentation on CAQH.

I am aware that under the CBH Provider Agreement, I am not permitted to provide Covered Services in the Medicaid or Medicare Program or any other state or federal assistance program if I am found ineligible as confirmed by my review of the following federal and Commonwealth resources on a monthly basis: List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM) (formerly Excluded Parties List System (EPLS)), and PA DHS Medicheck List. I am able to provide proof of monthly review of these databases upon request from CBH. If I become aware I have been named in any of the aforementioned lists, I shall cease providing services to CBH members and notify CBH (via email to CBH.ComplianceContact@phila.gov) within three business days of becoming aware that I have been excluded from participation in any state or federal program.

Name (Signature) ______________________________ Date____________________

Name (Print) ______________________________
APPENDIX E: REREDENTIALING LETTER: INDEPENDENT AND GROUP PRACTITIONERS

(Date)
(Name and Title)
(Organization Name and Title)
(Organization Address)

Dear Provider,

CBH has contracted with the Council for Affordable Quality Healthcare, Inc. (CAQH) to complete primary source verification of key credentialing elements for independent practitioners and group practice members. CAQH is a credentialing verification organization, widely known and utilized, and is certified by the National Committee for Quality Assurance (NCQA). (CBH Bulletin 18-16, October 9, 2018)

You are receiving this letter because, as an independent practitioner or provider in a group, you are due for CBH recredentialing.

If you are currently enrolled with CAQH you will be contacted by CAQH to advise you that they will be initiating the recredentialing process on behalf of CBH.

If you are not currently enrolled with CAQH you will need to enroll as a condition of providing services as a CBH Network provider. You are required to complete your enrollment with CAQH no later than __/__/2020. Failure to complete a CAQH application within this timeframe may result in termination from the CBH Network. You can access the CAQH Proview registration portal here.

It is essential that your CAQH application is filled out completely, reflecting all training, residency, and fellowship information. CBH is unable to recredential providers with an incomplete CAQH report.

Please note that providers who are unable to be credentialed are prohibited from participating in the CBH network.

You are required to sign and date the attached attestation and return to CBH at CBH.ComplianceContact@phila.gov by __/__/2020. You may also be asked to provide additional information to the CBH Contracting department.

Please refer to the CBH Provider Manual at www.cbhphilly.org for further support. Practitioner rights can be found in section 2.5.13 of the Provider Manual.

Please direct any questions to CBH.ComplianceContact@phila.gov.

Sincerely,
COMMUNITY BEHAVIORAL HEALTH PROVIDER CREDENTIALING – ATTESTATION

Practitioner Name:

Individual PROMISe (MAID) Number:

License Number:

NPI:

CAQH Number:

I, (practitioner), attest that I have met each of the following requirements:

• Completed all CBH mandatory trainings (or will complete within 90 days of contracting, and ongoing as required)
• Completed a CPR training and maintain current CPR certification, when required. (All physicians, children’s RTF, and partial hospitalization program staff must be CPR certified. For all other programs, at least 50% of staff must be CPR certified)
• Obtained and maintain a valid PA Criminal History Report
• Obtained and maintain a valid PA Child Abuse Clearance (for staff likely to have contact with children per Commonwealth definition)
• Obtained and maintain a valid FBI Clearance (for staff likely to have contact with children per Commonwealth definition, and for staff who live or have lived outside of Pennsylvania within the past two years)
• Reported directly to CBH any history of arrest or allegation that appears on the PA Criminal History Report, PA Child Abuse Clearance, or FBI Clearance.
• Created a CAQH profile, attested or re-attested to the content, and authorized CBH to access my profile and documentation on CAQH.

I am aware that under the CBH Provider Agreement, I am not permitted to provide Covered Services in the Medicaid or Medicare Program or any other state or federal assistance program if I am found ineligible as confirmed by my review of the following federal and Commonwealth resources on a monthly basis: List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM) (formerly Excluded Parties List System (EPLS)), and PA DHS Medcheck List. I am able to provide proof of monthly review of these databases upon request from CBH. If I become aware I have been named in any of the aforementioned lists, I shall cease providing services to CBH members and notify CBH (via email to CBH.ComplianceContact@phila.gov) within three business days of becoming aware that I have been excluded from participation in any state or federal program.

Name (Signature) ______________________________ Date____________________

Name (Print) ______________________________
APPENDIX F: PROVIDER TYPES AND SPECIALTY CODES: INDEPENDENT AND GROUP PRACTITIONERS

CBH contracted providers who are considered independent providers or group practices will be licensed as such by the Commonwealth of Pennsylvania. They will be assigned the following provider types and specialty codes by the Commonwealth. All other provider types and specialty code combinations that are eligible for reimbursement by CBH are considered facilities.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Specialty Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>09</td>
<td>103</td>
<td>CRNP – Family and Adult Psychiatric Mental Health</td>
</tr>
<tr>
<td>09</td>
<td>548</td>
<td>CRNP – Therapeutic Support Staff (TSS)</td>
</tr>
<tr>
<td>09</td>
<td>549</td>
<td>CRNP – Mobile Therapy</td>
</tr>
<tr>
<td>09</td>
<td>558</td>
<td>CRNP – Behavior Specialist for Children with Autism (BSC Autism)</td>
</tr>
<tr>
<td>09</td>
<td>559</td>
<td>CRNP – Behavior Specialist (BSC)</td>
</tr>
<tr>
<td>11</td>
<td>112</td>
<td>Outpatient Practitioner - MH</td>
</tr>
<tr>
<td>16</td>
<td>162</td>
<td>Psychiatric Nurse</td>
</tr>
<tr>
<td>17</td>
<td>171</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>17</td>
<td>174</td>
<td>Art Therapist</td>
</tr>
<tr>
<td>17</td>
<td>175</td>
<td>Music Therapist</td>
</tr>
<tr>
<td>19</td>
<td>190</td>
<td>General Psychologist</td>
</tr>
<tr>
<td>19</td>
<td>548</td>
<td>Psychologist – TSS</td>
</tr>
<tr>
<td>19</td>
<td>549</td>
<td>Psychologist – Mobile Therapy</td>
</tr>
<tr>
<td>19</td>
<td>558</td>
<td>Psychologist – BSC Autism</td>
</tr>
<tr>
<td>19</td>
<td>559</td>
<td>Psychologist – BSC</td>
</tr>
<tr>
<td>31</td>
<td>339</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>31</td>
<td>315</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>31</td>
<td>316</td>
<td>Family Practice</td>
</tr>
<tr>
<td>31</td>
<td>322</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>31</td>
<td>345</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>31</td>
<td>548</td>
<td>Physician – TSS</td>
</tr>
<tr>
<td>31</td>
<td>549</td>
<td>Physician – Mobile Therapy</td>
</tr>
<tr>
<td>31</td>
<td>558</td>
<td>Physician – BSC Autism</td>
</tr>
<tr>
<td>31</td>
<td>559</td>
<td>Physician – BSC</td>
</tr>
</tbody>
</table>

The provider types and specialty codes listed above are individuals who the State of Pennsylvania has identified as being able to provide behavioral health reimbursable services per the HealthChoices Behavioral Health Services Reporting Classification Chart (BHRSCC). Group practices are possible when groups of individuals holding the same provider types and specialty codes form a professional corporation or partnership.
APPENDIX G: BUSINESS DOCUMENTS FOR INITIAL CREDENTIALING: FACILITIES

Agency/Parent Organization

- CBH Provider Information Form (Parts A, B, and C)
- Verification of corporate status (i.e. profit/non-profit)
- IRS Treasury Letter
- Completed W-9
- Board of Directors membership
- Table of Organization/Organizational Chart
- Proof of Accreditation—Joint Commission/CARF/COA
- Minority Status
- Insurance Information

Facility

- CBH Provider Information Form (Parts B and C)
- Certificate of Licensure or Approval Letter
- Accreditation Certificate or Letter—Joint Commission/CARF/COA
- Proof of PA Medicaid (i.e. PROMISE) enrollment or verification of pending application
- NPPES Verification of NPI and taxonomy
- Program/Service description
APPENDIX H: STAFF DOCUMENTS FOR INITIAL CREDENTIALING: FACILITIES

Submission to CBH required:

- Completed Network Personnel Analysis Unit (NPAU) staff roster, including notations for all vacant positions
- Job descriptions for each position included on staff roster

Providers must maintain the following individual staff documents on file and provide copies to CBH upon request:

- Licenses (Physicians, CRNPs, Physician Assistants, RN, LPN, Psychologists, Behavior Specialist, LSW, LCSW, LPC, LMFT) or certificates (Certified Peer Specialist, Certified Recovery Specialist, Certified Psychiatric Rehabilitation Practitioner)
- Resume/Curriculum Vitae
- Verification of previous employment or performance evaluation
- Degree, diploma, or copy of transcript. For foreign-trained staff, degree verification from a National Association of Credential Evaluation Services (NACES)
- Pennsylvania State Criminal History Report
- Pennsylvania Child Abuse Clearance (if applicable)
- FBI Criminal History Report (if applicable)
- Evidence of completion of CBH Mandatory trainings (if present)
APPENDIX I: INITIAL CREDENTIALING INTRODUCTION LETTER: FACILITIES

(Date)
(Name and Title)
(Organization Name and Title)
(Organization Address)

Dear (practitioner),

Thank you for your interest in participating in Community Behavioral Health’s (CBH’s) Provider Network. Per the discussion at our (date of meeting), please submit the following documentation to (name of initial credentialing team leader) within thirty (30) days of the date of this correspondence:

**Personnel Files**
(list of requested documents)

**Business Documents:**
(list of requested documents)

**Policies and Procedures:**
(list of requested documents)

Additionally, a facility site visit will be scheduled for a date and time mutually convenient for CBH and facility staff.

All documentation will be reviewed by CBH upon receipt. Once all documentation has been reviewed and a site visit has been conducted, you will receive additional correspondence summarizing the findings of the initial credentialing review. The outcome of the credentialing review and recommendations for network inclusion will subsequently be presented to the CBH Credentialing Committee.

Thank you again for your interest in participating in the CBH Provider Network. Should you have any further questions regarding the initial credentialing process, please contact (name of the initial credentialing team leader).

Respectfully,

(CBH Staff Person and Title)
cc: Director of Operations
APPENDIX J: INITIAL CREDENTIALING REQUIREMENTS FOR
STAFF FILES – ATTESTATION: FACILITIES

I, (CEO or executive director), attest that (provider agency name) staff members serving
Community Behavioral Health (CBH) members have each met the following requirements for
their individual staff files. Consistent with the parameters outlined in the CBH Manual for
Review of Provider Personnel Files (MRPPF) and the CBH Credentialing Handbook, Appendix H,
each staff file includes the following documents:

- Licenses (Physicians, CRNPs, Physician Assistants, RN, LPN, Psychologists, LSW,
  LCSW, LPC, LMFT) or certificates (Certified Peer Specialist, Certified Recovery
  Specialist, Certified Psychiatric Rehabilitation Practitioner)
- Resume/curriculum vitae
- Signed job description
- Verification of previous employment or performance evaluation
- Degree, diploma, or copy of transcript. For foreign-trained staff, degree verification
  from a National Association of Credential Evaluation Services (NACES) is required
- Pennsylvania State Criminal History Report
- Pennsylvania Child Abuse Clearance (if applicable)
- FBI Criminal History Report (if applicable)
- Evidence of completion of CBH mandatory trainings (if present)

Facilities must maintain complete and up-to-date staff files for each staff person on the roster
consistent with the above requirements. CBH reserves the right to request and review staff files
as part of the initial credentialing review or for compliance or quality monitoring purposes.

I am aware that under the CBH Provider Agreement, I am not permitted to employ or engage
any individual who is ineligible to provide Covered Services in the Medicaid or Medicare
Program or any other state or federal assistance program, as confirmed by my review of the List
of Excluded Individuals and Entities (“LEIE”), the Medcheck List, and System for Award
Management (“SAM”) on a monthly basis. I am able to provide proof of monthly review of all
personnel in these databases upon request from CBH.

If (provider agency name) becomes aware that an employee has been named in any of the
aforementioned lists, (provider agency name) shall issue notice of termination to the employee
or Subcontractor and notify CBH (via email to the CBH.ComplianceContact@phila.gov) within 3
business days of becoming aware that an employee or Subcontractor has been excluded from
participation in any state or federal program.

____________________  ____________________  ____________________
Name (signature)     Name (print)            Title

____________________  ____________________
Date

Community Behavioral Health Provider Manual | August 6, 2020 | 150
APPENDIX K: INITIAL CREDENTIALING APPROVAL LETTER: FACILITIES

(Date)
(Name and Title)
(Organization Name and Title)
(Organization Address)

Dear (practitioner),

Welcome to Community Behavioral Health as an In-Network Provider! We are excited to have you join our network of skilled Facilities and Practitioners! The CBH Credentialing Committee approved (name of provider agency) to provide (type of program or service) effective (date of Credentialing Committee approval) and received a one (1) year credentialing status.

Enclosed in this packet, you will find an official copy of your Schedule A and signed Provider Agreement. We have included a quick reference guide and contact list to help answer frequently asked questions. We would also like to remind you about our website: https://dbhids.org where you can view and/or download information about Community Behavioral Health, including the following:

- The most current Provider Manual
- Member Rights and Responsibilities statement on the Member Services section of the website and in the Member Services Handbook, also on the website
- Bulletins, Notices and Contracting Opportunities (RFP, RFQ, etc.)
- Sign-up for electronic CBH News emails under “Contact Information”
- Credentialing Manual, which includes details about credentialing and recredentialing processes
- CBH’s policy prohibiting financial incentives for utilization management decision-makers, found on the Affirmative Statement Notification on the Notices page
- The Utilization Management Guide, which includes medical necessity criteria for prior authorized services
- Information about the availability of staff 24 hours a day via our toll-free number, 1-888-545-2600, to answer questions about Utilization Management issues
- The process to refer members to Mommy’s Helping Hands, our Complex Case Management Program for women who are pregnant with opioid use disorder

The most recent information about Community Behavioral Health and our services is always available on our website. Additionally, we will be contacting you to schedule Provider Orientation. If you have any questions about accessing our website or if you would like more information, please contact your Provider Relations Representative or Provider Relations Hotline at (215) 413-7660.

Thank you,

(Name) Provider Relations Representative
APPENDIX L: INITIAL CREDENTIALING EXIT LETTER: FACILITIES

(Date)
(Name and Title)
(Organization Name and Title)
(Organization Address)

Dear (practitioner),

Thank you for (name)’s communication and assistance during Community Behavioral Health’s (CBH) initial credentialing of (provider agency name), with administrative offices located at (address).

The initial credentialing was conducted as a desk review from (date) through (date) and included an electronic review of program business documents, policies and procedures, and personnel documents. A site visit was conducted on (date). Below is a detailed report of our findings.

Personnel Files
(summary of findings)

Business Documents:
(summary of findings)

Policies and Procedures:
(summary of findings)

Site Visit
(summary of findings)

The outcome of the credentialing review and recommendations for network inclusion will be presented to the CBH Credentialing Committee on (date of schedule Credentialing Committee review). The Credentialing Committee will make the decision on the credentialing status of your program based upon credentialing staff’s recommendations. Once a decision regarding the credentialing status of (facility or program name), a letter will be sent to you with the outcome.

Thank you again for your cooperation throughout the credentialing process. Should you have any further questions with respect to this process, please contact (name of CBH contact for the credentialing process).

Respectfully,
(CBH Staff Person and Title)
cc: Director of Operations
### APPENDIX M: CREDENTIALING COMMITTEE SUMMARY

**TEMPLATE: INITIAL CREDENTIALING: FACILITIES**

<table>
<thead>
<tr>
<th>Parent Name and CBH Parent #:</th>
<th>Name of Review and Review Date(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Address:</td>
<td>Date Exit Letter Mailed (if applicable):</td>
</tr>
<tr>
<td>Population Served:</td>
<td>Schedule A Effective Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider/Provider Type:</th>
<th>CBH Child #:</th>
<th>PROMISe #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommended Status:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Current Provider Agency Status**
- System involvement: *Provider history of providing services within the DBHIDS system*
- CBH contracted services: *Current contracted services by service category (i.e. OP MH, Residential Rehab, etc.)*

**Specific Services to be Delivered**
- Program overview: *Brief description of newly credentialed service, including target population, practice model or EBP, etc*
- Specific Levels of Care: *Specific LOCs to be provided, including LOC 1 & 2 descriptions*

**Program Review**
- Staff file review: *Any significant findings or omissions from staff file review*
- Policy and procedure review: *Findings from policy and procedure review for both required core policies and ancillary policies*
- Site visit: *General impressions from CBH site visit conducted for initial credentialing*

**Miscellaneous**
- *Other items not addressed above, i.e. pending litigation*

---

Status Legend: 1 = one year; 2 = two years; 3 = three years; 4 = pended
APPENDIX N: TRACKING SPREADSHEET FOR INITIAL CREDENTIALING: FACILITIES

<table>
<thead>
<tr>
<th>Provider/Facility Name</th>
<th>Date of Request</th>
<th>Service Type</th>
<th>Provider Type / Specialty Code</th>
<th>License #</th>
<th>License Type</th>
<th>Accreditation Date of CBH Site Visit</th>
<th>Credentialing Committee Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# APPENDIX O: INITIAL CREDENTIALING SITE VISIT CHECKLIST: FACILITIES

**Date of Site Visit:** _______________  
**CBH Reviewer(s):** ___________________________

**Parent Facility Name and Address:** ___________________________

**Facility Contact Person:** ___________________________

## Section 1: Facility Site Information

<table>
<thead>
<tr>
<th>Item</th>
<th>Criteria</th>
<th>Met Y/N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Facility identified by visible signage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Accessible by public transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>On-Site parking available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Handicapped parking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Wheelchair/Handicapped accessible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(continued)
**Section 2: Waiting/Reception Area**

<table>
<thead>
<tr>
<th>Item</th>
<th>Criteria</th>
<th>Met Y/N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Office hours and emergency contact information posted in reception area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>State and local licenses posted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>CBH Member Rights information posted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>CBH Compliance Hotline information posted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Notice of Privacy Practices/HIPPA information posted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Resource information posted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Reception area clean and well-lit w/ sufficient space for members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Adequate privacy for member registration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(continued)
### Section 3: Facility/Therapy Room/Medication Management

<table>
<thead>
<tr>
<th>Item</th>
<th>Criteria</th>
<th>Met Y/N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Clean, identified bathrooms accessible to both staff and members</td>
<td>Met</td>
<td>Y/N</td>
</tr>
<tr>
<td>15</td>
<td>Facility is clean, well-maintained and free from hazards</td>
<td>Met</td>
<td>Y/N</td>
</tr>
<tr>
<td>16</td>
<td>Treatment rooms provide for adequate privacy</td>
<td>Met</td>
<td>Y/N</td>
</tr>
<tr>
<td>17</td>
<td>Adequate office and meeting space for staff</td>
<td>Met</td>
<td>Y/N</td>
</tr>
<tr>
<td>18</td>
<td>Secure area for record storage</td>
<td>Met</td>
<td>Y/N</td>
</tr>
<tr>
<td>19</td>
<td>Secure area for medication storage</td>
<td>Met</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

**Summary of Findings:**
APPENDIX P: NETWORK INCLUSION AND ACCOUNTABILITY COLLABORATIVE (NIAC) CREDENTIALING PROCESS (REcredentialing: Facilities)

- Identify facilities due for NIAC site visit using Tracking Log of previous credentialing status
- Other visits to consider: Performance Improvement Process (PIP) visits, Department of Drug and Alcohol Programs (DDAP) visits, new levels of care (LOC), special or interdepartmental visits
- Collaborate with DBHIDS departments to confirm site visit dates
- Present NIAC site visit findings to the CBH Credentialing Committee
- CBH Chief Operating Officer presents recommended Recredentialing status to CBH Board of Directors
- Recredentialing Letters are sent via certified mail to the facility

(continued)
**NIC Scoring Tool**

The NIC scoring tool identifies the possible weighted percent values for each domain in the practice guidelines.

### Final Score Sheet

<table>
<thead>
<tr>
<th>Foundations of Excellence in Service Delivery</th>
<th>Score 0/1/2</th>
<th>Score 0/1/2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Earned Points for Foundations of Excellence in Service Delivery</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Possible Points for Foundations of Excellence in Service Delivery</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unweighted Percent for Foundations of Excellence in Service Delivery</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Weighted Percent for Foundations of Excellence in Service Delivery</td>
<td>20%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Domain 1: Assertive Outreach & Initial Engagement**

<table>
<thead>
<tr>
<th>Total Earned Points for Domain One</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Possible Points for Domain One</td>
<td>0</td>
</tr>
<tr>
<td>Unweighted Percent for Domain One</td>
<td>0%</td>
</tr>
<tr>
<td>Weighted Percent for Domain One</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Domain 2: Screening, Assessment, Service Planning and Delivery**

<table>
<thead>
<tr>
<th>Total Earned Points for Domain Two</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Possible Points for Domain Two</td>
<td>0</td>
</tr>
<tr>
<td>Unweighted Percent for Domain Two</td>
<td>0%</td>
</tr>
<tr>
<td>Weighted Percent for Domain Two</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Domain 3: Continuing Support and Early Re-Intervention**

<table>
<thead>
<tr>
<th>Total Earned Points for Domain Three</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Possible Points for Domain Three</td>
<td>0</td>
</tr>
<tr>
<td>Unweighted Percent for Domain Three</td>
<td>0%</td>
</tr>
<tr>
<td>Weighted Percent for Domain Three</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Domain 4: Community Connection and Mobilization**

<table>
<thead>
<tr>
<th>Total Earned Points for Domain Four</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Possible Points for Domain Four</td>
<td>0</td>
</tr>
<tr>
<td>Unweighted Percent for Domain Four</td>
<td>0%</td>
</tr>
<tr>
<td>Weighted Percent for Domain Four</td>
<td>20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Earned Points for Foundations of Excellence in Service Delivery &amp; Domains 1 - 4</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Possible Points for Foundations of Excellence in Service Delivery &amp; Domains 1 - 4</td>
<td>0</td>
</tr>
<tr>
<td>Unweighted Percentage of Foundations &amp; Domains One - Four</td>
<td>0%</td>
</tr>
<tr>
<td>Weighted Percentage - Level of Care Score</td>
<td>0%</td>
</tr>
</tbody>
</table>

(continued)
## Practice Guidelines – Framework

The framework of the practice guidelines, shown below, includes 4 domains, 10 core values, and 7 goals. See here for the full version.

<table>
<thead>
<tr>
<th>4 DOMAINS</th>
<th>10 CORE VALUES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1:</strong> Assertive outreach and initial engagement</td>
<td>In each domain, all of the goals for the delivery of effective care are pursued through strategies. Each of these strategies reflects one or more of the ten core values that drive this work:</td>
</tr>
<tr>
<td><strong>2:</strong> Screening, assessment, service planning and delivery</td>
<td>1. Strength-based approaches that promote hope</td>
</tr>
<tr>
<td><strong>3:</strong> Continuing support and early Re-intervention</td>
<td>2. Community inclusion, partnership and collaboration</td>
</tr>
<tr>
<td><strong>4:</strong> Community connection and mobilization</td>
<td>3. Person and family-directed approaches</td>
</tr>
</tbody>
</table>

| 7 GOALS | |
|---------| |
| **A.** Provide integrated services | 4. Family inclusion and leadership |
| **B.** Create an atmosphere that promotes strength, recovery and resilience | 5. Peer culture, support and leadership |
| **C.** Develop inclusive, collaborative service teams and processes | 6. Person-first (culturally competent) approaches |
| **D.** Provide services, training and supervision that promote recovery and resilience | 7. Trauma-informed approaches |
| **E.** Provide individualized services to identify and address barriers to wellness | 8. Holistic approaches toward care |
| **F.** Achieve successful outcomes through empirically informed approaches | 9. Care for the needs and safety of children and adolescents |
| **G.** Promote recovery and resilience through evaluation and quality improvement | 10. Partnership and transparency |
APPENDIX Q: PROVIDER PREPARATIONS FOR THE NETWORK IMPROVEMENT & ACCOUNTABILITY COLLABORATIVE SITE REVIEW (RECREREDENTIALING: FACILITIES)

The following activities will be completed during the site review:

- **Entrance Conference**
- **Executive Level Interview** (detailed below)
- **Living Review**: This activity employs a “360 degree” review of a person’s involvement with a provider, which allows for a full exploration of the personal experience of the relational, recovery, and resilience aspects of care. Interviews with the person receiving services, their primary staff person, and the primary staff person’s supervisor, as well as a review of the person’s clinical chart, will take place.
- **Facility Tour** (preferably led by an individual receiving services)
- **Planned Observations**
- **Peer Discussion Group** (this may be completed in a group or individual format)
  - Peer Discussion Groups are held with individuals age 18 and older
  - Adolescent Focus Groups are held with individuals age 14-17
  - Family Inclusion Focus groups are held with parents and caregivers of children under 14
- **Staff Focus Group** (this may be completed in a group or individual format)
- **Clinical Record Review**
- **Staff File Review**
  - Review of Supervision Notes and Logs
  - Review of Training Materials
  - Review of Performance Evaluations
- **Exit Conference**: This is a brief discussion of findings from the site review

**Tracking Log**: This is an example of the tracking log used for recredentialing of facilities.

<table>
<thead>
<tr>
<th>2017 Site Visit List</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider</strong></td>
</tr>
<tr>
<td>- DDAP Only</td>
</tr>
<tr>
<td>Health System Recredentialing visit + DDAP Review</td>
</tr>
<tr>
<td>Community Provider Recredentialing visit</td>
</tr>
<tr>
<td>Residential Program Provider</td>
</tr>
<tr>
<td>DDAP Only</td>
</tr>
</tbody>
</table>
APPENDIX R: POLICIES AND PROCEDURES FOR INITIAL AND REREDENTIALING: FACILITIES

The following policies are required by CBH for all parent organizations and facilities at the time of initial credentialing. Additionally, these policies must be maintained and provided to CBH upon request during recredentialing and oversight and monitoring processes. Some policies may not apply depending on the type of services provided (e.g., Medication Management Policy will not apply to providers who do not deliver medication services). These policy requirements are in addition to all policies required by the licensing entity.

1. Employee Screening and Sanction Policy
2. Incident Management Policy
3. On-call/Emergency Protocol Policy
4. Comprehensive Medication Management Policy:
   a. Use of Psychotropic Medications in Children and Adolescents (FDA-approved and Off-Label)
   b. Use of Antipsychotic Medications in Children and Youth
   c. Screening for and Treatment of the Components of Metabolic Syndrome
   d. Policy on the Full Range of Treatment Services Provided by Methadone Treatment Centers
   e. Policy Related to On-site Maintenance, Administration, and Prescription of Naloxone
   f. Prescribing of Benzodiazepines policy
5. Staff Development Policy (applies to full-time/benefit-eligible employees only)
   a. Clinical Supervision
   b. Performance Evaluation
6. Quality Assurance Policy:
   a. Feedback from Participants, Families, Allies, and Program Alumni Policy
   b. Measuring the Effectiveness of Services Policy
7. Completion of High-Risk Behavioral Assessments Policy
8. Peer and Family Inclusion Policy
9. Preventative and Diagnostic Healthcare Policy
10. SCA Monitoring Policy:
    a. Confidentiality Policy
    b. Sexual Harassment Policy
    c. Policy Regarding the Review of Interim Services
    d. Policy on Priority Populations
    e. Single County Authority (SCA) Grievance and Appeal Procedures Policy
    f. Policy on Treating Injection Drug Users (IDU)
11. Smoking/Tobacco Use Policy
12. Evidence-based Treatment Linkage Policy
APPENDIX U: POLICY REQUIREMENTS CHECKLIST: INITIAL AND RECREREDENTIALING: FACILITIES

1. Employee Screening and Sanctions Policy

**Required Levels of Care:** All Levels of Care

**Description:** The provider will establish a policy describing the mechanism for reporting criminal convictions, reports of child abuse, and/or license/certification suspension/revocation to the provider, pre-employment and throughout the term of hire. Areas to be identified include criminal history, child abuse clearance, and employee sanctions.

**Minimum Elements of the Policy:**

- The policy includes language that discusses the duty of staff members to report sanctions (e.g. criminal arrests, convictions, license suspensions/revocations, child abuse reports) taken against them to the provider agency or affiliate.

- The policy includes language that discusses the duty of all staff members to inform the provider about criminal convictions, child abuse reports, and license suspensions and/or revocations at the time of hire as well as throughout the entire duration of employment.

- The policy includes language that addresses the process the provider will use to inform staff members when information received during credentialing contradicts with information provided by the employee.

- The policy includes language including mandates that staff members will be given an opportunity to explain or correct misinformation in the file, subject to clearly delineated sanctions explained in the provider policy, and addresses in great specificity the procedure the staff member will use to respond to the conflicting information.

- The policy includes language that discusses the provider’s disciplinary action(s) for an employee’s failure to report the aforementioned events.
2. Incident Management Policy

**Required Levels of Care:** All Levels of Care

**Description:** The provider will have a policy that addresses the provider’s efforts towards identification, reporting, management, and investigation of all reportable significant incidents involving a Community Behavioral Health (CBH) member.

Please refer to [Bulletin 18-13](#) and its attachment.

**Minimum Elements of the Policy:**

- The policy includes language defining an unusual or significant incident.

- The policy includes language indicating that this policy is applicable whenever a provider reports a significant incident involving an adult or child member of mental health and drug and alcohol services, whether they are: CBH members receiving in-plan services, or County-funded individuals receiving supplemental funding through the Office of Mental Health, or the Coordinating Office of Drug and Alcohol Programs, including those served by the Behavioral Health Special Initiative (BHSI).

- The policy details the provider’s reporting process; see CBH Bulletin for requirements for reporting on the following:
  - Death
  - Where to fax reportable incidents
  - An internal investigation process
  - Process for reporting incidents involving alleged physical abuse, sexual abuse, and/or neglect of children
  - Process for reporting incidents involving alleged physical abuse, sexual abuse, and/or neglect of an adult 18 years and older, who has a physical or mental impairment
  - A missing person who may be at-risk

- The policy includes a list of where to send Significant Incident Reports.
3. On-Call/Emergency Procedures

**Required Levels of Care:** Outpatient Level of Care

**Description:** The provider will have an on-call emergency protocol that addresses the member’s ability to access the agency/independent practitioner during non-business hours (outpatient services only) [**Legal Reference:** 55 Pa Code §5221.23(a)].

**Minimum Elements of the Policy:**

- The policy includes language that discusses the member’s ability to access the treatment provider during non-business hours (e.g., text, answering system).

- The policy includes language that discusses how the member is informed about the provider’s on-call emergency procedure. **Note:** this should be a part of the member’s initial orientation to the program.

- The policy includes language that identifies the names of providers/agencies utilized for emergency services. Addresses and phone numbers should be included within the policy.

4. Comprehensive Medication Management Policy

**Required Levels of Care:** All Levels of Care as applicable

**Description:** The provider will establish a Comprehensive Medication Management Policy, incorporating the following:

- Use of Psychotropic Medications in Children and Adolescents (FDA approved and Off-Label)
- Use of Antipsychotic Medications in Children and Youth
- Screening for and Treatment of the Components of Metabolic Syndrome
- Full Range of Treatment Services Provided by Methadone Treatment Centers
- On-site Maintenance, Administration, and Prescription of Naloxone
- Prescribing of Benzodiazepines

**Minimum Elements of the Use of Psychotropic Medications in Children and Adolescents (FDA approved and Off-Label) Policy:**

- The rationale for an initial prescription of medication, including the condition or targeted symptoms; along with the proposed strategy for tapering and or discontinuing the prescribed medication, when appropriate should be clearly documented.
• The policy includes details regarding informed consent, use of off-label medications, and the use of educational materials for parents about the risks and benefits of all of the major medications.

• Please reference Provider Bulletin 10-03. Please Note: this policy is required only for those providers who serve children and adolescents (0-21).

Minimum Elements of the Use of Antipsychotic Medications in Children and Youth Policy:

• The policy details a new requirement for an annual psychiatric evaluation for every child and youth (0-21) on an antipsychotic medication.

• The policy requires that careful monitoring of side effects, and appropriate documentation of dose titrations and rationale to be included in medical records, along with documentation of members’ response (or lack thereof) to treatment and consequently indicated actions.

• The policy reiterates best practices, that psychotropic medications should not be used other than as part of a multimodal treatment that includes effective behavioral therapy; as such, documentation of concurrent non-medication treatment should be clearly documented.

• Please reference Provider Bulletin 18-12, clinical guideline #4. Please Note: this policy is required only for those providers who serve children and adolescents (0-21).

Minimum Elements of the Screening for and Treatment of the Components of Metabolic Syndrome Policy:

• The policy is required for all providers who prescribe medications.

• The policy addresses all required elements and medication management progress notes reflecting the practice of this policy.

• Please reference Provider Bulletin 07-07 for further guidance and specifications.

Minimum Elements of the Full Range of Treatment Services Provided by Methadone Treatment Centers Policy:

• The policy indicates methadone treatment centers provide, or be able to refer to, a full range of services including vocational, educational, legal, and health. Note: this does not apply to Suboxone.
• The policy language includes that treatment centers will comply with all state and federal licensing regulations.

• The policy includes language about how the agency offers an integrated and holistic treatment approach that provides psychosocial treatment, in addition to the provision of methadone, and that adequately screens for and treats co-occurring psychiatric conditions.

Minimum Elements of the On-site Maintenance, Administration, and Prescription of Naloxone Policy:

• The policy is in place at all behavioral health provider agencies regarding the administration of Naloxone.

• The policy includes language ensuring that there is staff equipped (via training) to identify persons in need of and to promptly administer Naloxone as indicated.

• Additionally, such policies and procedures ensure the acquisition, storage, monitoring, administration, and safe disposal of used and expired Naloxone. Please reference Provider Bulletin 16-04 for further guidance.

Minimum Elements of the Prescribing of Benzodiazepines Policy:

• The policy is required for all providers who prescribe medications. Please reference Appendices for the Network Inclusion Criteria (NIC) for guidance and further specifications.

5. Staff Development

Required Levels of Care: All Levels of Care

Description: The provider will establish a staff development policy to apply to full-time, benefit-eligible employees that incorporates the following:

• Clinical Supervision Policy
• Performance Evaluation Policy

Minimum Elements of the Clinical Supervision Policy:

• The policy indicates all clinical and direct care staff members receive recovery/resilience-oriented supervision.
• The policy describes how supervision is focused on improving outcomes for people receiving services as well as addressing staff strengths and challenges.

• The policy must also describe how supervision sessions support the individualized learning plan for each staff member. Please reference Appendices for the Network Inclusion Criteria (NIC) within this document for further specifications around supervision.

**Minimum Elements of the Performance Evaluation Policy:**

• The policy indicates the requirement of performance evaluations occurring for all staff.

• The policy indicates that after the staff person’s probationary period ends, performance evaluations are conducted on an annual basis, at a minimum.

• Further, the policy provides language about the areas for staff improvement that are identified as part of the performance evaluation and that are linked to the individual’s ongoing learning plan or yearly goals.

**6. Quality Assurance**

**Required Levels of Care:** All Levels of Care

**Description:** The provider will establish a quality assurance policy that incorporates the following:

• Feedback from Participants, Families, Allies, and Program Alumni
• Measuring the Effectiveness of Services Policy

**Minimum Elements of the Feedback from Participants, Families, Allies and Program Alumni Policy:**

• A policy must be in place to ensure that there is ongoing feedback from participants (to include children, youth, and adults), families, allies, and program alumni.

• The feedback obtained should be both quantitative and qualitative.

• The policy must include language about the findings from the data collection and feedback from a sampling of participants, families, allies, and program alumni that are analyzed on a quarterly basis.
Minimum Elements of the Effectives of Services Policy:

- A policy must be in place that indicates that agencies measure the effectiveness of the services provided.

- This policy must include language about how disparities concerning access, engagement, service quality, and outcomes are routinely assessed and monitored.

7. Completion of High Risk Assessment Policy

Required Levels of Care: All Levels of Care

Description: The provider will have a policy that addresses the need for high-risk behavioral assessments to be completed, including the screening for suicidality, homicidality, and any biomedical/physical concerns which may require a medical evaluation and assessment of withdrawal-symptom severity.

Minimum Elements of the High Risk Assessment Policy:

- The policy includes language that indicates the screening for suicidality and should include the history of prior attempts, assessment of potential lethality of these attempts, needed medical interventions as a result of the attempts, confirmation of self-reports from ancillary sources, current plan, means to carry out the plan, and potential lethality of the current plan.

- The policy indicates that the agency has measures in place for high-risk screens, to include possible referrals for an emergent evaluation.

- The policy includes language about incident reporting, which occurs at the state and CBH level if a suicidal/homicidal attempt is made.

- All providers offering substance use services funded through DDAP have answered the specified emergent care questions as identified in the DDAP Treatment Manual, Section 9.01.

8. Peer and Family Inclusion

Required Levels of Care: All Levels of Care

Description: The provider will establish a Peer and Family Inclusion policy that incorporates how peer support and a more vibrant peer culture will contribute to the overall culture of the
program. Questions that should be taken into consideration when developing the policy include the following:

- How is the power of peer culture/peer support being recognized?
- Define roles of Peer Support Staff vs. Peer Volunteers?
- What are the supervision and training requirements of Peer Support Staff and Peer Volunteers?
- What opportunities are created for peers to support each other?
- What opportunities do peers have to engage in active leadership roles at all levels of the program?
- What collaborations or relationships have been established in the community to link individuals to other behavioral health agencies or recovery support groups?

**Minimum Elements of the Peer and Family Inclusion Policy:**

- The policy clearly indicates the purpose of peer culture within the framework of the services offered.

- The policy specifies the provider’s stance in relation to ensuring peers participate in planning, developing, delivering, and evaluating program content and outcomes. Consider the role and functions of peer support staff and peer volunteers, as well as how their role enhances the program.

- The policy defines who is responsible for implementation of the various aspects of the policy and procedures stipulated.

- The policy offers step-by-step detail regarding how they will promote and enhance peer support and culture throughout the agency. Some examples to consider include:
  
  - Detail regarding how to create an engaging and welcoming environment for individuals in the program.
  - Detailing the process of how to orient individuals to program structure and expectations for a successful experience.
  - Detailing how the agency ensures individuals have input on deciding group topics and other therapeutic supports.
  - Detailing how the agency is ensuring that peers take the lead in recovery/resilience planning as well as continuing support planning.
  - Detailing a plan to foster successful integrations of peer support staff into the agency.
  - Detailing the role of alumni (e.g. are they serving as mentors?).
• Providers should also reference the [DBHIDS Peer Support Toolkit](#) as a guide to ensure full implementation of Peer Support practices throughout the agency.

9. Preventative and Diagnostic Healthcare Policy

**Required Levels of Care**: All Levels of Care

**Description**: The provider will establish a Preventative and Diagnostic Healthcare Policy indicating that holistic care and ensuring continuity of services are provided.

**Minimum Elements of the Preventative and Diagnostic Healthcare Policy**:

- The policy indicates how agencies assist participants in accessing critical preventative and diagnostic healthcare services through referrals or coordination with community healthcare supports.

- The policy indicates how education about behavioral health diagnoses, treatment, and trends, as well as education on physical/public health challenges including chronic diseases and community illness trends, are provided to participants.

- The policy incorporates how outcomes of the education of, referrals to, and coordination with physical health providers are tracked.

10. Single County Authority (SCA) Monitoring Policy

**Required Levels of Care**: All Department of Drug and Alcohol Programs (DDAP) funded programs

**Description**: The provider will establish a SCA Monitoring Policy, incorporating the following:

- Confidentiality Policy
- Sexual Harassment Policy
- Policy Regarding the Review of Interim Services
- Policy on Priority Populations
- SCA Grievance and Appeal Procedures Policy
- Policy on Treating Injection Drug Users (IDU)

**Minimum Elements of the Confidentiality Policy**:

The policy addresses the following areas:

- Releases of individual-identifying information
• Storage and security of clinical records
• Computer security of clinical records
• Staff access to records
• Confidentiality training for all applicable staff
• Disciplinary protocols for staff violating confidentiality regulations
• Revocation of consent
• Notification that re-disclosure is prohibited without proper consent

Minimum Elements of the Sexual Harassment Policy:

The policy is required for all DDAP-funded programs as noted in the DDAP Operations Manual.

• The policy includes language ensuring that employees are aware of the policy
• The policy includes language ensuring that sexual harassment will not be tolerated, and that employees who violate the policy will be disciplined

Minimum Elements of the Review of Interim Services Policy:

This policy must be in place for all DDAP-funded providers who serve both pregnant women and Injection Drug Users (IDU).

• The policy clearly details the procedures for ensuring the provision of interim services for the identified individuals if they are not able to be admitted within 14 days after the completion of the level of care assessment.
• The policy includes language that interim services are provided and arranged for within 48 hours of the level of care assessment.

Minimum Elements of the Priority Populations Policy:

• The policy specifies the provider’s priority populations, which should be indicated in the following order:
  1. Pregnant Injection Drug Users
  2. Pregnant Substance Users
  3. Injection Drug Users
  4. Overdose Survivors
  5. Veterans

• The policy includes language stating that all individuals identified as part of the priority population are offered admission to the recommended level of care immediately.
Minimum Elements of the SCA Grievance and Appeal Procedures Policy:

- The policy is in place for all DDAP-funded providers as it relates to the SCA.

Minimum Elements of the Treating Injection Drug Users (IDU) Policy:

- The policy ensures the SCA is notified within 7 days upon reaching 90% capacity for admission of individuals who are identified as IDU.

11. Tobacco-Free Policy

Required Levels of Care: This policy is required for all Acute Inpatient, Residential Drug and Alcohol, and Outpatient LOC providers and those providers offering substance use services funded through the Pennsylvania Department of Drug and Alcohol Programs (DDAP); it is recommended as a best practice for all other levels of care.

Description: The provider will establish a Tobacco/Smoke Free policy.

Minimum Elements of the Feedback from Participants, Families, Allies, and Program Alumni Policy:

- The policy includes language stating that the use of tobacco products—including electronic delivery systems (e-cigarettes or e-vaporizers)—is prohibited on campus including not only individuals receiving services but also staff members, visitors, contractors, etc.

- The policy addresses procedures for staff training and tobacco use screening, counseling, and pharmacotherapy treatment for individuals receiving services, as well as how they plan to monitor the policy.

- The policy details a description of the plan to communicate the policy to individuals receiving services, staff, visitors, contractors, etc.

12. Evidence-Based Treatment Linkage Policy

Required Levels of Care:

- All licensed drug and alcohol providers
- Crisis Response Centers (CRCs)
Minimum Elements of the Policy:

**APPLICABLE TO: CRCs AND DRUG AND ALCOHOL TREATMENT PROVIDERS**

- How programs discuss medication-assisted treatment (MAT) options (to include buprenorphine, methadone, and naltrexone ER) with members for the treatment of opioid use disorder (OUD).

- That the provider documents informed consent discussions with the members, to include the risks, benefits, and alternatives of evidence-based treatments, to include MAT.

- How members have access to and are quickly linked with evidence-based treatments, particularly medication-assisted treatment (MAT).

- The process for tracking and aggregating the number of individuals with OUD who are receiving MAT; this should clearly be defined in the procedure of the policy, to include the platform for tracking this information, the person (title) responsible for tracking this information, and that this data will be submitted to CBH on a quarterly basis.

**APPLICABLE TO: OUTPATIENT DRUG AND ALCOHOL TREATMENT PROVIDERS**

- Plan to promote access, including enhanced access avenues, including night or weekend hours, or dedicated open access hours.

- For providers offering methadone or buprenorphine, the process to track and report time from a member’s first appointment (with any staff) to the time of induction.

**APPLICABLE TO: RESIDENTIAL DRUG AND ALCOHOL PROVIDERS**

- How admissions are occurring during night and weekend hours.

- How admissions occurring across shifts are tracked, and this data is submitted to CBH quarterly.

**APPLICABLE TO: CRCs**
• The process and protocols to promote aftercare linkages for members with substance use disorder (SUD) who are not authorized for residential level of care, including “warm handoff” and a plan to track and follow up.

• The tracking process for transition activities for members referred to community drug and alcohol providers, with data submitted to CBH quarterly.
**APPENDIX V: SERVICE REQUEST FORM**

This form should be faxed to CBH Operational Support Services (OSS) unit at 215-413-7983 within **90 days** of the service start date. This form can be used to submit multiple requests. Questions about this form can be directed to OSS can at 267-602-8580.

- **Type of Service:** ________________________
- **Date of Submission:** ________________________
- **CBH Provider Number:** ________________________
- **Date CBH Received:** ________________________

<table>
<thead>
<tr>
<th>Client Name</th>
<th>CIS #</th>
<th>Soc Sec #</th>
<th>Living Arrangement Code</th>
<th>Voc Educ Code</th>
<th>Requested Service Code</th>
<th>Initial Service Start Date</th>
<th>Requested Auth Service Start Date</th>
<th>Requested Auth Service End Date</th>
<th># of Units</th>
<th>Primary Dx</th>
<th>Second Dx</th>
<th>Priority Group Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Community Behavioral Health Provider Manual | August 6, 2020 | 176*
### APPENDIX W: PES PRIOR AUTHORIZATION TEMPLATE

Providers requesting an initial or concurrent prior authorization (aside from services that require packet submissions) must provide the following details to CBH at the time of the request, as applicable:

<table>
<thead>
<tr>
<th>Details to Provide</th>
<th>Details to Provide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caller name</td>
<td>Mental Status Exam</td>
</tr>
<tr>
<td>Phone number/extension</td>
<td>Staff who conducted</td>
</tr>
<tr>
<td>Provider name</td>
<td>Date</td>
</tr>
<tr>
<td>Medical Assistance (MA) number</td>
<td>Time</td>
</tr>
<tr>
<td>Third party insurance (if applicable)</td>
<td>Suicidality (history/current/unable to assess)</td>
</tr>
<tr>
<td>Member’s current phone number and address</td>
<td>Homicidality (history/current/unable to assess)</td>
</tr>
<tr>
<td>Arrival date and time</td>
<td>Other MSE details</td>
</tr>
<tr>
<td>Mode of arrival</td>
<td>Urine drug screen (results/date/time)</td>
</tr>
<tr>
<td>Living situation</td>
<td>Breathalyzer (results/date/time)</td>
</tr>
<tr>
<td>Special needs (none/ visually impaired /hearing impaired/ physically impaired/intellectually impaired)</td>
<td>Blood alcohol level (results/date/time)</td>
</tr>
<tr>
<td>Legal involvement</td>
<td>Withdrawal symptoms (none reported or observed/headache/restlessness/runny nose/tremors/nausea/vomiting/irritability/watery eyes/muscle pain/fatigue/other)</td>
</tr>
<tr>
<td>Treatment history</td>
<td>American Society of Addiction Medicine (ASAM) criteria</td>
</tr>
<tr>
<td>Current services</td>
<td>Patterns of substance use- complete for each substance used</td>
</tr>
<tr>
<td>Presenting problems</td>
<td>Amount</td>
</tr>
<tr>
<td>Medical history</td>
<td>Frequency</td>
</tr>
<tr>
<td>Family support</td>
<td>Onset of first use</td>
</tr>
<tr>
<td>Employment</td>
<td>Last used</td>
</tr>
<tr>
<td>Trauma history</td>
<td>Method</td>
</tr>
<tr>
<td>Department of Human Services/Community Umbrella Agency (DHS/CUA) info</td>
<td>Medications (names, dosages, and frequency)</td>
</tr>
<tr>
<td>Name of school, grade, any special education services, current grades if available</td>
<td>Vital signs (date and time, results for most recent set taken as follows)</td>
</tr>
<tr>
<td>Precipitating events</td>
<td>Diagnosis</td>
</tr>
<tr>
<td></td>
<td>Alternative services considered</td>
</tr>
<tr>
<td></td>
<td>Case conceptualization and service requested</td>
</tr>
</tbody>
</table>
APPENDIX X: COMPREHENSIVE BIOPSYCHOSOCIAL EVALUATION (CBE) REQUIRED ELEMENTS

- Referral source
- Reason for evaluation
- Identifying data demographics
- History of presenting challenges/needs – multiple sources and integrate discrepant information
- Review prior/current treatment- multiple sources
- Medications – current and past
- Medical history
- Family psychiatric
- Developmental
- Educational
- Psychosocial history and current functioning
- Trauma assessment
- Aggression/self-harm/risk
- Substance use assessment
- MSE
- Diagnosis/provisional
- Strengths and protective factors
- Family Engagement
- Community supports/preferences
- Potential barriers/challenges
- Formulation
- Comprehensive recommendations/discharge option