Quest Behavioral Health

Provider Handbook

July 2019

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Introduction to Quest Behavioral Health

Welcome to Quest Behavioral Health, a managed care organization specializing in mental health and chemical dependency treatment. Quest has developed its provider network to ensure members of local health plans and employers receive the highest quality services available when in need of behavioral health treatment. Quest collaborates with our participating provider network in areas as quality management, case management, and provider relations, to improve services and emphasizing quality while managing costs.

This handbook contains important and helpful information regarding Quest policies and procedures, best practice guidelines and important operational procedures of Quest Behavioral Health. By reviewing this, you will help us to better serve you and our members.

Who We Are

Quest Behavioral Health was incorporated in April of 1997 to administer the mental health and chemical dependency benefits for employer-sponsored health plans (self-funded ERISA plans). Quest administers behavioral health benefits to employees and their family members throughout Pennsylvania, Northern Maryland, Delaware and New Jersey.

Quest provides services for health plan members through our provider network of approximately 4500 providers located primarily in Pennsylvania, but also in 11 other states. These providers are contracted with Quest to give our members access to mental health and chemical dependency treatment through inpatient, partial hospitalization, intensive outpatient and traditional outpatient levels of care. These benefits and array of services are defined by the health plans, which operate independently. Quest currently contracts with seven self-funded, employer-sponsored health plans serving over 125,000 covered members.

Quest provides a Call Center for verification of benefits, claims inquiries and general information during regular business hours of 8:00 A.M. to 6:00 P.M. Monday through Friday, except for holidays. After regular business hours, licensed clinical Doctorate level staff are available for emergency admissions and urgent clinical issues 24 hours a day, 7 days a week through the Quest Call Center number, 800-364-6352. During regular business hours, Quest Care Management staff work with providers to review treatment plans and assist in determining what level of care is needed.

Communication and Informed Consent

Due to the nature of services provided by Quest, it is at times necessary and appropriate to release information for purposes of treatment. This can include admission information, discharge planning, case management, primary care physician notification, and level of care changes. Although members have given consent for the release of information when enrolling with a benefit plan, it is the responsibility of the provider to obtain the applicable written consent from the member regarding the release of information. Our providers are expected to have current releases of information for:

Admissions - Because we need to discuss cases immediately upon admission, please make sure the admitting staff has secured a release. This is required to also include notification to the primary care physician.

Discharge Planning/Aftercare - Our provider is required to always furnish discharge information when referring a member to the next level of care, including agencies that will be continuing to serve the member.

Case Management/Level of Care Changes - Ongoing concurrent reviews and individual case management are important and vital aspects of ensuring our members obtain optimal utilization of their benefits. In certain situations, it may also be necessary to change a level of care for the security and benefit of the member.

Network Participation / Provider Relations

To receive Quest referrals and reimbursement, a provider or group must have a signed provider agreement indicating the intent to adhere to provider guidelines of Quest. Quest has a nondiscriminatory practice when credentialing providers. Quest does not make credentialing decisions solely on the applicant's race, ethnic / national identity, gender, age, sexual orientation or the types of procedures or patients in which the provider specializes in treating.

Initial Credentialing Process

The initial credentialing process requires the completion of a Participating Provider Application. As part of this process, a completed pre-application, copies of licensure, certification, education, training, and malpractice insurance, as well as any information required by the state must be submitted for review. A signed attestation that all information submitted is true and accurate is required. A site visit may also be required.

Upon receipt of all required information, the application is reviewed by the Quest Credentialing Committee, which includes representation from a range of participating providers of psychiatrists, psychologists, CRNPs, and master's level licensed professionals. Applicants considered for inclusion in the Quest network must meet appropriate credentialing requirements. Applicants have the right to review all information submitted to the Credentialing Committee, except National Provider Data Bank (NPDB) information and peer references. Applicants may correct erroneous information submitted as part of the credentialing application and are notified and afforded the opportunity to correct any discrepancies between information submitted by the applicant and information received from monitoring agencies. Upon request, applicants may be informed of the status of their credentialing application. All information obtained during the credentialing process is considered confidential and is only used for the purpose of provider appointment. Applicants are notified within 30 days of the Credentialing Committee's decision.

Re-Credentialing Process

Provider re-credentialing and facility re-credentialing occurs on a continuing basis with a programmatic completion every 3 years. Re-credentialing applicants submit licensure, attestation and other updates. Quest has a process for the ongoing monitoring of provider sanctions, complaints and adverse events between re-credentialing cycles. Re-credentialing applicants considered for inclusion in the Quest network must meet appropriate re-credentialing requirements. Re-credentialing applicants have the right to review all information submitted to the Credentialing Committee, except National Provider Data Bank (NPDB) information and peer references; and may correct erroneous information submitted as part of the re-credentialing application. Re-credentialing applicants are notified and afforded the opportunity to

correct any discrepancies between information submitted by the applicant and information received from monitoring agencies. Upon request, applicants may be informed of the status of their re-credentialing application. All information obtained during the re-credentialing process is considered confidential and is only used for the purpose of provider appointment. Re-credentialing applicants are notified within 60 days of the Credentialing Committee's decision.

Site Visits

Quest Behavioral Health shall conduct site visits to offices as required by the Credentialing Policies and Procedures and Quality Management Program. Site visits are conducted to verify compliance with Quest policies and procedures for claims submission and coverage of services. Site visits include: review of provider administrative procedures related to members' records, the physical aspects of the office or facility, including handicap access, and office practices that concern privacy and patient safety issues and compliance with claims requirements for appropriate billing for services rendered.

Provider sites are required to participate in the site visit program and may need to have records available for review, staff members available to answer questions and agree to assist in recommended improvements.

Provider Status Changes

As a Quest provider, you are required to notify the Provider Relations Department regarding any changes in the status of your practice. Status changes include a leave of absence, retirement, change in office location, change in billing service or address, revocation of licensure, disciplinary action, tax identification change, name changes, or temporary need to cease referrals. In addition, it is helpful to let Quest know of any degrees, certifications, licensures, or training that are awarded post credentialing; updating allows a more effective referral process. Provider changes may be submitted electronically via the provider change/addition form under Providers, Forms and Documents page on www.questbh.com.

Termination of Contract / Withdrawal from Network

If a Quest provider chooses to withdrawal from the Quest Network, they are required to notify the Provider Relations Department in writing 90 (ninety) calendar days before the date of termination. Members who are receiving services from a terminating provider may continue to do so for a transitional time period of up to 90 (ninety) days. The contracted rate will be paid through the completion of the transition period.

Membership, Eligibility and Notification Requirements

Quest Behavioral Health is responsible for multiple lines of business with different health plans. Members have different benefit plans offering coverage for various behavioral health services that may include inpatient and outpatient mental health, inpatient and outpatient chemical dependency services, chemical dependency detoxification, psychological testing and emergency care. In addition, Quest providers may participate in Quest's Employee Assistance Program which offers assessment and referral with master's level clinicians, Supervisory Referrals, Critical Incident Stress Management Response and Mediation Services. Quest's responsibility with these lines of business may be different depending on the contract with the employer group. Obtaining the correct insurance information from the member and verifying benefits with Quest allows for a smooth transition into treatment while maximizing a member's benefits.

Eligibility

Each member's benefits are determined by their health plan. Depending on the benefit plan, a member may be eligible for a spectrum of benefits, and Quest contracted providers should verify these benefits before providing services. The member may be responsible for reimbursing a portion of the provider's charges in the form of a co-payment, co-insurance or deductible. Authorization is required for Partial Hospitalization Programs, Intensive Outpatient Programs, Residential and Detoxification services, Inpatient Treatment, Psychological Testing, Electroconvulsive Therapy (ECT), Employee Assistance Program sessions, as well as autism services and Transcranial Magnetic Stimulation (TMS) subject to the member's benefit plan coverage. Contacting Quest directly to verify benefits prior to delivering service is in the provider's and member's best interest to verify eligibility of covered services. Electronic submission of the Membership Eligibility and Benefit Request form can be accessed through the Quest website under Providers, on the Forms and Documents page at www.questbh.com for a response within 24 business hours. This will allow for the proper benefit explanation of covered services, as well as any limitations the member's chosen plan may have. In addition, Quest can provide important information regarding co-payments, co-insurances, and/or deductibles required by the member's behavioral health/EAP benefit plan. Verification of eligibility does not guarantee payment. Payment will be made based on behavioral health services covered by the member's specific benefit plan; and may be affected by potential exhaustion of benefits (e.g. EAP sessions), dis-enrollment of the member during the service dates, failure to certify or re-certify services, lack of medical necessity or other benefit limitations.

Member Rights and Responsibilities

Quest Behavioral Health is committed to respecting members' rights, as well as communicating our expectations of members' responsibilities. We require our providers to furnish a copy of the rights and responsibilities statement to our members. The provider is required to keep a record that this statement has been communicated to Quest members.

Member Rights:

Quest is committed to respecting the rights of its members. Members have the right to:

- Obtain information about Quest services and providers.
- Obtain information about Quest Clinical Practice Guidelines.
- Obtain information about their rights and responsibilities as a Quest member.
- Obtain information about Quest's Quality Management Program.
- Be treated with dignity and respect.
- Privacy and confidentiality.
- Obtain a copy of Quest Privacy Notice detailing additional, specific privacy rights.
- Participate with their provider in making decisions about their treatment.
- An open and candid discussion with their provider of appropriate or medically necessary treatment options for their condition, regardless of the cost or benefit coverage.
- Privileges and rights granted to them by State and Federal law.
- Ask for and expect a reasonable effort on the part of Quest to accommodate their cultural, language, or gender preferences.
- Quest staff support in selecting a provider.
- Voice a complaint should a dispute arise about Quest staff or operations or the care they are receiving.
- Request an appeal regarding adverse benefit determinations

- Make recommendations regarding Quest member rights and responsibilities policies.
- Make recommendations regarding Quest services and providers.
- Make recommendations regarding Quest Clinical Practice Guidelines.
- Make recommendations regarding Quest Quality Management Program.

Member Communication Requirements

Quest Behavioral Health participating providers are required to advise members about procedures, rights, and responsibilities during their treatment episodes. This notification allows members to have a fully informed treatment experience. The list below provides a summary of information that we want our participating providers to discuss with Quest members.

- A copy of the Quest authorization for services, as applicable.
- A copy of the Quest Member Rights and Responsibilities Statement.
- A copy of the Quest privacy notice.
- Confidentiality Policies and Procedures (Attachment A).
- Co-pays, co-insurances, or deductibles.
- Office policies regarding a member's financial responsibility, missed appointment fees and cancellation of appointments.
- Clinical emergency procedures and on call, who to contact if member's are in an emergency.
- Potential medication risks, interactions and side effects.
- Options for treatment.
- Communication with PCP's, health care professionals, or behavioral health providers to provide continuity and coordination of care for members.

If you have any questions regarding this requirement, please contact our Provider Relations Department at 800-364-6352.

Care Management Program

Quest Behavioral Health is committed to quality behavioral health care offered at the least restrictive and least disruptive level of care for our members, while maximizing clinical outcomes and improving patient safety. Our care management team, which includes Care Managers and call center support staff, work together to support both the member and the provider. Our goal is to balance the recommendations for treatment from our network providers with the member's benefit plan and the services of our local delivery system.

Quest Call Center

The Quest Call Center functions in multiple ways to serve the needs of members and providers. The Call Center is equipped to handle and triage calls to appropriate providers, provide individual care management, review requests for services, verify benefit information, and collaborate on aftercare needs. Our regular business hours are 8:00 am – 6:00 pm, Monday through Friday, excluding holidays.

Clinicians are available 24 hours a day, 7 days a week through our on-call system for emergency admissions and urgent clinical issues. Members experiencing emergent situations should call 911 or visit their nearest emergency room. Members experiencing crises should contact their local crisis hotline. Our Care Managers are available to speak with providers who have emergencies or admissions after-hours. The Call

Center's support staff is available during regular business hours to expedite benefit verification, obtain information for pre-certification and answer questions for providers.

Incentives

Quest authorizes services based only on appropriateness of care and service and existence of coverage. Staff members, providers or other individuals do not receive rewards for issuing denials of coverage or service care. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization or offer incentives to reduce care and services.

Clinical Necessity

Most benefit plans necessitate that Quest Behavioral Health review behavioral health services for clinical necessity, particularly higher levels of care and specialized outpatient services. Through the utilization review and care management process, all requests for services and programs are based on medically necessary criteria. A determination for care is made based on individual member needs. Medical necessity criteria are applied in order to provide for the level of care that is least disruptive to the member while maintaining safety. Quest reimburses only for covered behavioral health and EAP services which have been determined to be clinically necessary. As a courtesy, the Quest medical necessity criteria are included in this handbook under Attachment B. Please feel free to contact Quest Care Managers or the Clinical Director at 800-364-6352 if you have any questions regarding the determinations made by Quest. Clinically necessary services are defined as those required to identify or treat a member's psychological, behavioral, or chemical dependency disorder and which, as determined by Quest's Care Management team:

1. Are consistent with the diagnosis and treatment of an acute psychological or behavioral disorder or acute chemical dependency problem identified;
2. Meet the medical necessity criteria for the severity of illness and the level of care requested as described in the Quest Medical Necessity Criteria;
3. Not solely for the convenience or preference of members, families, or their providers; and
4. Are offered at the least restrictive level of behavioral health services, which can be safely provided to the member.

Quest's Medical Necessity Criteria are designed to be clinically flexible, covering a wide range of clinical circumstances and presentations. Such criteria, however, cannot cover every potential set of circumstances. In addition to the clinical flexibility inherent in the Medical Necessity Criteria, Quest accommodates the individual needs of members during the review by a Physician or Psychologist Reviewer. When the Care Manager cannot authorize the requested care based on the information available, the case is referred to a Physician or Psychologist Reviewer.

Physician and Psychologist Reviewers are instructed to consider the individual clinical needs of the member in addition to the Medical Necessity Criteria themselves when rendering a medical necessity decision.

In rendering medical necessity decisions, Quest accommodates the capabilities of the local delivery system. If the appropriate level or setting of care is not available within a reasonable geographic distance from the member's location, Quest authorizes the next highest level of care that is available provided that the clinically indicated level of care is a covered benefit. Accommodating the capabilities of the local

delivery system by authorizing a higher level of care that is clinically indicated requires review and approval by the Clinical Director or Medical Director.

Assessment and Referral

Members may contact Quest directly for a participating provider referral. Care Managers, who are licensed clinicians, conduct a short telephonic triage assessment of the member prior to recommending a network provider or service phone number. Care Managers collect information about the presenting problem, symptoms, level of impairment, potential harm to self and/or others, history of treatment, and individual member needs. After considering the member's individual benefit coverage, Care Managers make a referral to appropriate providers or services in the member's community for an assessment and potential treatment. Practice information regarding treatment of specific age groups, disorders, or specialties is derived from provider credentialing and re-credentialing applications. It is important to have an accurate description of the provider specialty areas, so members may be referred to a provider that is best able to treat their specific behavioral health needs. In the case of a member who is in need of a non-life-threatening, urgent or emergent referral, Quest may contact the provider's office directly to arrange an appointment and follow-up with care needed for the member.

Accessibility

Accessibility is the timeliness with which a Quest member is able to obtain an appointment. Members are referred to providers based on the level of urgency of their behavioral health needs. Providers are expected to offer a member an appointment within the time frame relevant to the member's identified need. These time frames are as follows:

Life-threatening Emergent **–** Member is in imminent danger of harming themselves or others or is in the midst of a life-threatening situation. Members are referred to the nearest emergency room.

Non-life-threatening Emergent – Member is experiencing a non-life-threatening crisis, and unable to meet their basic needs, or are in danger of harming themselves or others. Member calls identified as emergent is required to be returned within one (1) hour and an evaluation must be completed within six (6) hours of the initial request.

Urgent – Member is experiencing a serious situation that is not emergent. Urgent member calls could become emergent without a prompt response. Providers are required to return member identified urgent calls within three (3) hours and an evaluation must be completed within forty-eight (48) hours of the initial request.

Routine – a Member is not experiencing a crisis or emergent problem; however, they require treatment. Routine member calls is required to be returned within one (1) business day and an appointment must be offered within ten (10) business days of the initial request.

Additionally, members discharged from inpatient settings should have an appointment scheduled within seven (7) calendar days, with the exception of medication management visits which should be scheduled within thirty (30) business days. Providers are expected to provide emergency coverage 24 hours a day, 7 days a week for patients currently involved in treatment.

We set standards for the availability of providers and services. Urban members are expected to drive no more than 20 miles to a provider and rural members are expected to drive no more than 45 miles to a

provider. We set ratios of providers per 1000 members. We measure and report information about access and availability on an annual basis.

Certification Process

Routine pre-certification

Pre-certification is required for Intensive Outpatient, Partial Hospitalization, Inpatient services, Detoxification services, Residential services, Psychological Testing, and other specialized outpatient services depending on the health plan. Those plans and employer groups contracting with the Quest Employee Assistance Program (EAP) sessions also require preauthorization to access their services. Psychological Testing Authorization and Quest EAP requests can be submitted electronically under the Providers, Forms & Documents page on the Quest website, www.questbh.com. After scheduling an appointment with the member, verify that the member contacted Quest to pre-certify the service. If the member has not pre-certified, contact Quest prior to rendering services. Quest staff will require patient demographics including insurance information, name of clinician performing the service, and presenting problem of the patient. Eligibility, co-payments, co-insurance or additional insurance information will be verified at that time. Quest will pre-certify the requested service (if member is eligible and service is medically necessary) and the provider will receive oral or written confirmation of the authorization.

Retrospective Review

A retrospective review of services may be requested under limited circumstances. Quest will review services retrospectively if the services occurred within 60 days of the initial appointment; if more than two visits occurred in those 60 days, progress notes must be submitted with a request for a retrospective review. The appropriate reviewer will review the request and a determination made. Our retrospective review process is designed for providers that encounter unusual situations preventing timely pre-certification. For HLDC, the chart must be submitted or reviewed within 60 calendar days of the request. The retrospective review process can only be completed after the chart had been reviewed by the Quest Clinical Director and the Quest Medical Director.

Higher Levels of Care

If a member needs a level of care higher than outpatient services or has urgent clinical concerns, please contact Quest Care Managers 24 hours a day, 7 days a week at 800-364-6352. Upon completing the initial assessment, discuss all treatment options with the member, including treatment options not covered by the member's benefit. Contact Quest with treatment recommendations to ensure the services are authorized for payment. If clinical services are required through an organized inpatient or outpatient treatment program, Quest will coordinate with the provider to utilize a participating facility or treatment program, within the Quest provider network, that is the most appropriate for treatment of the member's behavioral health needs. If Quest refers a member to your program or facility and the member does not begin treatment in the time frame agreed upon or fails to complete a scheduled admission, the facility is required to contact Quest Care Managers, who will attempt to re-establish contact with the member.

Concurrent Review

Following a referral, Care Managers will monitor the member throughout an episode of treatment. The provider monitors the member's clinical progress as well as the delivery of care and service. Coordination

of care is required (unless member declines) for transfer to each level of care, i.e. inpatient to intensive outpatient or partial hospitalization.

It is the treating provider's responsibility to contact Quest to provide the concurrent review of higher levels of care. The provider is required to provide information concerning the member's clinical progress, an updated treatment plan, and discharge and aftercare plans. The care manager requires regular clinical updates on the patient's progress to provide ongoing authorization and prevent interrupted care. The member's treating provider or another staff person familiar with the member's clinical treatment is required to be available to discuss the member's status with the Care Manager. It is recommended that all higher levels of care be discussed telephonically so all safety needs of the member are addressed.

If there is a disagreement concerning the need for continued treatment of inpatient or partial hospital levels of care or the level of intensity of treatment, the Clinical Director will be consulted and available to discuss the case directly with the provider. If an adverse determination results, the treating provider or appropriate clinician may request to speak with our reviewer by telephone to discuss the adverse determination by calling Quest at 800-364-6352 and requesting to speak with one of the licensed Care Managers.

Discharge Planning / Aftercare

Quest requires discharge planning to be an active part of all treatment services from the time of admission. The provider must be prepared to discuss discharge plans in conjunction with any concurrent review with the Quest Care Managers.

When a member completes an authorized course of treatment, the care manager remains involved to collaborate on the discharge plan. Providers are responsible for ensuring a member is scheduled with the next level of treatment when required. Periodic follow-up calls to the member and/or the treating provider or program are made by Quest Care Managers to ensure appropriate continuity and coordination of care with recommendations such as outpatient therapy, medication management, or participation in support groups. After securing the member's release of information, Quest providers are able to share discharge information to the provider at the next level of care, including primary care physicians and agencies that will be continuing to serve the member. Continuity and coordination of care is important to ensure the best outcomes for members.

Enhanced Care Management (ECM)

ECM members have chronic, persistent Mental Health and/or Chemical Dependency Disorder Accompanied by Co-morbid Medical and/or Axis II Condition that may complicate the disorder and/or Significant Social Stressors and a reduced level of functioning (such as Limited Support system). Case Managers will perform a monthly outreach contact with the ECM member (contact will take place with the member's parent or guardian if the participant is a child). Case Managers will perform a monthly contact with the provider(s) of services. ECM is based on a holistic approach to the treatment of the member (e.g. following through with PCP on a regular basis, community support such as 12 Step meetings, educational series) as well as individual mental health providers.

Quality Management Program

At Quest we are committed to the highest quality of service for our members and providers. Quality management is a systematic, integrated, organization-wide program that incorporates examination and assessment of all aspects of the managed behavioral healthcare system, from internal functioning to delivery of treatment. Professional integrity and mutual respect are defining characteristics of the model. Open communication throughout the organization and continual learning are essential guiding principles promoting the achievement of Quest's mission. The philosophy is people oriented, customer focused, and data driven.

The Quest Quality Management Program monitors accessibility, quality of care, appropriateness, effectiveness, timeliness and customer satisfaction. Quest understands that providers are a significant part of members' satisfaction. Quest encourages provider participation in the quality management program. Our provider advisory panel is consulted from time to time for input into quality management activities. If you would like to be part of our provider advisory panel, contact Quest's QM Department. We would welcome and appreciate provider input.

Accreditation and Regulatory Bodies

Quest Behavioral Health adheres to the accreditation standards of the National Committee for Quality Assurance (NCQA). In addition, Quest also complies with relevant Federal and State regulations and laws. Quest operates as a Certified Utilization Review Entity on Behalf of Managed Care Plans and is certified by the Pennsylvania Department of Health. Many of our policies, procedures, and organizational processes are instituted to comply with these requirements. Maintaining these standards is a Quest commitment and achieving new and better customer satisfaction is a continuous goal. Additional information regarding Quest standards or other regulations can be obtained by contacting our Quality Management Department.

Member Satisfaction

Member satisfaction is a top priority for Quest. Quest periodically measures member satisfaction through satisfaction surveys. Member satisfaction surveys provide information about members' perspectives on a spectrum of care and service issues. Complaints as well as compliments are important vehicles for identifying issues of concern to members or strengths within the process. Quest implements interventions to improve member satisfaction based on this information.

Provider Satisfaction

Provider satisfaction is also a key component to the partnership between Quest and its participating network. We recognize that, from time to time, some providers may feel our performance does not meet their expectations. Participating providers are encouraged to communicate any concerns and problems regarding our services to the Provider Relations department.

Claims and Billing Concerns

Claims and billing related concerns are required to be directed to the Claims Department of Quest Behavioral Health. To inquire about status of claims, electronic submission request forms are available under the Forms and Documents page of the Quest website, www.questbh.com. Electronic status requests will receive a response within 24 business hours, whereas telephonic status requests will receive

a response within 72 business hours. The claims department can be reached via phone at 800-364-6352. Please have the following required items on submitted claims: patient demographic information, date(s) of service, procedure code, charged amount, diagnostic code, specific provider who provided services, billing address, and any applicable authorization numbers. Please remember Quest administers different lines of business, which means sometimes billing concerns are the responsibility of another vendor. If that is the case, the business department will direct you to the appropriate payor.

Provider Concerns

Credentialing and re-credentialing are the primary responsibility of the Provider Relations Department. In addition, any issues regarding Quest's contractual requirements, administrative procedures, complaints or general concerns can be directed to the Provider Relations Department via email at provider@questbh.com or telephonically to 717-851-1478.

Complaints

A complaint is defined as an oral or written dissatisfaction with Quest or services provided by Quest contracted providers including those related to contract exclusions, non-covered benefits and other coverage issues, operations and management policies of Quest directed to the Quality Management Department. Each concern is thoroughly investigated and the result of the investigation is communicated to the complainant.

Denials

On occasion Quest may deny a service (adverse determination) due to a benefit coverage issue or failing to meet our medical necessity criteria. If a service is denied based on **medical necessity**, you as the provider are entitled to review the case with an appropriate clinical reviewer to discuss Utilization Management (UM) options. If you receive a denial and would like to review your UM options, please contact the Quest Care Management Department with your request at 800-364-6352. Appropriate appeal information, including information on external review rights, is provided at the time of the denial.

Appeals

Pursuant to ERISA regulations, Quest members have the right to appeal adverse benefit determination of their claims through the Quest Appeals Process. Appeals must be received within 180 days of notification of the adverse benefit determination. For appeals regarding medical necessity, Quest utilizes External Review Organizations to re-examine clinical denials. Appeals regarding adverse benefit determinations which are not clinical in nature will be submitted to the member's benefit plan for review. Appeal decisions will be rendered in writing within 30 days for post-service claims, 15 days for pre-service claims, and within 72 hours when medical exigency requires an expedited decision.

Physician and psychologist reviewers will be utilized in a peer review process to re-examine appeal concerns. The appeal will be completed within 30 days if the service has not been rendered or within 60 days if the service has already been provided.

Member Complaints

Quest Behavioral Health encourage members or their designees to communicate any problems or concerns regarding our services and benefits. Members are directed to contact the Quality Management Department by telephone or in writing if they are dissatisfied with any aspect of our services or the care

they have received. Quest will immediately investigate the complaint and attempt to resolve it within thirty (30) days of receipt of the complaint. If you are aware of a member's dissatisfaction, please encourage them to contact Quest. If a member complaint involves a provider, Quest will notify the provider of the complaint and request their perception of the event and any relevant clinical information.

Treatment Records

Consistent and thorough documentation in the treatment record is an essential component of quality patient care. Well-documented treatment records facilitate communication, coordination, and continuity of care. The efficiency and effectiveness of treatment is promoted by such documentation. The treatment record as the primary source of data about the patient also reflects the quality of behavioral healthcare provided by the clinician. Providers are expected to maintain clinical records for each member in accordance with the Quest treatment record documentation standards. The treatment record must be securely filed to ensure confidentiality and limited access. They must be retrievable to ensure availability to providers, office staff, and Quest, when needed. Quest may routinely conduct a treatment record documentation audit of participating providers who provide behavioral health services to Quest members. Feedback will be provided and, where deficiencies exist, improvement will be requested. Follow-up audits will be conducted and compared with prior results.

Attachment D provides the guidelines for treatment record documentation and record keeping practices. Offices are required to be able to meet requirements for treatment record keeping and the maintenance of a consistent and flowing chart system.

Billing and Claims Administration

Quest Behavioral Health reimburses behavioral health and chemical dependency services through our Claims Department. This department is responsible for the adjudication of claims, coordination of billing, and compilation of fiscal data. Claims from participating provider offices are required to be submitted to this office. Please remember Quest administers different lines of business and some plans may utilize other vendors for claims reimbursement. The Claims Department will direct you to the appropriate parties.

Billing

Your program is required to bill normal charges to Quest for admissions, programs and services. Billing is required to be on a HCFA 1500 or standard UB-92 form and should include an itemized statement listing services with the complete ICD-10 CM diagnostic classification. Printable and form-fillable versions of the HCFA 1500 form are located under the Forms and Documents page of the Quest website at www.questbh.com.

Quest has contracted with an external vendor, IHS ClaimsBridge, to process claims electronically. However, providers must submit their claims through their respective clearinghouse, who will then forward the claim in EDI format to IHS ClaimsBridge. The claims clearinghouse must submit Quest claims using the correct Payer IDs for Quest Behavioral Health: **#10956 for EAP claims** and **#44219 for all other behavioral health claims (non-EAP)**.

Paper claims on the appropriate forms (as mentioned previously) should be submitted to the appropriate PO Box listed below:

Quest EAP Claims
Quest EAP
PO Box 864
Arnold, MD 21012
Electronic Submission Payer ID: 10956

Behavioral Health Claims (Non-EAP)
Quest Behavioral Health
PO Box 565
Arnold, MD 21012
Electronic Submission Payer ID: 44219

Providers will also have the option to select from a variety of electronic payment options in the near future. Quest has contracted with Zelis Payments for all electronic payments. If a provider chooses to opt out of electronic payments, they will receive a paper check through the United States Postal Service to the address stipulated on the claim.

Quest Behavioral Health reimburses services authorized by Quest under current CPT procedural codes and ICD10 diagnostic criteria. Quest does not reimburse all CPT codes as stated in the published manual; it is the provider's responsibility to verify with Quest if a service is billable under the health plan of the member. Some health plans exclude certain services while others do not. As a provider under contract with Quest, you have agreed to bill Quest, not the member, for services rendered. Your program may bill the member only for applicable deductibles, co-insurance, or co-payments. However, we recommend the entire amount be billed to Quest to ensure accurate claims payment. Your program has agreed not to balance bill the member for the difference between your usual charges and the Quest negotiated rate.

A member may be billed for services, determined by Quest's care management process to not be clinically necessary, only if the member, or the member's representative, acknowledges in writing prior to the rendering of services that these specific services will not be covered by the Payer and assumes financial responsibility. Unless otherwise indicated, all claims must be submitted to the appropriate Quest Behavioral Health PO Box listed above. Claims must be received within sixty (60) days after services are provided to the member.

Reimbursement

Quest Behavioral Health and you have agreed upon the level of reimbursement most beneficial to all participants, which are recognized as the usual and customary rates for the region. The terms are referenced in the Fee Schedule included in the participation agreement with Quest and define rates applicable for services which you agreed to provide to Quest members. These rates are to be considered payment in full for your services. Please remember that co-payment and/or deductible amounts are subtracted from the fee rates; it is your responsibility to collect these additional amounts. Quest will adjudicate claims according to the negotiated rates, provided the claim form is complete, legible, and accurate. If your negotiated rates with Quest are all-inclusive (include physician fees, etc.), your program is responsible for payment to all treating physicians and for notifying the physician(s) that payment will be made by you. If you are not certain if services require preauthorization, it is recommended your office manager contact Quest to verify and authorize if necessary. All higher levels of care require preauthorization, as do certain "specialized" outpatient services such as Psychological Testing, ECT, TMS, Autism Services and a few others.

Benefit Exclusions

Benefit plans for members are determined by the member's employer group and their health plans. Employers with self-funded ERISA health plans develop the benefit package. The agreed-upon package is then forwarded to Quest to advise members and their providers of their particular plan and its limitations. Please check with Quest to determine any benefit exclusions, as they vary from plan to plan.

Quest Behavioral Health will pay clean claims, defined as a claim for payment for a behavioral health and/or chemical dependency service, which has no defect or impropriety (Act 68), within 45 days of receipt of the claim. Clean claims do not include claims that are under investigation for fraud or abuse. Claims are processed in order of the date received. Claims which do not meet the definition of a clean claim are claims that have a defect or impropriety, including lack of required substantiating documentation or a circumstance requiring special treatment, which prevents timely payment from being made on the claim. The provider and the member/subscriber will receive notification from Quest when such instances occur. Please remember, Quest may not be responsible for claim reimbursement services for all lines of business. If you have any questions regarding the claims process, our Claims Office can assist in directing you to the appropriate place.

The following elements are necessary for a claim to be considered a clean claim:

- Demographic information (name, address, date of birth, social security number / ID number) of the member and subscriber.
- Member's insurance plan.
- Appropriate behavioral health and/or substance abuse diagnosis code.
- Date of service(s) and procedure code(s) (CPT) must match service approved by Quest (services not covered by the member's benefit plan will not be reimbursed).
- Service provided must be a recognized contractual procedure code.
- Provider information (name of provider must match authorization approved by Quest), address where service occurred, and tax ID number.
- Number of sessions must not have exceeded number of sessions authorized by Quest.
- Applicable authorization by Quest must be current and not expired.
- Member must be eligible for services under insurance plan.
- Member's benefits must not be exhausted.
- Provider and service provided must be eligible under member's benefit plan.
- One unit of service per date of service per provider cannot be exceeded.
- EOB must be included and/or documentation of denial of services when Quest is the secondary payer.
- Coordination of benefits must be received or in place from member prior to claims processing.

Reimbursement and Explanation of Payment (EOP)

Following claims adjudication, a provider will be reimbursed for services either electronically (sign up is required and will not be available until a later date) or by check; either method will be accompanied with an explanation of payment (EOP).

If you are interested in registering for an electronic payment option, please go to www.zelispayments.com, and select the Providers tab. Alternately, you may contact Zelis Payments at 877-828-8770, Monday through Thursday 9:00 AM – 7:00 PM EST or Friday, 9:00 AM – 5:30 PM EST, or send your inquiry via email to info@zelispayments.com.

Coordination of Benefits (COB)

Many members are covered under more than one health plan. During enrollment, members and their dependents are asked about other insurance coverage. If Quest has not received any COB information from the insurer or the member, contact will be needed prior to processing claims. Missing COB information may interrupt the adjudication of the claim. It is in the provider's best interest to verify every insurance plan for potential coverage of the member's service. Attachment E is available for anyone who has not notified Quest concerning insurance coverage.

In order to prevent overpayment of plan benefits, Quest utilizes industry-standard coordination of benefits rules, where applicable. If a member has coverage with another insurance plan, your bill is required to be submitted to the other plan, as well as to Quest. Standard coordination of benefits rules will be used to determine which plan is primary and which is secondary. In cases where Quest is secondary, the primary carrier will be expected to issue payment to your program first. Quest requires a copy of the Explanation of Benefits (EOB) from the primary insurance carrier in order to process the claim. Pre-certification for services is required to be obtained from all potential sponsors according to their policies and procedures.

General Business

Our general business hours are Monday through Friday, 8:00 AM – 6:00 PM EST, excluding holidays. Licensed Care Managers are available 24 hours a day, 7 days a week for emergency admissions and urgent clinical concerns. If you have any questions about procedures, or if you need additional information about Quest Behavioral Health, please contact the Provider Relations Department directly at 717-851-1478.

Contact Information

General Mailing Address
P.O. Box 1032
York, PA 17405-1032
Web Address: www.questbh.com

Telephone Number: 800-364-6352
Fax Number: 717-851-1414

Claims Mailing Addresses and Payer IDs *(see page 16)*

Provider Relations
provider@questbh.com
717-851-1478

Quality Management
qm@questbh.com
717-851-1471

Sales
sales@questbh.com
717-851-5357

Member Services
membership@questbh.com
717-851-1486

Claims
claims@questbh.com
800-364-6352

Forms and Documents Available in Electronic Format

As a current provider, you can remain in constant communication with the Quest Provider Relations Department using the available online forms through the Quest website: www.questbh.com. The expanded online services for providers accelerate access to provider resources for claim processing,

credentialing, and overall information exchange. As part of our continuous quality improvement, we have streamlined all communications with the provider to increase efficiency and improve provider satisfaction. Electronically available forms are listed below:

- Claim Status Inquiry
- EAP Authorization
- HCFA 1500 Claim Form
- Membership Eligibility and Benefit Request
- Provider Change/Addition Form
- Provider Handbook
- Provider Pre-Application
- Request for Information
- Psychological Testing Authorization
- Out of Network Claims Form

Attachment A – Confidentiality Policy and Procedures

Policy

Quest, its staff and agents, shall protect the confidentiality of all confidential data and information to which they have access.

Purpose

To assure that all data and information obtained by Quest and its agents are maintained and used with the degree of confidentiality and security that the data and information warrant.

Definitions

Agents—Organizations that perform services for, or on behalf of Quest under the terms of a written or verbal agreement with Quest.

Contractors—Individuals who are paid for performing services for, or on behalf of Quest as Independent Contractors under the terms of a written or verbal agreement with Quest.

Data—Uninterrupted material, facts or observations.

Employees—Individuals below the level of managers employed by Quest on a permanent or temporary, full-time or part-time basis.

Enrollee—Members who are using or who have used Quest's services.

Information—Interpreted set(s) of data that can assist in decision-making.

Medical Record—The record in which clinical information related to providing physical, social, and mental health services is recorded and stored. A medical record may be maintained in a paper, electronic, magnetic, optical or other format.

Member—An individual for whom Quest manages health care benefits. Members may be subscribers or the dependents of subscribers.

Member-Identifiable Data or Information—All data or information where the member is identified or is potentially identifiable.

- Explicit member-identifiable data or information refers to that which contains a member's name or other unique identifier (such as a social security number) that can be traced directly to the member.
- Implicit member-identifiable data or information refers to that which can be used to identify a member when combined with other data or information available to the recipient of the data or information. The probability that a specific member can be identified with implicit member-identifiable data or information is directly related to the other types of data and information available to the recipient.
- All data elements identified by HIPAA regulations.

Representative—An agent, contractor, employee, staff or volunteer acting for, or on behalf of, Quest.

Research—Experimentation aimed at the discovery and interpretation of facts or the revision of accepted theories or laws in the light of new facts. Research is differentiated from quality management and improvement, which is aimed at measuring performance and intervening using non-experimental techniques to improve performance.

Staff—Individuals employed in managerial positions for Quest on a permanent or temporary, full-time or part-time basis.

Subscriber—An individual who arranges with Quest for the management of health care benefits for himself/herself and/or a dependent.

Treatment Record—The same as "Medical Record."

Utilization Management Record—The information maintained by a utilization management agent and used for the purposes of evaluating and determining the appropriateness of health care services.

Volunteer—Individuals performing services for Quest who are not paid for their service.

Collecting and Using Member-Identifiable Information

1. Quest collects and uses member-identifiable data and information routinely in the performance of its work.
2. Data and information are routinely collected and used for the following purposes:
    a. Verification of eligibility
    b. Management of behavioral health benefits, including prospective, concurrent and retrospective reviews and authorization or denial of coverage for requested treatment
    c. Coordination of care
    d. Billing
    e. Adjudication of claims
    f. Performance measurement and improvement (AKA "quality assurance")
    g. Prevention and disease management activities
    h. Practitioner credentialing
    i. Peer review
    j. Investigating and resolving inquiries and complaints
    k. Processing appeals
    l. Complying with regulatory requirements and accreditation standards
3. Quest requires that subscribers be notified of Quest's routine collection and use of member-identifiable data and information for the purposes described above.
4. The use of member-identifiable information for purposes other than those listed above requires written authorization from the subscriber or member unless permitted or required by applicable law or required by a valid court order.
5. Quest uses the following methods to notify subscribers of Quest's routine collection and use of member-identifiable information.
    a. When Quest is responsible for managing the enrollment process, subscribers are notified in writing at the time of enrollment of Quest's routine collection and use of member-identifiable information.

b. In many instances, Quest is not responsible for managing the enrollment process. To ensure that subscribers are notified of Quest's routine collection and use of member-identifiable information, annually Quest inserts a written description of the procedures for routine collection and use of member-identifiable information.

6. The following language is used to notify members of Quest's routine collection and use of member-identifiable information, at the time of enrollment, if applicable, and in all utilization management letters:

"Quest is responsible for administering all mental health and chemical dependency treatment benefits under your health plan. In order to carry out these responsibilities, we receive and use information about the individuals who are eligible to receive these benefits. When an eligible individual uses his or her behavioral health benefits, we usually need to obtain and use additional information about that individual to carry out the required clinical and administrative services we provide."

"Quest uses information about you and your dependents (if applicable) to enable us to verify eligibility for services; authorize treatment; pay claims; coordinate care; resolve inquiries, complaints and appeals; improve the care and service rendered by Quest and its network of practitioners and facilities; and meet regulatory requirements and accreditation standards."

"If we use information for reasons other than those described above, we will change or remove any portions of the information that could allow someone to identify you or your dependent or we will contact you or your dependent to ask for written consent to use the information."

Handling of Member-Identifiable Information

1. All data and information where the member or subscriber is, or could possibly be, identified are confidential. An individual's status as a member or subscriber covered by Quest is considered confidential member-identifiable information.
2. A treatment record is a confidential document that is the record of privileged communication between a patient and a health care practitioner or facility.
    a. Quest may obtain copies of treatment records for legitimate business purposes.
    b. Quest believes the information contained in the treatment record is the property of the treating practitioner or facility.
    c. Quest discourages the re-release of treatment records and the data and information contained therein.
        i. Under no circumstances other than a valid court order or compliance with applicable law will Quest re-release treatment records, or the data and information they contain, without a valid release of information as described in the policy on "Consent to Disclose Information."
        ii. Should a member or a member's legal representative request a copy of a treatment record that Quest has obtained from the treating practitioner or facility, Quest will refer the member or member's legal representative to the practitioner or facility.

iii. Under unusual circumstances, it may be appropriate for Quest to release a treatment record to the affected member or member's legal representative rather than referring the member or member's legal representative to the practitioner or facility. Authorization to release treatment records to the member or members' legal representative must be made in consultation with Quest's legal counsel.

3. Member-identifiable information may not be divulged by telephone without first verifying the identity of the other party.
    a. A case number or social security number and data of birth may be used to verify the identity of an individual claiming to be a member or beneficiary. If there is suspicion about the identity of an individual, even when such person can supply a correct case number or social security number and date of birth, the Quest representative should seek additional verification or request assistance from a supervisor or manager.
    b. A member requesting information about his or her treatment should be referred to the treating practitioner.
    c. Member-identifiable information may not be disclosed to the member's relatives or friends except as described in the policy on "Consent to Disclose Information."
4. Data and information derived from treatment records, utilization management records or other clinical sources shall not be considered confidential if they are de-identified or combined and aggregated with other data and information in a manner that precludes the identification of specific members.
    a. When considering the adequacy of such aggregation or de-identification to maintain member confidentiality, the Quest representative disclosing the data or information must consider what other data or information may be available to the recipient that could enable the recipient of the information to identify specific members. For example, an employer receiving de-identified claims data may be able to identify specific employees by combining the claims data with available information on employee sick time.
5. Members have the right to request special limits on access to member identifiable information. For example, a member who is also an employee of Quest may request that information on his or her treatment be afforded special protection.

Ability to Give Informed Consent

1. Quest does not provide direct care or treatment to members.
2. Quest does not obtain consent for treatment since Quest is not a direct provider of care or treatment.
3. Quest obtains consent to release member-identifiable information as described in the policy on "Disclosure of Information."
4. Quest considers the following individuals capable of giving valid consent for the release of member-identifiable health information:
    a. A member, who has reached the age of majority as identified by Quest's eligibility data is capable of giving informed consent on his or her own behalf unless Quest has received notification that the individual has been adjudicated incompetent.
    b. The natural or adoptive parent of a minor, as identified in Quest's eligibility data is capable of giving informed consent on behalf of the minor unless Quest has been informed that the parent

has been adjudicated incompetent, is not the legal guardian or that the minor has been legally emancipated.

c. An emancipated minor is capable of giving informed consent on his or her own behalf. If not already on file with Quest, Quest will request proof of the minor's status from the minor before honoring the consent.

d. A legally authorized representative is capable of giving informed consent on behalf of the individual he or she represents. Quest requires written proof of the individual's status as legally authorized representative and that the status covers the area for which the consent is being sought.

5. Quest extends all reasonable effort to develop and maintain an accurate and efficient information system for member information.
    a. Having established such a system, Quest reasonably relies on the absence of information indicating that a member or parent of a minor has been adjudicated incompetent and that a parent is not a minor's legal representative.
    b. Verifying the accuracy of the absence of such information would not only be logistically impossible, it would, in most instances, require a breach of confidentiality.
6. Individuals capable of giving valid consent for the release of member-identifiable health information are entitled to have access to such information except as follows:
    a. Parents or guardians of children age 14 years or over may not have access to the child's health information without the consent of the child.

Disclosure of Information

1. Except as described in the previous section on "Collecting and Using Member-Identifiable Information" and "Disclosure of Information to Employers," Quest requests consent from the member or member's legally authorized representative prior to disclosures of member-identifiable data or information.
    a. The member or the member's legally authorized representative has the right to deny the request for consent to release member-identifiable information without consequence for the member or the member's coverage.
    b. If member-identifiable data and information are to be disclosed for purposes other than those described in the policies cited in number 1, above, the consent of the member or member's legally authorized representative is required. Among other reasons, consent of the member or member's legally authorized representative is required prior to disclosing member-identifiable data and information:
        i. For research purposes.
        ii. Requested for a worker's compensation or automobile insurance claim.
        iii. On behavioral health signs, symptoms, diagnoses or treatment to a primary care physician or other clinician not providing behavioral health care.
        iv. That could foreseeably result in the member being contacted by another organization for marketing purposes.
2. Only that information necessary to accomplish the purpose of the disclosure is released.

3. Member-identifiable information can be disclosed without consent of the member or member's legally authorized representative in the following circumstances:
    a. When such disclosure to health care personnel, a health care facility, the member's identified significant other or to the police is required to prevent loss of life or injury to a member.
    b. When authorized by an appropriate and valid court order.
    c. When authorized by Quest's legal counsel to meet the requirements of any applicable state or federal law.
4. Quest considers a consent to release information to be valid only if:
    a. The member or member's legally authorized representative is informed of the specific information to be released and the purpose(s) of the release in language which he or she can understand.
    b. The member or member's legally authorized representative is informed that the provision of care or treatment will not be affected by the decision of the member or member's legally authorized representative.
    c. The consent is obtained in a manner that complies with applicable law and regulation.
5. Consent to release information should be in writing.
    a. Under some circumstances, it may be necessary to obtain consent verbally.
    b. The use of a verbal consent should be approved in advance by Quest's legal counsel or, if circumstances indicate the need for a rapid decision about the acceptability of a verbal consent, by a member of Quest's senior management.
    c. The member or member's legally authorized representative should be provided with the information described in paragraph 6, below, prior to consenting to the release of information.
    d. The entire process of obtaining verbal consent to release information must be witnessed by two representatives of Quest.
6. Quest's "Consent to Release Information" requires the following information:
    - The name of the person or entity providing the information.
    - The specific information to be released.
    - The purpose for the release.
    - The individual or entity authorized to receive the information.
    - The expiration date of the consent.
    - Signature of member or member's legally authorized representative.
    - Address of member or member's legally authorized representative.
    - Signature of witness.
    - Date of the consent.
7. Quest complies with all applicable state laws regarding HIV-related information. Should Quest need to release information related to a member's HIV status, after obtaining appropriate written consent, Quest will release the records with the following disclosure statement attached:

    "This information has been disclosed to you from records protected by Pennsylvania State Law. Pennsylvania law prohibits you from making any further disclosure of this information unless

further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-related Information Act. A general authorization is not sufficient for this purpose."

Disclosure of Information to Employers

1. Quest does not share member-identifiable data or information with employers without consent of the subscriber, member or member's legally authorized representative.
    a. Quest recognizes that the member or member's legally authorized representative, and not the subscriber (unless the subscriber is also the member or the member's legally authorized representative) is the preferred individual from whom to obtain consent to release member-identifiable information to an employer.
    b. Quest acknowledges, however, that current industry practice is for the subscriber, and not each member, to sign consent forms and other documents at the time of enrollment. Requiring the signature of each member or member's legally authorized representative at the time of enrollment is impractical.
    c. Quest accepts its role as an advocate of member's rights and will work to effect change in the industry to increase protections for confidential member-identifiable information.
2. When Quest is responsible for managing the enrollment process, Quest obtains consent from the subscriber to release member-identifiable data or information to the employer at the time of enrollment.
3. In many instances, Quest is not responsible for managing the enrollment process.
    a. If Quest manages behavioral health benefits through an agreement with a managed care organization (MCO), Quest's policy is to release member-identifiable data or information to the MCO, knowing that in the absence of the MCO's agreement with Quest, the MCO itself would be responsible for managing behavioral health benefits and would therefore have access to the member-identifiable data or information.
    b. In any instance where Quest must release member-identifiable data or information to an employer, whether self-insured or fully insured, and for which Quest cannot verify that the subscriber has signed a consent to release such data or information to the employer, Quest will require that the employer agree in writing to protect all member-identifiable data and information from being used in any decisions affecting the member.
        i. In all contracts with employers executed on or after July 1, 2000, Quest incorporates language requiring that the employer agree to protect all member-identifiable data and information from being used in any decisions affecting the member.
        ii. For contracts with employers in effect prior to July 1, 2000, Quest will request that the employer sign an addendum to the contract requiring that the employer agree to protect all member-identifiable data and information from being used in any decisions affecting the member. Quest will not release member identifiable data or information to employers without obtaining such agreement.
4. Many requests from employers for data and information can be fulfilled with data and information that are not member-identifiable.

a. In instances where an employer requests member-identifiable information, Quest will inquire as to the proposed use of the data and information and attempt to meet the need with data and information that are not member-identifiable, for example aggregated data or information.
b. In instances where member-identifiable data or information are required, Quest will attempt to satisfy the employer's request with data or information that are implicitly, not explicitly, member-identifiable. Although the identification of specific employees is still possible with implicitly member-identifiable data or information, the probability is less and therefore affords greater protection for the member.

5. In all instances, Quest only discloses that information necessary to accomplish the purpose of the disclosure.

Handling of Practitioner-Specific Information

1. Quest considers practitioner credentialing and re-credentialing information confidential to the extent permitted by law.
2. Practitioner files are maintained in a locked room or locked file cabinet when not being used by Credentialing staff or the Credentialing Committee.
3. Access to practitioner files is limited to Credentialing Department staff and the Credentialing Committee.
4. Practitioners may request to review the information submitted in support of credentialing or re-credentialing activities.
    a. Practitioners may review the information in their file except for any information from the National Practitioner Data Bank (NPDB). Review of NPDB information is prohibited by federal statute.
    b. Practitioners are informed of the right to review information in their file through the cover letter in the application and reapplication packages.
    c. Practitioners may receive a copy of their file.
        i. The request must be in writing.
        ii. Credentialing staff send a copy of the practitioner's file to him or her within ten business days of receipt of the written request for the file.
        iii. NPDB information is not included.
        iv. Peer review information is not included.
5. Practitioners are notified by Credentialing staff of any information obtained during credentialing or re-credentialing activities that varies substantially from the information provided by the practitioner. Practitioners have the right to correct erroneous information. Practitioners may submit any corrections in writing or additional documents to the Credentialing Department.

   Credentialing staff document any verbal information or corrections provided by the practitioner in the file including the date and signature of the individual who obtains the information.

Practitioner Office Confidentiality

1. Practitioners who are covered entities under HIPAA Privacy and Security regulations are expected to be in compliance with these regulations by the established deadlines.

2. Member-identifiable data and information maintained in paper-based or removable computer storage media must be maintained under lock and key, either in locked cabinets or in a locked area.
    a. Member-identifiable data and information includes, but are not limited to, medical records, appointment books, correspondence, laboratory results, billing records, and treatment plans whether maintained on paper, magnetic disk or tape, optical disk or any other removable storage medium.
    b. These paper-based records and removable computer storage media must be locked except at times when the practitioner or another member of the office staff, who is authorized to access treatment records, is present.
    c. When unlocked, these paper-based records and removable computer storage media must be maintained in a secure location where they are not accessible to unauthorized individuals.
    d. In addition, when unlocked, these paper-based records must be maintained in a manner that their content is not visible to unauthorized individuals.
3. Computers used to store member-identifiable data or information must be protected with a password.
    a. Password protection is not required if all persons at the practice site are authorized to access, for legitimate business purposes, the member-identifiable data or information stored on the computer; AND
    b. The computer is located in a secure location not accessible to unauthorized individuals.
4. When a computer is used to store member-identifiable data or information, the monitor is positioned such that it is not visible to unauthorized individuals.
5. If email is used to transmit member-identifiable data or information, the email is flagged as confidential and a confidentiality notice is prominently displayed at the beginning of the email that conveys a message substantively similar to the following:

    "This email contains confidential and privileged information for use only by the intended recipient. Do not read, copy or disseminate this material unless you are the intended recipient. If you believe you have received this email in error, please notify the sender by return email, securely delete this file and any copies, and destroy any paper copies."

6. Facsimile machines are not located in areas where faxes may be intercepted or viewed by individuals not authorized to access member-identifiable data and information.
7. If facsimile machines are used to transmit member-identifiable data or information, a confidentiality notice is prominently displayed on the facsimile cover sheet that conveys a message substantively similar to the following:

    "This facsimile transmission contains confidential and privileged information for use only by the intended recipient. Do not read, copy or disseminate this material unless you are the intended recipient. If you believe you have received this message in error, please notify the sender by facsimile or telephone and destroy this document."

Attachment B – Medical Necessity Criteria

Quest's Medical Necessity Criteria are designed to be clinically flexible, covering a wide range of clinical circumstances and presentations. Such criteria, however, cannot cover every potential set of circumstances. In addition to the clinical flexibility inherent in the Medical Necessity Criteria, Quest accommodates the individual needs of members during the review by a Physician or Psychologist Reviewer. When the Care Manager cannot authorize the requested care based on the information available, the case is referred to a Physician or Psychologist Reviewer.

Physician and Psychologist Reviewers are instructed to consider the individual clinical needs of the member in addition to the medical necessity criteria themselves when rendering a medical necessity decision.

In rendering its medical necessity decisions, Quest accommodates the capabilities of the local delivery system. If the appropriate level or setting of care is not available within a reasonable geographic distance from the member's location, Quest authorizes the next highest level of care that is available provided that the clinically indicated level of care is a covered benefit. Accommodating the capabilities of the local delivery system by authorizing a higher level of care that is clinically indicated requires review and approval by the Clinical Director or Medical Director. As additional electronic or paper-based utilization management data collection systems are developed, they will incorporate provisions for documenting the clinical status of the member relative to the appropriate medical necessity criteria.

Quest Clinical Leadership:
Jakob Schulz, M.D., Medical Director
Tad Santos, PhD, Clinical Director and Director of Care Management

Medical Necessity Criteria for Chemical Dependency Treatment

Procedure

Quest's Medical Necessity Criteria are designed to be clinically flexible, covering a wide range of clinical circumstances and presentations. Such criteria, however, cannot cover every potential set of circumstances. In addition to the clinical flexibility inherent in the Medical Necessity Criteria, Quest takes into consideration the individual needs of members and the availability of services during the review by a Physician or Psychologist Reviewer.

When the Care Manager cannot authorize the requested care based on the information available, the case is referred to a Physician or Psychologist Reviewer. Physician and Psychologist Reviewers are instructed to consider the individual clinical needs of the member in addition to the medical necessity criteria themselves when rendering a medical necessity decision.

In rendering its medical necessity decisions, Quest accommodates the capabilities of the local delivery system. If the appropriate level or setting of care is not available within a reasonable geographic distance from the member's location, Quest authorizes the next highest level of care that is available provided that the clinically indicated level of care is a covered benefit. Accommodating the capabilities of the local delivery system by authorizing a higher level of care that is clinically indicated requires review and approval by the Clinical Director or Medical Director.

All Chemical Dependency levels of care require an initial evaluation by a licensed clinician or a certified addictions counselor (CAC / CAADC) to determine appropriateness and medical necessity, as well as a pre-certification by Quest. When there is a delay (more than 48 hours for inpatient care; one week for IOP; one month for outpatient care) between pre-certification and admission, Quest is to be notified of the admission on the starting date, and an additional level of care determination may be required. The following matrix was developed for children, adolescents, and adults with substance abuse issues. The age and specific developmental presentation of each patient will be taken into consideration during the pre-certification process. Patients will be referred to the least restrictive level of care that is appropriate. Referrals will be made to an appropriate facility-based program considering the individual needs of the patient and the characteristics of the local delivery system (i.e. availability of requested or needed specialties and provider's ability to meet the patient's special or cultural needs or preferences). The duration of treatment varies with the severity of the illness and the patient's response to treatment. Transfer to a higher level of care is indicated if the patient is unable to resolve the problem(s) at the present level of care, despite amendments to the treatment plan; the patient has demonstrated a lack of capacity to resolve the problem(s); or the patient has experienced an intensification of problem(s) or developed new problem(s). Continuity of care decisions are based on the least restrictive level of care, treatment availability, patient developmental and cultural characteristics, and response to treatment. A patient will be discharged, or authorized for a less restrictive level of care, when the approved treatment plan goals have been achieved resolving the problem(s) that justified admission to the present level of care.

References: American Society of Addiction Medicine Patient Placement Criteria, Second Edition-Revised.

Level of Care Matrix for Patients with Chemical Dependency Disorders

Dimension	Hospital Based Medical Detox Level IV	Medically Monitored Inpatient Treatment Level III	Intensive Outpatient (IOP) Level II	Outpatient Level I
	Excluding emergencies, an	**evaluation is required prior**	**admission to these levels**	
	Must meet criteria for dimension 1 and either dimension 2 or 3.	Must meet criteria for at least 2 dimensions. If dimension 1, 2, or 3 is not met, the pt. must have had a failed treatment experience within the past three (3) months.	Must meet criteria for dimensions 1, 2, & 3 and one of dimensions 4, 5, or 6.	Must meet criteria for all dimensions.
1 - Acute Intoxication and/or Withdrawal Potential	The patient is at high risk of withdrawal, Requires the full resources of a licensed hospital, and Cannot be safely treated in a Level III facility.	The patient is at high risk of withdrawal but Does not require the full resources of a licensed hospital. **NOTE:** Ambulatory Detox may be indicated if recommended by provider, program is available, & patient would prefer.	The patient is at minimal risk of withdrawal or Is experiencing minimal or stable withdrawal.	The patient is at minimal risk of withdrawal or Is experiencing minimal or stable withdrawal.
2 - Biomedical Conditions and Complications	The patient requires 24-hour medical and nursing care, Requires the full resources of a licensed hospital, and cannot be safely treated in a Level III facility.	The patient requires 24-hour medical monitoring but not intensive treatment.	No biomedical complications; Conditions are stable; or The patient is receiving concurrent medical monitoring and conditions are not a distraction from treatment.	No biomedical complications; Conditions are stable; or The patient is receiving concurrent medical monitoring and conditions are not a distraction from treatment.
3 – Emotional / Behavioral or Cognitive Conditions and Complaints	Severe and unstable problems. Requires 24-hour psychiatric care with concurrent addiction treatment. (See criteria for Inpatient Mental Health Treatment)	Moderate severity The patient needs a 24-hour structured setting. If the patient has a mental health diagnosis, concurrent mental health services in a medically monitored setting are required.	Mild severity with the potential to distract from recovery and Requires monitoring in a structured program several times per week.	None, Stable, or Receiving concurrent mental health monitoring.
4 - Readiness to Change	N/A	High treatment resistance. Poor impulse control despite negative consequences. Requires motivating strategies available only in a 24-hour structured setting.	Variable engagement in treatment/recovery, Ambivalence or lack of awareness of substance use/recovery, and Requires a structured program several times per week to promote progress in treatment through the stages of change.	Ready for recovery but requires motivating and monitoring strategies to strengthen readiness for change.
5 - Relapse, Continued Use, or Continued Problem Potential	N/A	The patient is unable to control use with imminently dangerous consequences despite active participation in treatment at a less intensive level of care.	The symptoms of addiction indicate high risk for relapse or continued use without close monitoring and support.	The patient is able to maintain abstinence or control use and pursue recovery with minimal support.
6 – The Recovery Environment	N/A	The living environment poses a danger and coping skills have not improved adequately to manage dangers or stressors in the living environment	The member is making progress but struggles with learning to cope with the environmental obstacles to recovery	The member has sufficient skills to cope with any non-supportive elements in the living environment, but is not yet able to maintain a self-directed plan of recovery

Medical Necessity Criteria for Inpatient Mental Health Treatment

1. All levels of care require an initial evaluation by a licensed clinician to determine appropriateness and medical necessity, as well as, a pre-certification by Quest. When there is a delay of more than 48 hours for inpatient care, one (1) week for partial hospitalization or IOP, or one (1) month for outpatient care between pre-certification and admission, Quest is to be notified of the admission on the starting date, and an additional level of care determination may be required.
2. **Inpatient Mental Health** care is defined as behavioral health care provided in a medically managed acute care facility that provides 24-hour care, seven days per week. It includes 24-hour medical monitoring, supervision, and provides a high degree of safety to stabilize mood and behavior.
    a. Inpatient care requires an individual plan of active mental health treatment which includes the 24-hour need for and access to the full spectrum of inpatient mental health services and availability of such behavioral management services such as quiet room, seclusion, or intermittent restraints.
    b. For **Admission to an Inpatient Mental Health Facility**, patients must have a diagnosed or suspected mental illness and one (1) or more of the following criteria must be met:
        i. All other lower levels of care have been determined to be unsuccessful or inadequate.
        ii. A need for suicide precautions, close observation on a 24-hour basis, or intermittent restraints as indicated by one (1) or more indicators of destructive behavior in which the patient exhibits or threatens:
            - Suicide attempt.
            - Suicide ideation coupled with the presence of a risk factor such as past suicide attempts, substance abuse, self-mutilation, dangerous risk-taking, or the availability of lethal weapons.
            - Command hallucinations with suicidal directive.
            - Serious and ongoing self-mutilation behaviors.
            - Serious and ongoing destructive behavior to one's social, business, or moral reputation as a result of mental illness.
            - Violent, unpredictable, or uncontrollable behavior which represents serious harm to body or property of others, or there is evidence for a clear and reasonable inference of serious harm to others.
            - Immediate danger from caregivers due to caregiver response to patient's illness-related behaviors.
            - Patient demonstrates the inability to adequately care for own physical needs, representing potential for imminent serious harm to self.
            - ***Exclusions:***
                a. Suicidal gestures with intent to manipulate others instead of intent to seriously harm self (e.g., chronic superficial cutting or minor self-mutilation acts).
                b. Suicidal gestures without intent to seriously harm self (e.g. chronic superficial cutting or minor self-mutilation acts).

c. Patient exhibits a serious and persistent mental illness consistent over time and current behaviors/symptoms do not reflect an acute exacerbation of the mental health illness.
d. Primary problem is social, economic, or one of physical health in the absence of a major psychiatric episode requiring this level of care.
e. Admission is being used as an alternative to incarceration.
f. Treatment focus is primarily for peer socialization and group support.

iii. Diagnostic assessment and treatment are unavailable, unsafe, or too complex on an outpatient basis including:
- Need for frequent psychotropic medication dosage changes or very close monitoring of medication.
- High risk of side effects or toxicity.
- High risk to withdraw patient from medication.
- Poor tolerance of medication.
- Multiple medication interactions.
- Advanced age coupled with multiple medical problems.
- Behavioral components of a medical illness are beyond the capabilities of a medical/surgical service.

c. For **Continued Stay in an Inpatient Mental Health Facility**, patients must have a diagnosed or suspected mental illness and two (2) or more of the following criteria must be met:

i. Treatment goals as defined by the attending psychiatrist and treatment teams are not yet achieved despite active interventions.

ii. A need for suicide precautions, close observation on a 24-hour basis, or intermittent restraints as indicated by one (1) or more indicators of destructive behavior in which the patient exhibits or threatens:
- Suicide attempt.
- Suicide ideation coupled with the presence of a risk factor such as past suicide attempts, substance abuse, self-mutilation, dangerous risk-taking, or the availability of lethal weapons.
- Command hallucinations with suicidal directive.
- Serious and ongoing self-mutilation behaviors.
- Serious and ongoing destructive behavior to one's social, business, or moral reputation as a result of mental illness.
- Violent, unpredictable, or uncontrollable behavior which represents serious harm to body or property of others, or there is evidence for a clear and reasonable inference of serious harm to self or others.
- Immediate danger from caregivers due to caregiver response to patient's illness-related behaviors.
- Patient demonstrates the inability to adequately care for own physical needs, representing potential for imminent serious harm to self.

- ***Exclusion:***
    a. Suicidal gestures with intent to manipulate others instead of intent to seriously harm self (e.g., chronic superficial cutting or minor self-mutilation acts).

iii. Diagnostic assessment and treatment are unavailable, unsafe, or too complex on an outpatient basis including:
- Need for frequent psychotropic medication dosage changes or very close monitoring of medication.
- High risk of side effects or toxicity.
- High risk to withdraw patient from medication.
- Poor tolerance of medication.
- Multiple medication interactions.
- Advanced age coupled with multiple medical problems.
- Behavioral components of a medical illness are beyond the capabilities of a medical/surgical service.

d. For **concurrent review of inpatient mental health treatment**, a summary of the treatment plan must be provided to Quest. The treatment plan must include the following:
   i. Diagnosis (ICD 10).
   ii. Current medications and medical tests ordered.
   iii. Date and summary of most recent contact with psychiatrist.
   iv. Daily progress documenting the facility's treatment, the patient's response to treatment, and continued problems consistent with the admission criteria.
   v. Treatment modalities needed and provided on a 24-hour basis.
   vi. Changes in treatment plan or goals.
   vii. Anticipated length of stay and discharge planning.
   viii. Chemical dependency evaluation, if appropriate.
   ix. Contacts with community resources, if appropriate.
   x. For children and adolescents, evidence of intensive family involvement occurring several times per week.

e. **Discharge from an Inpatient Mental Health Facility** is arranged when a less intensive level of care is determined to be safe and appropriate, as indicated by the following:
   i. Patient no longer poses a threat of danger towards self, to any other person, or to property.
   ii. Patient has met approved treatment goals to allow transition to a less intensive level of care.
   iii. There is no severe reaction to medication and/or further monitoring and adjustment of medication dosages in an inpatient setting.
   iv. There is no clinical evidence that re-entry into the community would result in an exacerbation of mental illness that would require continued hospitalization or re-hospitalization.

v. There is a continued care plan available and arranged for the patient's continued treatment at an appropriate lower level of care.

vi. ***Exclusion:***

- Patients deemed appropriate by a facility for release from the hospital on a pass do not meet medical necessity criteria for continued inpatient care as they no longer require 24-hour care.

Medical Necessity Criteria for Partial Hospitalization Mental Health Treatment

1. **Partial Hospitalization MH** care is defined as a supervised level of care that is provided for non-residents. A partial hospitalization program meets daily, five (5) days per week, for a minimum of 4-6 hours per day.
    a. Specific programmatic expectations required for partial hospitalization care include:
        i. A psychiatric evaluation is to be completed within one (1) working day after the admission date, with immediate initiation of medication recommendations.
        ii. Psychiatric contact shall occur no less than twice weekly, which must include one face to face contact.
        iii. Child and Adolescent: Family sessions are to be held no less than one (1) time weekly.
    b. For **Admission to a Partial Hospitalization MH Facility**, the primary indication for admission to a PHP is a clinical situation in which patients must have a diagnosed or suspected mental illness and symptom severity meeting all requirements of inpatient care, except the presence of imminent danger to self or others. An admission to the Partial Hospitalization level of care is appropriate if the patient is unstable and there is a need for close medication monitoring and/or a high degree of symptomatology, but no imminent danger (e.g., PTSD with flashbacks or mania and/or active psychosis, or significant problems in the school despite appropriate accommodations).
        i. Each of the following criterion must be met:
            1. Patient exhibits disabling mental health symptoms of significant impairment in day-to-day personal care, social, vocational, and/or educational functioning relative to baseline functioning that require daily multi-disciplinary treatment interventions in an acute partial hospital setting.
            2. The patient has a community-based network or family support that assists in maintaining the patient within a less-restrictive environment.
            3. The patient has the capacity and is willing to actively participate in all phases of the program.
        ii. ***Exclusions:***
            1. Chronic superficial cutting or minor self-mutilation without intent to kill or seriously harm self.
            2. Patient exhibits a serious and persistent mental illness consistent over time, and whose current behaviors/symptoms do not reflect an acute exacerbation of the mental illness.

3. Primary problem is social, economic, or one of physical health in the absence of a major psychiatric episode requiring this episode of care.
4. Admission is being used as an alternative to incarceration.
5. Treatment focus is primarily for peer socialization and group support.

c. For **Continued Stay in a Partial Hospitalization MH Facility**, patients must have a diagnosed or suspected mental illness, and appropriate short-term treatment goals for this level of care as defined by the treatment team (in coordination with and approved by the Quest care manager), have not yet been achieved despite active interventions.

i. ***Exclusions:***

1. Chronic superficial cutting or minor self-mutilation without intent to kill or seriously harm self.
2. Patient exhibits a serious and persistent mental illness consistent over time, and current behaviors/symptoms do not reflect an acute exacerbation of the mental illness.
3. Patient's symptoms and behavior are judged to be of a chronic nature, such that acute partial is not appropriate, and referral to a long-term program should be considered (e.g., patient demonstrates little to no progress in the acute care setting).
4. Primary problem is social, economic, or one of physical health in the absence of a major psychiatric episode requiring this episode of care.
5. Admission is being used as an alternative to incarceration.
6. Treatment focus is primarily for peer socialization and group support.

d. **Discharge from a Partial Hospitalization MH Facility** is arranged when a less-intensive level of care is determined to be safe and appropriate, as indicated by the following:

i. Appropriate short-term treatment goals for this level of care as defined by the treatment team, in coordination with and approved by the Quest care manager, are achieved.

ii. Clinical evidence that therapeutic re-entry into a less-intensive level of care would not result in an exacerbation of the psychiatric illness to the degree that would warrant continued need for partial hospitalization.

2. All levels of care require an initial evaluation by a licensed clinician to determine appropriateness and medical necessity, as well as, a pre-certification by Quest. When there is a delay of more than one (1) day for inpatient care, one (1) week for partial hospitalization or IOP, or one (1) month for outpatient care between pre-certification and admission, Quest is to be notified of the admission on the starting date, and an additional level of care determination may be required.
3. For concurrent review of partial hospital MH treatment, a summary of the treatment plan must be provided to Quest. The treatment plan must include the following:
    a. Diagnosis (ICD 10).
    b. Current medications and medical tests ordered.
    c. Date and summary of most recent contact with psychiatrist.

d. Daily progress documenting the facility's treatment, the patient's response to treatment, and continued problems consistent with the admission criteria.
e. Treatment modalities needed and provided.
f. Changes in treatment plan or goals.
g. Anticipated length of stay and discharge planning.
h. Chemical dependency evaluation, if appropriate.
i. Contacts with community resources, if appropriate.
j. For children and adolescents, evidence of intensive family involvement occurring at least once per week.

Medical Necessity Criteria for Intensive Outpatient (IOP) Mental Health Treatment

1. **Intensive Outpatient (IOP) MH** care is defined as a supervised, but not necessarily medically managed, level of care that is provided for non-residents. An IOP program generally meets two to three times per week for three hours per meeting.
    a. For **Admission to an IOP MH Facility**, patients must have a diagnosed or suspected mental illness and have failed to make sufficient clinical gains within a traditional outpatient setting or not attempted such outpatient treatment, and the severity of presenting symptoms is such that success of traditional outpatient treatment is doubtful. Each of the following criteria must be met:
        i. Patient is not judged to be dangerous to self or others and has a mental status that is compatible with outpatient treatment but requires more intensive supervision and/or treatment than available through outpatient sessions. Prior to admission, this may be verified with a formal evaluation by a mental health professional.
        ii. IOP care can be safely used as an alternative to inpatient or partial hospital treatment or to shorten an inpatient treatment or partial hospital treatment. The patient has a safe, supportive living environment or has the ability to seek help when needed and has access to identified support services outside of treatment hours.
        iii. Patient requires intensive, structured intervention for two or more hours each treatment day in order to meet specified therapeutic goals as developed by a multi-disciplinary team to include a psychiatrist.
        iv. Patient commits to voluntarily participate in all phases of the program and has sufficient intact functioning to benefit from an active intensive treatment program.
    b. For **Continued Stay in an IOP MH Facility**, patients must have a diagnosed or suspected mental illness and all of the following criteria must be met:
        i. Progress notes for each program session documenting the provider's treatment, the patient's response to treatment, and the persistence of the problems that necessitated the admission to the program, despite treatment efforts, or the emergence of additional problems requiring an intensive, structured outpatient treatment approach.

ii. Documentation that attempts at therapeutic re-entry into a less intensive level of care would result in relapse or exacerbation of the mental illness to the degree that would warrant the continued need for intensive treatment services.
iii. Initiation or continued regulation of medication for the treatment of a psychiatric symptoms which may be complicated by the presence of a medical condition, or limited or failed response to medication trial, compliance, or education regarding side effects.
iv. Evidence of family involvement occurring at least once per week, unless a specific clinical reason is given as to why this is not needed and is documented in the medical record.

c. **Discharge from an IOP MH Facility** is arranged when a less intensive level of care is determined to be safe and appropriate, as indicated by the following:
   i. Patient no longer requires an intensive structured integrated program in order to obtain treatment goals as determined by the multi-disciplinary team and the Quest Case Manager.
   ii. An outpatient appointment has been scheduled for patient's continued care.
d. All levels of care require an initial evaluation by a licensed clinician to determine appropriateness and medical necessity, as well as, a pre-certification by Quest. When there is a delay of more than one (1) day for inpatient care, one (1) week for partial hospitalization or IOP, or one (1) month for outpatient care between pre-certification and admission, Quest is to be notified of the admission on the starting date, and an additional level of care determination may be required.
e. For concurrent review of IOP mental health treatment, a summary of the treatment plan must be provided to Quest. The treatment plan must include the following:
   i. Diagnosis (ICD 10).
   ii. Current medications and medical tests ordered.
   iii. Date and summary of most recent contact with psychiatrist.
   iv. Daily progress documenting the facility's treatment, the patient's response to treatment, and continued problems consistent with the admission criteria.
   v. Treatment modalities needed and provided.
   vi. Changes in treatment plan or goals.
   vii. Anticipated length of stay and discharge planning.
   viii. Chemical dependency evaluation, if appropriate.
   ix. Contacts with community resources, if appropriate.
   x. For children and adolescents, evidence of family involvement occurring at least twice per week.

Medical Necessity Criteria for Outpatient Mental Health Treatment

1. All levels of care require an initial evaluation by a licensed clinician to determine appropriateness and medical necessity.
2. **Outpatient MH** care is defined as ambulatory care of non-urgent conditions provided on a periodic basis. A comprehensive diagnostic evaluation, including assessment of the psychiatric, medical,

psychological, family, social, vocational, and educational factors important to the individual, is conducted.

a. For **Admission to Outpatient MH Treatment**, patients must have a diagnosed or suspected mental illness. A mental health professional determines that the outpatient level of care is appropriate, and that there is potential for the person to benefit from outpatient care. The patient must meet at least one (1) of the following criteria:
    i. Patient has a mental health disorder listed in the current International Classification of Diseases characterized by reduced levels of functioning (occupational, educational, or social) or subjective distress in response to an acute precipitating event.
    ii. Patient exhibits signs or symptoms of a mental health disorder, behavioral and/or cognitive dysfunction associated with reduced levels of functioning (occupational, educational, or social) and/or subjective distress.
    iii. Patient has a history of mental illness and presents in partial or complete remission in which there is reason to believe that relapse is likely, and without treatment there is significant potential for serious regression.
b. For **Continued Stay in Outpatient MH Treatment**, patients must have a diagnosed or suspected mental illness and all of the following criteria must be met:
    i. Patient mental status continues to be compatible with outpatient treatment.
    ii. Patient has developed new signs or symptoms that meet admission criteria and could be expected to benefit from the outpatient level of care.
    iii. De-compensation or recurrent signs or symptoms may result from absence of treatment.
c. **Discharge from Outpatient MH Treatment** is indicated when:
    i. Appropriate short-term treatment goals for this level of care as defined by the provider, in coordination with and approved by the Quest Care Manager, are achieved.
    ii. Patient impairments in functioning, psychiatric symptoms, behavior, and/or cognitive dysfunction have abated to a baseline level, supporting termination.
    iii. Ongoing medication management could be conducted by the Primary Care Physician. Patients who have been stabilized on psychotropic medication and for whom continued stability is expected should be returned to the primary care physician (PCP) for medication management.
    iv. Patients who have responded well and for whom compliance is not anticipated to be a problem should be considered from return to PCP care, including patients with uncomplicated Mood Disorders, Anxiety Disorders, ADHD, and those patients on maintenance doses of psychotropic medication who are stable.
    v. Patients for whom referral back to PCP care is not recommended include:
        1. Patients with psychotic disorders who are on antipsychotic medications or who may be at risk for a movement disorder.
        2. Patients diagnosed with Bipolar Disorder for whom compliance is a concern.

3. Patients who are frequent utilizers of higher levels of care.

Medical Necessity Criteria for Medical-Surgical Psychiatric Consultations

1. Initial consultations can be authorized when one (1) or more of the following criteria are met:
    a. The patient is suspected of suffering from an undiagnosed psychiatric condition, and the condition is impacting on the medical condition for which the patient is receiving treatment.
    b. The patient has behaved in such a way as to indicate that a mental illness is suspected, and consultation is required to formulate a diagnosis and treatment plan.
    c. The patient is a potential danger to himself or others due to a suspected psychiatric condition.
    d. Differential diagnostic consultation to assist physicians in determining contributing psychiatric/psychological conditions when patient is not responding to usual medical protocol or treatment.
2. Follow-up consultations (maximum of one (1) follow-up consultation; two (2) total consultations per inpatient admission) can be authorized when one (1) or more of the following conditions are met:
    a. The initial consultation indicated that the patient required continued monitoring while the patient remained hospitalized.
    b. The patient's condition has failed to improve or has worsened such that a new treatment plan is necessary.
    c. Additional information about the patient or patient's condition has been obtained that may change the recommendations from the initial consultation.

Medical Necessity Criteria for Electro-Convulsive Therapy (ECT)

1. ECT will be authorized for those patients for whom it is medically necessary, and only when required standards are met. ECT may be performed in either an inpatient or outpatient setting. Approval of ECT will be given when two network psychiatrists or one psychiatrist in conjunction with the Quest Medical Director recommends the ECT to Quest and at least one (1) of the following criteria are met:
    a. Patient demonstrates a pattern of non-responsiveness to medication.
    b. The side effects associated with pharmacological treatment cannot be well-tolerated.
    c. The patient's condition, because of marked hyperactivity, sleeplessness, refusal to eat or drink, or suicidal behavior is such that the rapid improvement attainable with ECT is essential.

Medical Necessity Criteria for Outpatient Psychological Testing

1. Outpatient psychological testing may be authorized following an evaluation from a Mental Health Professional and following the completion of a Request for Psychological Testing Authorization Form (Attachment C) within two (2) business days of the request. Testing may also be authorized by the Quest Clinical Director or Medical Director without an evaluation by a network provider. The request form for psychological testing will be referred to the Clinical Director, or designee, who will review the relevant clinical data, make a decision regarding the authorization, and notify the provider of the determination. Testing will be authorized when:
    a. Psychological testing is performed directly by a licensed psychologist.
    b. There is a specific referral question relative to the formulation of a mental health treatment plan.

c. Testing is the most efficient and clinically appropriate means to answer the specific referral question.
d. The results of the psychological testing will assist in the formulation of a mental health treatment plan and contribute to a positive treatment outcome.
e. Coverage is available under the member's health plan and benefit structure.

2. The following are specific ***exclusions*** that do not meet medical necessity:
   a. Testing to determine IQ or a learning disability.
   b. Testing for the purpose of educational or vocational evaluation, placement, assessment, or decision-making.
   c. Disability evaluations.
   d. Child custody evaluations.
   e. Court-ordered or legally required testing in absence of above criteria.
   f. Any other exclusion specific to the member's health plan and benefit structure.

Medical Necessity Criteria for Bariatric Bypass Surgery Psychiatric Evaluation

Due to the medical nature of the procedure, all initial evaluations of Bariatric surgery candidates will be performed by a licensed Psychiatrist or PhD Psychologists under a 90791 or 90792 procedural code for full evaluation. Specialized psychological testing is not routinely medically necessary in these evaluations. The Guidelines of the American Society for Bariatric Surgery[1] states the following regarding preoperative psychological testing:

> *Numerous studies in the literature attempting to identify patient characteristics related to outcome have been reported, but no reliable psychological predictors of success have been identified. (See Vallis and Ross 1993 for a comprehensive review of this area). Only two general recommendations emerge from this study: (1) The more distressed patients are by their obesity, (reflected by exogenous depression) the more likely they are to lose weight, and (2) Serious psychiatric disturbance, to the extent that psychiatric treatment or admission is required, appears to be a negative predictor of outcome. While other psychological variables have been shown to be associated with post-surgical weight loss, none have been replicated in independent studies. Accordingly, routine pre-operative psychological evaluation should be required in patients who have a history of severe psychiatric disturbance, who are currently under the care of a psychologist/psychiatrist, or who are on psycho-tropic medications.*

Purpose

To provide a structured protocol for requests for psychological testing in association with the screening process involved in candidacy for Bariatric bypass.

Definition

Bariatric Bypass Surgery: Bariatric Surgery is known as stomach stapling, weight loss surgery, and obesity surgery and offers several procedures that are designed to achieve dramatic weight reduction and can be performed using the minimally invasive Laparoscopic technique.

[1] Guidelines of the American Society for Bariatric Surgery. http://www.obesity-online.com/guidelines_ASBS.htm. Accessed 09/29/05.

Procedure

The initial evaluation will be performed by a Quest network credentialed licensed Psychiatrist or PhD Psychologist under the procedure code 90791 or 90792. The evaluating psychiatrist or psychologist can recommend specialized psychological testing. Further psychological testing can be authorized with a licensed psychologist under the procedural code 96101 for full battery. The full battery for psychological testing should consist of a clinical interview, a Milon Personality Inventory, and a WALI. The evaluation may also be supplemented with an MMPI and a substance abuse screening tool.

Medical Necessity Criteria for Eating Disorders

The Level of Care Matrix for Patients with Eating Disorders was developed not as absolutes or replacement for existing Level of Care and Medical Necessity criteria, but as guidelines to be used by both treating practitioners and Quest Utilization Review staff. They are adapted from La Via et al. (1998) and published in the American Journal of Psychiatry, 157:1, January 2000 Supplement. Treatment availability in the patient's home region will be an additional consideration in LOC decisions for eating disorders treatment.

Level of Care Matrix for Patients with Eating Disorders

	Inpatient Hospitalization Level IV	**Partial Hospitalization Level III**	**Intensive Outpatient Level II**	**Outpatient Level I**
Characteristic	Two or more items in this category should qualify the patient for the higher LOC. Must meet at least one of 1, 2, or 3.	Must meet at least 1 item in this category and tx at a lesser LOC is either unavailable, unsafe, or too complex.	Must meet at least 1 item in this category and tx at a lesser LOC is either unavailable, unsafe, or too complex.	
1 - Medical Complications	For Adults: Heart rate < 40 bpm; Blood pressure < 90/60 mm Hg; Glucose < 60 mg/dl; Potassium < 3 meq/liter; Electrolyte imbalance; Dehydration; Cardiovascular organ compromise requiring acute treatment; or Blood in vomitus For Children & Adolescents: Heart rate < 50 bpm; Orthostatic BP changes (>20-bpm increase in heart rate or >10-20 mm Hg drop); BP below 80/50 mm Hg; Hypokalemia or hypophosphatemia.	Medically stable to the extent that more extensive medical monitoring as defined in Level IV is not required.	Medically stable to the extent that more extensive medical monitoring as defined in Level IV is not required.	Medically stable to the extent that more extensive medical monitoring as defined in Level IV is not required.
2 – Suicidality	Intent and plan.	Possible SI without plan or intent	Possible SI without plan or intent	Possible SI without plan or intent
3 - Weight as % of healthy body weight or BMI	<75% or BMI<16.5. For BMI 16.5-18: Acute weight decline with food refusal.	>75% or BMI 16.5 - 18.	>75% or BMI 16.5 - 18.	>80% or BMI>17.
4 - Motivation to recover (cooperativeness, insight, & ability to control obsessive thought)	Very poor to poor; preoccupied with obsessive thoughts; uncooperative with treatment or cooperative only in highly structure environment.	Poor to fair; preoccupied with obsessive thoughts 4-6 hours / day; cooperative with structured treatment.	Fair; preoccupied with obsessive thoughts >3 hours / day; cooperative.	Fair to good.

5 - Comorbid Disorders (substance abuse, depression, anxiety)	Any existing psychiatric disorder that meets standard Quest inpatient admission criteria.	Presence and severity of comorbid condition may influence choice of LOC.	Presence and severity of comorbid condition may influence choice of LOC.	Presence and severity of comorbid condition may influence choice of LOC.
6 - Need for structure for weight gain / eating	Needs professional supervision during and after all meals or has nasogastric / special feeding requirements.	Needs professional supervision at some meals in order to gain or maintain weight.	Needs professional supervision during at least 1 meal in order to gain or maintain weight.	Able to report meals and intake accurately.
7 - Impairment & ability to care for self: ability to control exercise	Complete role impairment, cannot eat and gain weight by self; structure required to prevent patient from compulsive over-exercising.	Professional supervision required to prevent patient from compulsive over-exercising.	Compulsive over-exercising may be intermittent, but generally controlled on a daily basis.	Compulsive over-exercising may be intermittent, but generally controlled on a daily basis.
8 - Purging behavior (vomiting, laxatives, diuretics)	Needs supervision during and after all meals and in bathrooms. Significant medical complications such as ECG abnormalities associated with purging.	Professional supervision required at some meals to counteract desires to purge. Medical complications are monitored and managed.	Able to report level of purging accurately. Can ask for and use support or skills for desires to purge. No medical complication requiring higher LOC.	Able to report level of purging accurately. Can ask for and use support or skills for desires to purge. No medical complication requiring higher LOC.
9 - Environmental Stress	Severe family conflict, problems, or absence so as unable to provide structured treatment in home, or lives alone without adequate support system.	Family or other support involved in treatment and able to provide at least limited structure or support.	Family or other support involved in treatment and able and willing to provide emotional and practical support and structure.	Family or other support involved in treatment and able and willing to provide emotional and practical support and structure.

Reviewed and Revised by:
Jakob Schulz, MD, Medical Director
Tad Santos, Ph.D., Clinical Director and Director of Care Management

Authorized by:
Robert Green, President

Attachment C – Psychological Testing Authorization Form

Psychological testing is a highly specialized component of the process of clinical assessment. It may be authorized under the mental health benefit only when data necessary for diagnosis and/or treatment planning is unavailable by other means of assessment (e.g., clinical interview, relevant history review, application of ICD-10 criteria, structured checklists, consultations with other treating providers, interviews with parents, teachers, review of school records, etc.).

Psychological Testing Authorization Form is available at www.questbh.com as a fillable form.

QUEST BEHAVIORAL HEALTH
REQUEST FOR PSYCHOLOGICAL TESTING AUTHORIZATION

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Social Security #: _____ Employer Group: _____

Previous Testing: Yes ☐ No ☐ If yes, when: _____

Psychological testing is a highly specialized component of the process of clinical assessment. It may be authorized under the mental health benefit only when data necessary for diagnosis and/or treatment planning is unavailable by other means of assessment (e.g., clinical interview, relevant history review, application of ICD-10 criteria, structured checklists, consultations with other treating providers, interviews with parents, teachers, review of school records, etc.)

Psychologist Name: _____ Psychologist License #: _____

Group/Practice Name: _____ Phone #: _____

Address: _____ Fax #: _____

Current Diagnosis(es): _____

Current Medication(s): _____

Patient's Current Symptoms: _____

Referral Question(s): Please state specific clinical questions you want the psychological testing to address.

_____

_____

_____

Please list <u>all</u> you have done to answer these questions prior to requesting psychological testing.

_____

_____

_____

How will testing aid in the patient's care?

_____

_____

<u>ONE (1)</u> of each primary procedure code permitted
Check All Applicable Tests Requesting
Scheduled Date of Testing: _____

Psychological Testing Primary Procedure (single 60-min unit)	☐	**96130**	**Units Permitted:**	**1**
60-min add-on:	☐	96131	Units Requested:	_____
Neuropsychological Testing Primary Procedure (single 60-min unit)	☐	**96132**	**Units Permitted:**	**1**
60-min add-on:	☐	96133	Units Requested:	_____
Administration & Scoring Primary Procedure by professional (single 30-min unit)	☐	**96136**	**Units Permitted:**	**1**
30-min add-on:	☐	96137	Units Requested:	_____
Administration & Scoring Primary Procedure by technician (single 30-min unit)	☐	**96138**	**Units Permitted:**	**1**
30-min add-on:	☐	96139	Units Requested:	_____

Fax completed form to 717-851-1414

QUEST BEHAVIORAL HEALTH
REQUEST FOR PSYCHOLOGICAL TESTING AUTHORIZATION

Please list the name(s) of all psychological tests you intend to perform:

Please list the name(s) of all neuropsychological tests you intend to perform:

Is the patient or legal guardian in agreement with the administration of these tests? ☐ Yes ☐ No

Comments/Notes:

FOR QUEST USE ONLY ☐ Approved ☐ Denied Date: _____

Fax completed form to 717-851-1414
Page 2 of 2

Attachment D – Treatment Record Guidelines

Policy

Quest establishes treatment record documentation guidelines, standards for availability of treatment records and performance goals to facilitate communication and coordination and continuity of care within the behavioral health continuum and between behavioral health clinicians and medical delivery systems and primary care physicians.

Quest expects network clinicians to implement the endorsed treatment record documentation guidelines, standards for availability of treatment records and to meet performance goals. Information contained in the medical record is considered protected health information. Refer to the Confidentiality P&P for the handling of the treatment record and protected health information.

Purpose

Treatment records are the primary vehicle for the maintenance and communication of a patient's personal health information. Consistent and complete treatment records are an essential component of quality patient care.

Quest's guidelines for treatment record documentation, standards for availability of treatment records and performance goals define its expectations for providers. Quest assesses treatment records to ensure that providers in its network comply with these guidelines and standards.

Definitions

Medical Record-The record in which clinical information related to providing physical, social, and mental health services is recorded and stored. A medical record may be maintained in a paper, electronic, magnetic, optical or other format.

Treatment Record - "Medical Record"

Protected Health Information - All data or information that Quest creates or receives that relates to the past, present or future physical or mental health or condition of a member or payment for services to the member, and which identifies or can be used to identify the individual.

This includes all individual identifiers outlined by HIPAA privacy regulations including:

- Names;
- Geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code (except for the initial three digits of a zip code for an area with a population over 20,000).
- All elements of dates related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89;
- Telephone numbers;
- Fax numbers;
- Electronic mail addresses;
- Social Security numbers;
- Account numbers;
- Certificate / license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;

- Web Universal Resource Locators (URLs);
- Internet Protocol (IP) address numbers;
- Biometric identifiers, including finger and voiceprints;
- Full face photographic images and comparable images; and
- Any other unique identifying number, characteristic, or code.

Documentation Guidelines

1. Each page in the treatment record contains the patient's name or other unique identifier.
2. The treatment record includes the patient's:
    - Address.
    - Employer or school.
    - Home telephone number.
    - Work telephone number.
    - Emergency contacts.
    - Marital status.
    - Legal status.
    - Appropriate consent forms.
    - Guardianship information, if relevant.
3. All entries in the treatment record include the responsible clinician's name, professional degree, and relevant identification number, if applicable. Solo providers need not use their professional degree or identification number.
4. All entries are dated.
5. Each entry is legible to individuals other than the writer.
6. Relevant medical conditions are listed, prominently identified and revised.
7. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status, are documented.
8. A medical and psychiatric history is documented, including:
    - Previous treatment dates.
    - Provider identification.
    - Therapeutic interventions and responses.
    - Sources of clinical data.
    - Relevant family information.
    - Results of laboratory tests.
    - Consultation reports.
9. Allergies and adverse reactions or the lack thereof are clearly documented.
10. For children and adolescents (through age 18), the following are documented:
    - Prenatal and perinatal events.
    - A thorough developmental history including physical, psychological, social, intellectual, and academic development history.
11. For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.
12. A mental status evaluation is documented including the patient's:

- Affect.
- Speech.
- Mood.
- Thought content.
- Thought process.
- Judgment.
- Insight.
- Attention.
- Concentration.
- Memory.
- Impulse control.

13. Special status situations, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with Quest's written protocols.
14. An ICD 10 diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.
15. If medications are prescribed, the treatment record maintained by:
    a. The prescribing provider documents:
        - Which medications have been prescribed.
        - The dosages of each medication.
        - The dates of initials prescription and refills.
    b. A non-prescribing provider, if any, documents:
        - Which medications have been prescribed.
        - The name of the prescribing provider.
16. If medications are prescribed, the treatment record maintained by the prescribing provider documents informed consent for medication.
17. A treatment plan is documented.
18. The treatment plan is consistent with diagnoses and has both:
    a. Objective measurable goals.
    b. Estimated time frames for goal attainment or problem resolution.
19. The patient's understanding of the treatment plan is documented.
20. The focus of treatment interventions is consistent with the treatment plan goals and objectives.
21. Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives.
22. Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.
23. The treatment record documents preventive services, as appropriate (e.g., relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).
24. The treatment record reflects continuity and coordination of care between behavioral health clinicians and the PCP or other non-behavioral medical providers.
25. The treatment record reflects continuity and coordination of care within the behavioral health continuum of care.

26. The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.

Treatment Record Keeping System

1. Quest expects its providers to maintain an organized treatment record-keeping system. Providers are informed of Quest's expectations through the provider handbook, provider newsletter or direct mailings.
2. The following elements are required components of an organized record-keeping system:
    - A unique treatment record for each patient.
    - Treatment record notes maintained in chronological order.
    - An organized system for maintaining documents for each patient. For example, all diagnostic reports maintained together in a section of a folder.
    - An organized filing system that provides easy access to unique patient files. For example, alphabetical filing or filing by unique patient identifier such as social security number.
3. Treatment records must be available as appropriate, to providers and staff other than the treating provider (for example, a covering provider).
    - There is a practice site-specific process for assuring treatment record availability whether the records are maintained centrally or in the treating provider's office.
4. Treatment record documentation occurs as soon as possible after the encounter. Special status situations, such as imminent harm, suicidal ideation or elopement potential, are prominently noted.

Communication of Treatment Record Information

1. Quest requires that providers have a process for communicating information to the patient's PCP and other health care providers within the behavioral health continuum and within the medical delivery system.
    a. The provider may use a specific form, a letter, verbal communication or other appropriate process to communicate information to other caregivers.
    b. The content and date of the communication with other providers must be documented in the treatment record.
2. Refer to the Confidentiality policy and procedure for direction on maintaining confidentiality of treatment records.

Treatment Record Practices

1. Quest requires documentation of appropriate:
    a. Consent to release of information.
    b. Informed consent for services.
2. Quest does not require use of specific forms for release of information and consent for services.
3. Quest procedures for treatment record maintenance require the following:
    a. Errors are corrected by drawing a line through the error and initialing it.
    b. Errors are always readable after correction.
    c. White out is never used in the treatment record.
    d. Entries are made only in ink.

e. Abbreviations, if used, are standard or readily identifiable to others.

4. Providers are informed of Quest's treatment record requirements through the provider handbook, provider newsletter or direct mailings.

Assessment of Treatment Records

1. Quest assesses treatment records using one or more of the following methods:
    a. Reviewing treatment records on-site at the provider's office.
    b. Obtaining treatment records from providers by mail-in to Quest.
    c. Reviewing treatment records sent to Quest for other reasons such as appeals.
2. Treatment records from high volume ambulatory care sites are included in the assessment.
    a. Ambulatory care sites include solo providers, group practices and clinics.
    b. Ambulatory care sites with more than twenty-five Quest members per year are considered high volume.
3. A report is generated every year to track the number of Quest members evaluated or treated at each specific ambulatory care site.
    a. The report may be based on claims, authorization data or referral data.
    b. The report includes the names and identification numbers of all Quest members evaluated, treated at, or referred to each ambulatory care site, the dates of treatment or referral and identification of the treating provider(s).
4. Treatment records for assessment are randomly selected from the report.
    a. The most recent treatment records are selected for assessment. Records of members who begin treatment in the six-month period prior to the assessment are preferable.
        i. Three treatment records are randomly selected for each provider when there are three or fewer providers at the ambulatory care site.
        ii. If the ambulatory care site has more than three providers a total of ten treatment records is randomly selected. Records are selected from all of the providers at the ambulatory care site.
5. Each high-volume ambulatory care site in the reporting period is scheduled for treatment record assessment.
    a. Treatment record assessment is completed within the next twelve months.
    b. Treatment record assessment is conducted once every twenty-four months for ambulatory care sites that remain high volume in consecutive reporting periods.
    c. Quest staff identify the specific treatment records for assessment.

    Either:

    a. An appointment is scheduled with the ambulatory care site for on-site treatment record assessment, or
    b. A letter requesting that identified treatment records be mailed to Quest is sent to the ambulatory care site for off-site treatment record assessment.
    c. The ambulatory care site is informed that the treatment records requested for off-site review have been selected from the total Quest members treated at the site and record substitutions are not permitted.

d. The ambulatory care site is informed that, at its discretion, patient identifiers may be removed before sending the treatment records to Quest.

6. Quest staff completes all treatment record assessments whether conducted on-site at the ambulatory care site or off-site by mail-in to Quest.
    a. A separate data collection tool is used for each treatment record assessed.
    b. Compliance with each of the treatment record documentation guidelines is evaluated for each record.
    c. A response of "yes", "no" or "N/A" is entered for each treatment record criterion.
    d. "N/A", non-applicable, may be selected as a response only when the data collection tool instructions allow this as an option.
7. Findings from the treatment record review are shared with the provider(s) or provider representative at the conclusion of an on-site review.
8. Upon request, copies of the completed data collection tools are made available to the provider(s) or provider representative.

Treatment Record Performance Goals

1. Quest's performance goal is 90% compliance with each treatment record documentation guideline.
2. Providers are informed of Quest's performance goal for treatment record guidelines through the provider handbook, provider newsletter or direct mailings.
3. Data from treatment record assessment are aggregated and graphed to display trends over time.
    a. The Quality Management and Improvement Committee (QMIC) reviews and analyzes treatment record performance data at least annually.
    b. Both organization-wide aggregate and ambulatory care site-specific data are reviewed and analyzed.
4. An ambulatory care site that does not meet the performance goal set by Quest will have an action plan to improve performance.
    a. The Quest staff member that assessed the ambulatory care site's treatment records develops the action plan in collaboration with the provider(s) or provider representative at the conclusion of the treatment record assessment:
        i. The lower the score, the more intensive the action plan.
        ii. Action plans are reviewed and approved by the QMIC.
        iii. Monitoring for performance improvement is conducted under the auspices of the quality improvement program.
            - Remeasurement is required to provide evidence of improvement. This treatment record assessment may be conducted on-site or off-site.
5. When Quest's aggregate results are below the minimum performance expectation set by Quest, the QMIC implements actions to improve overall treatment record documentation quality in the provider network.
    a. Providers are informed of the results of treatment record assessments and the need for improvement.
    b. In order to improve treatment record documentation in the network, Quest may:

i. Provide providers technical assistance including recommended forms to meet guidelines.
ii. Provide educational events to review documentation guidelines and ways to meet them.
iii. Publish best practices and documentation techniques in the provider newsletter.
iv. Distribute examples of appropriate documentation practices to the network.

6. Copies of treatment record assessment results are placed in the credentialing/re-credentialing file of each provider who is active at the ambulatory care site.
7. Providers are informed of the aggregate results of Quest's treatment record assessment activities and performance goals at least annually through the provider newsletter or by direct mail.

Record Review Organization

1. Quest may contract with medical record review organizations or other review entities to assess treatment records.
    a. These organizations and entities must include Quest's treatment record documentation guidelines in the review process.
    b. Quest's policies and procedures apply to the review conducted by these organizations and entities.
2. The medical record review organization or other review entity provides Quest with aggregate and site-specific findings from treatment record assessments.
3. Quest analyzes the data and determines actions to improve performance, if needed.

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Coordination of Benefits Form

We want to be ready to handle your claims. Please complete the following information and return as soon as possible. We cannot pay claims until we have this information from you.

QUEST BEHAVIORAL HEALTH

Subscriber Information	
Please Print Your Full Legal Name Below *Avoid nicknames and abbreviations, Include title (Jr., Sr., III., etc.)*	
Subscriber Name (Last, First, Middle Initial)	**Birthday (MM/DD/YY)**
Subscriber Employer Name	**Subscriber Phone Number**

Other Coverage Information		
Are you or any dependents (including spouse) covered under another health plan? ☐ Yes - Complete form ☐ No - Simply sign and date.		
Dependent Name 1 (Last, First)	Effective Date (MM/DD/YY)	Term Date (MM/DD/YY)
Subscriber Name (Last, First)	Relationship to Above Enrollee: ☐ Enrollee (self) ☐ Spouse ☐ Dependent	
Plan Name / Plan Phone Number		Policy #

Dependent Name 2 (Last, First)	Effective Date (MM/DD/YY)	Term Date (MM/DD/YY)
Subscriber Name (Last, First)	Relationship to Above Enrollee: ☐ Enrollee (self) ☐ Spouse ☐ Dependent	
Plan Name / Plan Phone Number		Policy #

Dependent Name 3 (Last, First)	Effective Date (MM/DD/YY)	Term Date (MM/DD/YY)
Subscriber Name (Last, First)	Relationship to Above Enrollee: ☐ Enrollee (self) ☐ Spouse ☐ Dependent	
Plan Name / Plan Phone Number		Policy #

**Use the back of this form for additional dependents

Signature _____ Date _____

Please submit this form to: Quest Behavioral Health
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Fax #: 717-851-1414