Quest Behavioral Health

Provider Manual

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Introduction to Quest Behavioral Health

Welcome to Quest Behavioral Health, a managed care organization specializing in mental health and substance use disorder 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 such as quality management, care management, and provider relations, to improve services, and emphasize quality while managing costs.

This manual contains important and helpful information regarding Quest policies and procedures, best practice guidelines and 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 manage the mental health and substance use disorder benefits for employer-sponsored health plans (self-funded ERISA plans). Quest manages 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 located primarily in Pennsylvania, but also in many other states. These providers are contracted with Quest to give our members access to mental health and substance use disorder 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 contracts with self-funded, employer-sponsored health plans to serve their covered members.

Quest provides a Call Center for verification of benefits, claim inquiries and general information during regular business hours of 8:00 A.M. to 5:00 P.M. Monday through Friday, except for holidays. Licensed clinical Care Management staff are available for emergency admissions and urgent clinical issues 24 hours a day, 7 days a week through the Quest Call Center by calling 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 the 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, care 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.

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

Network Participation / Provider Relations

To receive Quest referrals and in-network reimbursement, a provider or group must have a signed provider agreement indicating the intent to adhere to the provider guidelines of Quest. Quest has a nondiscriminatory practice when credentialing providers. Quest does not make credentialing decisions based upon the applicant's race, color, creed, sex, sexual orientation, gender identity or expression, age, religion, national origin, citizenship status, non-qualifying physical or mental disability, ancestry, marital status, veteran status, medical condition, or any protected category prohibited by local, state, or federal law. All credentialing is decided based on qualifications, merit, and business need.

Credentialing Requirements

Providers must hold a valid license in the state where the member is receiving treatment. Quest does not allow incident to billing. Specific requirements are outlined below:

- Psychiatrist – Board certification in Psychiatry or Addiction Medicine is required.
- Nurse Practitioner – Board certification as Psychiatric Mental Health nurse practitioner is required.
- Physician Assistants – Certificate in Added Qualification in Psychiatry is required.
- Psychologist – PsyD or PHD
- State licensed Masters clinician working independently; LCSW, LPC, LMFT, LCPC, LMHC, etc.
- State licensed Masters clinician under supervision; LAC, LSW, LGPC, LAMFT, etc.
- Autism providers– LBS or BCBA (Board Certified Behavior Analyst)

Professional Liability Requirements

A certificate of insurance declaration page from the insurance policy setting forth the policy

number, effective date, expiration date and dollar amounts of coverage. A licensee must maintain professional liability insurance in the minimum of $1,000,000 per occurrence and $3,000,000 per annual aggregate.

Quest requests licensee's participating in telehealth services shall make commercially reasonable efforts to maintain cyber liability insurance in amounts not less than $1,000,000 per date breach.

Initial Credentialing Process

The initial credentialing process requires the completion of a Participating Provider Application. As part of this process, a completed Initial Credentialing Application, copies of state licensure, board certification, applicable DEA registration, curriculum vitae, malpractice insurance, and W9, are required. All information obtained during the credentialing process is considered confidential and is only used for the purpose of provider appointment.

Upon receipt of all required information, the application is reviewed by the Quest Credentialing Committee, which includes representation from a range of participating owner-group providers including psychiatrists, psychologists, CRNPs, and master's level licensed professionals. Applicants considered for inclusion in the Quest network must meet appropriate credentialing requirements. Upon request, applicants have the right to review all material submitted to the Credentialing Committee apart from National Provider Data Bank (NPDB) information and peer references; and may correct erroneous information submitted as part of the application process. Applicants are notified within ten (10) business 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 three (3) years. As part of the process, a completed Re-credentialing Application, copies of licensure, malpractice insurance, W9, and applicable DEA registration and board certifications are submitted for review. All information obtained during the re-credentialing process is considered confidential and is only used for the purpose of provider appointment.

Re-credentialing applicants considered for inclusion in the Quest network must meet appropriate re-credentialing requirements. Upon request, applicants have the right to review all material submitted to the Credentialing Committee apart from National Provider Data Bank (NPDB) information and peer references; and may correct erroneous information submitted as part of the application process. Re-credentialing applicants are notified within ten (10) business days of the Credentialing Committee's decision.

Quest has a process for ongoing monitoring of provider sanctions, complaints, and adverse events between re-credentialing cycles.

Site Visits

Quest Behavioral Health may 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 claim 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, patient safety issues and compliance with claim requirements for appropriate billing of 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 on our website under Providers, Forms and Documents page or email to provider@questbh.com.

Termination of Contract / Withdrawal from Network

If a Quest provider chooses to withdraw from the Quest Network, they are required to notify the Provider Relations Department in writing ninety (90) calendar days before the date of termination. Members who are receiving services from a terminating provider may continue to do so for a transitional period of up to ninety (90) 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 substance use disorder services, substance use disorder 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 all Higher Level of Care services; some outpatient services also require authorization, subject to the member's benefit plan coverage (e.g., Psychological Testing, Electroconvulsive Therapy (ECT), autism services, Transcranial Magnetic Stimulation (TMS), etc.). Contacting Quest directly to verify authorization requirements and benefits prior to delivering services is in the provider's and member's best interest to confirm eligibility of covered services. Electronic submission of the Membership Eligibility and Benefit Request form can be accessed through the Quest website under Providers, Forms and Documents page for a response within three (3) business days. For urgent admissions, please call Quest at 800-364-6352. This will allow for the proper benefit explanation of covered services, as well as any limitations or exclusions 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 or exclusions.
If you use Tapestry Link as provided by Quest, please call us at 800-364-6352 if eligibility is unable to be determined. Our staff can assist with confirmation and addition of appropriate member coverage.

Member Rights and Responsibilities

Quest Behavioral Health is committed to respecting members' rights and 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 summarizes information 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.
- 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 members 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 and membership services teams 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.

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, refer to individual care management, review requests for services, verify benefit information, and collaborate on aftercare needs. Our regular business hours are 8:00 am – 5:00 pm, Monday through Friday, excluding holidays.

Care Managers 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 or call/text 988. 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 preauthorization 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, sourced by MCG. A determination for care is made based on individual member needs. Medical necessity criteria are applied 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. 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 substance use 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 substance use disorder 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 is 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's 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 needs 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 are 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 two (2) business days of the initial request.

Routine – A member is not experiencing a crisis or emergent problem; however, they require treatment. Providers should return routine member calls 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, except for 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.

Authorization Process

Routine Preauthorization

Preauthorization is required for Intensive Outpatient, Partial Hospitalization, Non-Emergent Inpatient services, Psychological Testing, and other specialized outpatient services depending on the health plan. Plans and employer groups contracting with the Quest

Employee Assistance Program (EAP) do not require preauthorization to access their services. Psychological Testing Authorization and Autism Treatment requests can be submitted electronically under the Providers, Forms & Documents page on the Quest website. The provider is responsible for obtaining preauthorization. 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 preauthorize 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 (Care Manager, involving Clinical Director and/or Medical Director as needed) will review the request and a determination will be made. Our retrospective review process is designed for providers that encounter unusual situations preventing timely pre-certification. For Higher Levels of Care the chart must be submitted or reviewed within 60 calendar days of the request.

Higher Levels of Care (HLOC)

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

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 the 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 for all levels of care or the level of intensity of treatment, the Clinical Director and Medical Director, if necessary, 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 can share discharge information with the provider at the next level of care, including primary care physicians and agencies that will continue to serve the member. Continuity and coordination of care is important to ensure the best outcomes for members.

Enhanced Care Management (ECM)

The Quest Behavioral Health Care Management Team aims to assist both members and providers with a heightened coordination of care experience. This program promotes member self-reliance, motivates adherence to provider-recommended behavioral health services, and reduces/prevents avoidable hospitalizations and readmissions.
ECM members have chronic, persistent mental health and/or substance use disorder, often accompanied by co-morbid medical conditions. Care Managers collaborate with providers to ensure members receive the highest quality coordinated care possible. This program provides clients with the support necessary to encourage long-term healthy functioning and well-being.

Quality Management Program

Quest is committed to providing the highest quality of service and satisfaction for our members and participating providers. Quality management program is an integrated and systematic organization-wide program that works collaboratively with all departments in establishing, implementing, evaluating, and maintaining the quality and effectiveness of service provided.

The Quest Quality Management Program implements quality and performance initiatives that are data driven and customer centered. To ask a question or report a concern to the Quality Management Department, please call 800-364-6352 or email qm@questbh.com.

Accreditation and Regulatory Bodies

Quest Behavioral Health complies with relevant Federal and State regulations and laws regulating ERISA self-funded health plans, and all applicable regulatory and accreditation requirements Quest operates as a Certified Utilization Review Entity on behalf of Managed Care Plans and is certified by the Pennsylvania Department of Health. 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 Satisfaction survey outcomes, as well as compliments and complaints received, provide actionable feedback that are used to develop improvement initiatives and maintain member satisfaction.

Member Complaints

A complaint is defined as an oral or written dissatisfaction with services provided by Quest or its contracted providers, including but not limited to contract exclusions, non-covered benefits and other coverage issues, operations and management policies.
Quest Behavioral Health encourages members or their designees to communicate any issues or concerns regarding our services and benefits. Members may file a formal complaint by contacting Quest Quality Management department, either by telephone or in writing. Each complaint is thoroughly investigated, processed, and resolved, within thirty (30) days of receipt, through Quest Internal Review process (Appeals, Grievances, and Complaints Committee). 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. Quest obtains a Release of Information for all complaints which may be requested by the provider.

Provider Satisfaction/Concerns

Provider satisfaction is a key component to the partnership between Quest and its participating network. Quest value engagement from our participating providers and highly encourage open communication, to help identify areas for improvement and ensure Quest services are aligned with best practices.

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 by telephone to 800-364-6352.

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 Claim Status Inquiry forms are available under the Forms and Documents page of the Quest website. Status requests, either electronic or telephonic, will receive a response within three (3) business days. The Claims Department can be reached via telephone at 800-364-6352. Please have the following required items on submitted claims:

- patient name and date of birth,
- date(s) of service,
- procedure code,
- charged amount,
- diagnosis code(s),
- specific clinician who provided services, including NPI and/or license number,
- billing address.

Please remember Quest manages EAP and behavioral health services, which means sometimes billing concerns are the responsibility of another vendor. If that is the case, Quest will direct you to the appropriate payer. Requests for payment correction by either the provider or Quest can be made by providing the other party notice within eighteen (18) months from the date of service, together with applicable documentation. When applicable, refunds must be paid, either by the provider or payor, within forty-five (45) days from the date of the refund Letter. If either party does not give notice to the other party, within eighteen (18) months from the date of service, of their desire to correct claim payment, they will have waived any right to subsequently seek such correction.

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 a denial and review your Utilization Management (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. Appeals regarding adverse benefit determination related to Plan benefits or terms, are considered as Administrative Appeal, and are processed through Quest Internal Review (Appeals, Grievances, and Complaints Committee), and as applicable, through the member's Plan. The right to appeal is reserved for members and their designees/beneficiaries only. Providers may not appeal claims decisions by Quest Behavioral Health. However, providers may request a Claims Review for claims they believe were underpaid or improperly denied by submitting a claim review letter to the member's benefit plan for review. Administrative Appeals must be received within 180 days of notification of the adverse benefit determination. Internal Review determinations are final.

Appeals regarding medical necessity are considered Clinical Internal or Federal External Reviews under ERISA and determinations are made by External Review Organizations. Peer reviews are available upon request. Members receiving a denial from an Internal Review of a clinically based appeal have the right to a Federal External Review. Federal External Reviews will be evaluated by an External Review Organization and the member notified in writing of the determination.

Appeal decisions for both administrative and clinical will be rendered in writing within 60 days of receipt for post-service claims, *15 days *(*with one time extension of 15 days from filing)* for pre-service claims, and within 72 hours when medical exigency requires an expedited decision. Post-service determinations of Federal External Reviews will be provided in writing within 45 days of receipt.

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 C provides guidelines for treatment record documentation and record keeping practices. Offices must 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 substance use disorder 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.

Billing

A provider, practice, or facility is required to bill normal charges to Quest for admissions, programs, and services. Billing is required to be on a CMS 1500 or standard UB-04 form with all required information. Quest provides an electronic claim submission option called Tapestry Link; this platform is available to all providers at no cost. Registration is required; please contact us at questtaplink@questbh.com for more information and to initiate the registration process. Quest has also contracted with an external vendor, ClaimsBridge, to accept electronic claims. However, providers must contract with and submit their claims through their respective clearinghouse, who will then forward the claim in EDI format to ClaimsBridge. The claims clearinghouse must submit Quest claims using the correct Payer IDs for Quest Behavioral Health.

Electronic Submission Payer IDs are noted below:

- Quest EAP Claims: **10956**
- Quest Behavioral Health Claims (non-EAP): **44219**

Providers also have the option to select from a variety of electronic payment options. 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. To establish electronic payment, please contact Zelis directly at 877-828-8770.

Quest Behavioral Health reimburses services authorized by Quest under current CPT procedural codes and ICD-10 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. You 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. You have agreed not to balance bill the member for the difference between your usual charges and the Quest negotiated rate.

Unless otherwise indicated, all claims must be submitted electronically. Itemized claims, secondary claims and corrected claims must be received within one (1) year from the date services are rendered to the member. Corrected claims must be clearly indicated as such with a resubmission code in the appropriate field on the claim form.

Reimbursement

Quest Behavioral Health and you, the provider, 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, co-insurance and/or deductible amounts are subtracted from the fee rates; it is your responsibility to collect these additional amounts from the member. Claims will be reimbursed at the contracted rate for the service(s) billed. If the provider is not credentialed with Quest, reimbursement will be made at the out-of-network usual, customary, and reasonable rate(s). 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 (including 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 you 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 Plan and its limitations and/or exclusions. Please check with Quest at 800-364-6352 to determine any benefit exclusions prior to rendering services, 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 substance use disorder 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 are not legible or 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 questions about the claims process, our Claims Department can help direct 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 use disorder ICD-10 diagnosis code.
- Date(s) of service, procedure code(s) and/or CPT code(s). For services that require authorization, codes must match service(s) approved by Quest.
- Service provided must be a code included in your contract.
- Provider information including name of rendering provider, address where service occurred, NPI/license number, tax ID number, and signature.
- EAP claims must include the HJ modifier.
- Number of sessions must not have exceeded number of sessions available or authorized by Quest (if authorization is required).
- Applicable authorization by Quest must be current and not expired.
- Member, provider, and service(s) provided must be eligible and reimbursable under member's benefit plan.
- Member's benefits must not be exhausted.
- 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) 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.

Providers are expected to share pertinent information from the EOPs with their billing staff and vendors. Quest cannot provide duplicate EOPs for paid claims as this is resource intensive

and environmentally unfriendly.

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.

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 to process the claim. Preauthorization for services is required to be obtained from all potential insurers according to their policies and procedures.

General Business

Our general business hours are Monday through Friday, 8:00 AM – 5:00 PM EST, excluding holidays. 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 at 800-364-6352.

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

Tapestry Link (Quest's electronic claim entry platform)
Email Address: questtaplink@questbh.com
Telephone Number: 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:

- Autism Treatment Request
- Claim Status Inquiry
- HCFA 1500 Claim Form
- Membership Eligibility and Benefit Request
- Provider Change/Addition Form
- Provider Pre-Application
- Psychological Testing Authorization
- Out of Network Claim Form

Practitioner Office Confidentiality

1. Practitioners covered entities under HIPAA Privacy and Security regulations are expected to comply with these regulations by the established deadlines. 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.
2. 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.

3. 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.
4. 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 end of the email that conveys a message substantively similar to the following:
   "HIPAA Privacy Notification: This message and any accompanying documents are covered by the Electronic Communications Privacy Act, 18 U.S.C. 2510-2521, and contain information intended for the specified individual(s) only. This e-mail message and any attachments are intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify me immediately by replying to this message or calling the number above and destroy all copies of this message and any attachments. Thank you."
5. Facsimile machines are not in areas where faxes may be intercepted or viewed by individuals not authorized to access member-identifiable data and information.
6. 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:
   "HIPAA Privacy Notification: This message and any accompanying documents are covered by the Electronic Communications Privacy Act, 18 U.S.C. 2510-2521, and contain information intended for the specified individual(s) only. This e-mail message and any attachments are intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify me immediately by replying to this message or calling the number above and destroy all copies of this message and any attachments. Thank you."

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.

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.

3. 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.
4. 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.
5. Quest's "Consent to Release Information" requires the following information:
   - The name of the person or entity providing the information.
   - 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.

6. 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 the 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. In the rare case 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.

c. Many requests from employers for data and information can be fulfilled with data and information that are not member identifiable. 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.

d. 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 affording greater protection for the member.

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

Medical Necessity Criteria

Quest utilizes Medical Necessity Criteria in determining authorization for levels of behavioral health care. Quest's Medical Necessity Criteria is sourced through MCG. For questions, please contact Care Management at 800-364-6352.

Attachment A – Psychological Testing Authorization Form

Psychological testing is a specialized component in clinical assessment. It may be authorized under the behavioral 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.

Attachment B – Autism Treatment Request Form

Autism Treatment is a highly specialized and may be authorized under the behavioral health benefit only when data necessary for diagnosis and/or treatment planning is provided. Please submit the treatment request form for ABA services.

Autism Treatment Request Form is available at www.questbh.com as a fillable.

Attachment C – 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 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.
- All elements of dates related to an individual, including birth date, admission date, discharge date, date of death;
- 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, if available.
    - 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, when available.
10. For children and adolescents (under 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.

- A mental status evaluation is documented including the patient's:
- Affect.
- Speech.
- Mood.
- Thought content.
- Thought process.
- Judgment.
- Insight.
- Attention.
- Concentration.
- Memory.
- Impulse control.

12. 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.
13. An ICD 10 diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.
14. 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 initial prescription and refills.
    b. A non-prescribing provider, if any, documents:
        - Which medications have been prescribed.
        - The name of the prescribing provider.
15. If medications are prescribed, the treatment record maintained by the prescribing provider documents informed consent for medication.
16. A treatment plan is documented.
17. The treatment plan is consistent with diagnoses and has both:
    a. Objective measurable goals.
    b. Estimated time frames for goal attainment or problem resolution.
18. The patient's understanding of the treatment plan is documented.
19. The focus of treatment interventions is consistent with the treatment plan goals and objectives.
20. Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives.
21. Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.
22. The treatment record documents preventive services, as appropriate (e.g., relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).

23. The treatment record reflects continuity and coordination of care between behavioral health clinicians and the PCP or other non-behavioral medical providers.
24. The treatment record reflects continuity and coordination of care within the behavioral health continuum of care.
25. 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. Providersare informed of Quest's expectations through the provider manual, 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 are 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.
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 prominentlynoted.

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. All forms for release of information must contain the following information:
    a. Patient name
    b. Patient date of birth
    c. Practice/facility name
    d. Rendering provider name
    e. Name of releasing entity
    f. Name of receiving entity
    g. opportunity to denote any information which is not to be released or not covered by the release of information
    h. Signature of member (if over 14) with date
    i. Signature of member guardian (if under 14) with date
    j. Notice on how to withdraw consent
    k. Notice of document expiration date
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 manual, 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. Quest generates annual Utilization Reports which may be based on claims, authorization, or referral data.
    a. The report may include 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 minimum of ten treatment records is randomly selected. Records are selected from all the providers at the ambulatory care site.

5. Quest reserves the right to schedule each ambulatory care site for a treatment record assessment.
    a. Quest staff identify the specific treatment records for assessment. Either:
        i. An appointment is scheduled with the ambulatory care site for on-site treatment record assessment, or
        ii. A letter requesting that identified treatment records be mailed to Quest is sent to the ambulatory care site for off-site treatment record assessment.
6. 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. 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 manual, 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) may review and analyze treatment record performance data.
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. 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, Quality Management 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. 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.

Quest analyzes the data and determines actions to improve performance, if needed.