



PROVIDER MANUAL

2007 - 2009

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SECTION 1

PROVIDER OPERATIONS

Provider Operations Area

The Provider Operations Area acts as a liaison among all participating practitioners (a professional who provides treatment), providers (an institution or organization that provides services), and the departments within APS Healthcare, Inc (APS).

Provider Operations is dedicated to assisting APS providers in the following ways:

- Orientation of new APS practitioners and providers and their staff
- Education of APS practitioners and providers regarding policies and procedures
- Conducting Site Visits and Treatment Record Reviews
- Provider Newsletters
- Resolving problems for practitioners and providers
- Contracting practitioners and providers
- Network development
- Recruitment of specialized practitioners and providers
- Working with practitioners and providers in the development and implementation of financial reviews and effective referral patterns

Provider Orientation Program

When new business is implemented in a market, APS sponsors an in-person or telephonic Provider Orientation Program for all network practitioners and providers and appropriate administrative staff. The purpose of this program is to orient new practitioners and providers to APS' clinical philosophy, operational policies and administrative procedures. The APS Provider Manual is reviewed and providers are briefed on APS' relationships with local clients. The Provider Orientation Program is a first step in the development of long lasting partnerships with practitioners and providers. The Provider Orientation Program allows for the solicitation of valuable input and feedback from network practitioners and providers.

Provider Operations Department

APS maintains a team in each service center to answer provider questions through toll free numbers. The phone lines are open from 8:30 a.m.- 5:00 p.m. Eastern or, as appropriate, Central Standard Time Monday - Friday. **The telephone number for APS' Silver Spring service center is 800-305-3720, and for APS' Houston Service Center is 800-554-6171.** Please note that all Credentialing-related inquiries are handled in Silver Spring.

Change of Address or Tax Identification Number

To ensure accurate and up to date information is supplied to our members and for timely claims processing, any change(s) in name, address, phone number, facsimile number, or tax identification number should be submitted in writing at least 30 days prior to the effective date. The notification must include:

- Effective date
- Information that is no longer valid
- Tax identification number of the address that is no longer valid
- New information
- Telephone/fax numbers
- Tax identification number
- Office hours

If the requested change(s) require re-contracting or amending a practitioner or provider's current agreement, the agreement or amendment must be executed before the change becomes effective; until then the practitioner is considered out of network. For example, if a practitioner or provider resigns from one APS practice group and then joins another, both APS practice group agreements will be amended. If a practitioner or provider resigns from an APS practice group to establish an independent practice, they will no longer be considered active unless accepted into the network as an independent practitioner. If re-contracting is necessary, the practitioner or provider is notified by APS.

To complete our on line form, visit our web site at www.apshealthcare.com and click on the Contact Us/ Provider Relations link. From there, click on the Updating Information link and complete the form. The form may be submitted electronically or printed and faxed to: 301-563-7393 Attn: Provider Updates. Demographic updates may also be mailed to:

APS Healthcare, Inc
PO BOX 991
Brookfield, WI 53008
Attn: Provider Updates

National Provider Identifier

The *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of standard unique identifiers for health care providers; the National Provider Identifier (NPI). The purpose of the mandate is to improve the efficiency and effectiveness of the electronic transmission of health information. Every healthcare provider was required to obtain, communicate and include the NPI on every electronic claim by May 23, 2007.

Failure to submit an NPI may result in unnecessary delays and possibly denial of claims.

To obtain more information or receive your NPI, you may visit <https://nppes.cms.hhs.gov>, or call 800-465-3203.

It is also very important that you notify APS of your NPI number in addition to including it on every claim.

To notify APS of your NPI, you may email: provideraddressupdates@apshealthcare.com, fax-301-563-7393 or mail to:

APS Healthcare, Inc
PO BOX 991
Brookfield, WI 53008
Attn: NPI Update

On-Call Coverage/Covering Practitioners

If a practitioner is temporarily unavailable to patients who are in active treatment, the practitioner is responsible for arranging adequate emergency coverage during the practitioner's absence. APS must be notified of all coverage arrangements. Covering practitioners must adhere to all of APS' administrative requirements, including, but not limited to: authorization procedures, accessibility standards, and co-payment collection. The covering practitioner must be of equivalent licensure level and must accept APS' fee schedule allowance.

When arranging emergency coverage, network practitioners are not required to work with a participating APS practitioner, but it is suggested. If the practitioner who is covering is not participating with APS, the APS practitioner is responsible for obtaining authorization for coverage from APS. All claims generated by the covering practitioner should include the authorization number and should indicate the provider for whom services are being covered. Payment for claims submitted without this documentation will be denied.

Guidelines for After-hours Access to Outpatient Practitioners

When you begin treating an APS member on an outpatient basis, it is our expectation that you will inform the member of your process for accessing therapeutic assistance outside of your normal business hours, should the need arise.*

You should provide your patients with a telephone number to call during non-business hours. Patients need to be assured that if they call this number they will be contacted by you (or the practitioner on call for you) within a reasonable timeframe, typically no greater than two hours, or as determined by the urgency of their clinical need.

If your patients receive an answering service, the service should instruct them how they will be placed in touch with you (or the practitioner on call for you.) Your answering service should know how to contact you (or the practitioner on call for you) and place the patient in communication with you.

* Any applicable state laws for 24-hour emergency response and care required by therapists who are part of a state-licensed outpatient mental health/substance abuse clinic is considered the minimum standard for a APS network practitioner.

If your patients receive a recording, it should clearly instruct them on how to access you. The recording should provide several options:

- It may include a telephone number where the patient may reach you (or the practitioner on call for you) and instruct the patient to dial that number; or
- It may include your pager number with instruction to the patient on how to activate it to receive a return call from you (or the practitioner on call for you); or
- It may include the option to leave a message in which you (or the practitioner on call for you) can return a call within a specified timeframe.
- It must also include the telephone numbers for the local emergency room and/or law enforcement. if the patient cannot wait for a response from a therapist

Suspending Referrals

When a practitioner is temporarily unable to schedule initial appointments within ten (10) business days, or if the practitioner is unable to accept new referrals due to a leave of absence, vacation or any other reason, the practitioner is to notify APS in writing. A letter stating the reason for the practitioner's inability to accept referrals, and the time frame during which referrals are to be suspended, should be submitted to the attention of the Provider Relations Department.

Provider Newsletter

Periodically, APS distributes a Provider Network Newsletter to all network practitioners and providers. The newsletters update practitioners and providers on APS' products and operational procedures. They provide information on quality initiatives and other APS programs. They are also available on the APS website, www.apshealthcare.com .

SECTION 2

ELECTRONIC DATA INTERCHANGE (EDI) CLAIMS SUBMISSION

Electronic Data Interchange (EDI) Claims Submission

We are pleased to announce that APS Healthcare accepts both institutional and professional HIPAA compliant electronic claims through three clearinghouses: MedAvant (ProxyMed), The Health Information Network (THIN), and Emdeon (WebMD Envoy).

APS makes it easy for you! Whether you are submitting claims through MedAvant (ProxyMed), The Health Information Network (THIN), or Emdeon (WebMD Envoy), the APS payer ID is always 54160.

Claim Submission Guidelines

When submitting claims electronically, the following information must be contained with each claim record:

- Tax Identification Number
- Name of provider rendering service
- Member's name and ID number
- Member's gender and date of birth
- ICD-9 Diagnosis Code
- Dates of service
- Procedure code
- Place of service
- Type of bill for institutional claims
- NPI number (effective 5/23/2007)

Note: Please remember to use only standard code sets.

If you need assistance, an APS Provider Operations Representative is available to assist you in the startup process and can be reached at 1-877-490-6854.

SECTION 3 PRACTITIONER AND PROVIDER STANDARDS

Access Standards

When APS contacts a practitioner or provider with a referral or a member in ongoing treatment calls a practitioner or provider to schedule an appointment, it is expected that the practitioner or provider will be able to offer an appointment to the member within the APS standards of accessibility. The following access standards supersede all lesser access standards in the provider agreement.

Access Type Care Access	APS Standard
Life Threatening Emergency	Seen immediately
Non-Life Threatening Emergency	Seen within 6 hours
Urgent Care	Seen within 48 hours
Routine Office Visit	Seen within 10 days

Life Threatening Emergent: A situation in which a member has made a suicide attempt or is in immediate danger of making a suicide or homicide attempt.

Non-Life Threatening Emergent: A situation in which the member is markedly distressed and there is a strong potential for rapid de-compensation.

Urgent: A situation in which a member's condition could be anticipated to deteriorate to the point of being at risk of harm to self or others if not evaluated/treated within 48 hours.

Routine Care: An appointment is to be offered within ten (10) business days of the initial referral for routine care.

New Patients

Remember that you must accept new referrals from APS on the same basis as you are accepting non-APS members; without regard to race, religion, gender, sexual orientation, place of residence, national origin, age, or physical or mental health status.

The only times you may refuse APS referrals are:

- The patient requires treatment that is outside the scope of your clinical licensure or expertise.
- Your panel is closed to all new patients.

Note: If you decide to stop accepting any new patients you must give APS notice in writing to:

APS Healthcare, Inc
PO BOX 991
Brookfield, WI 53008

On-Site Evaluation Process

Practitioner/Practitioner Groups

In accordance with the APS Provider standards, an on-site review will be completed with selected individual practitioners and practice groups. As part of the credentialing process, an on-site review may be conducted for these practitioners prior to acceptance to the network, especially if it is anticipated that these practitioners will treat a high volume of APS client members. Additionally, practitioners may be reviewed when quality performance monitors, such as complaints from members, clients, or APS staff, indicate a need for such a review.

A Provider Operations staff member will meet with the practitioner to discuss the role of the practitioner and APS in the provision of behavioral healthcare services to our members. APS policies and procedures will be reviewed and the practitioner's adherence to APS standards will be evaluated.

The evaluation may consist of a review of the practitioner's accessibility to APS members, the practitioner's medical record-keeping standards, and the practitioner's office site appearance (see Attachment B for a copy of the onsite review tool, which contains the APS performance goals). Records must be kept in locked files, maintained in an area that protects the confidentiality of the patient and are not accessible to the general public. Any electronic treatment records must be secured by unique passwords for each staff/practitioner. The practitioner will be informed of any deficiencies, given a corrective action plan, and a specific timeframe to complete the action plan.

Hospitals, Facilities and Agencies

Generally, APS does not conduct site visits on Hospitals, Facilities, and Agencies that are accredited by one of the following organizations:

- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- The Commission for the Accreditation of Rehabilitation Facilities (CARF)
- The Community Health Accreditation Program (CHAP)
- Council on Accreditation of Services for Families and Children (COA)

The APS policy is to contract with accredited providers whenever these are available and meet our requirements. However, there are times when it is necessary to contract with a provider that is not accredited, but meets our credentialing standards in every other way. In this instance, APS would conduct a site visit at the time of initial credentialing and again at the time of recredentialing.

General Service Standards

The following service standards apply to all practitioners:

- There is at least one staff member available for patient intake during business hours
- Routine phone calls from patients are returned by the next business day
- Urgent calls from patients are returned within one (1) hour
- Life-threatening Emergent calls are returned immediately
- Non-life-threatening Emergent calls from patients are returned within thirty (30) minutes
- The practitioner informs all patients on how the provider is to be contacted during and after business hours in an urgent or emergent situation
- Routine initial outpatient appointments are scheduled within ten (10) business days after receiving a referral
- Urgent outpatient appointments are scheduled within forty-eight (48) hours of the referral or contact from a member in ongoing treatment
- Emergency outpatient appointments are scheduled immediately if the patient has a life-threatening emergency or within six (6) hours of the referral or contact from a member in non-life-threatening emergencies
- Practitioners are trained in de-escalation techniques
- Patient education materials are distributed routinely
- Practitioners are encouraged to receive training in brief therapy
- Practitioners are trained and/or experienced in working effectively with Managed Behavioral Health Care Organizations
- HMO members are charged only the co-payment amount when an appointment is canceled With less than twenty-four (24) hours notice or when the member fails to provide any notice
- Release of information to the member's Primary Care Physician (PCP) as part of the intake process, if applicable
- Member Rights and Responsibilities statement is displayed or distributed to the member prior to rendering service

Provider Standards

Our provider standards refer to the inpatient and outpatient facilities and sites where members receive services. These standards address the appearance, safety, and licensure, if applicable, of the office or facility. The following standards are required of APS facility providers:

- Visible signs clearly identify the facility
- The exterior of the building is clean and well maintained
- Parking is adequate and nearby
- The area surrounding the facility is safe when exiting at night
- The waiting room has adequate seating for patients
- The facility is clean and in good repair (this includes the waiting room, admission area, patient rooms and halls, offices, kitchen, dining area, rest rooms, and common areas)
- The facility meets the requirements of the Americans with Disabilities Act (ADA)
- Emergency phone numbers (police, fire, ambulance) are posted in common staff areas
- Fire extinguishers are readily available
- Smoking is restricted to an outdoor location or a separately ventilated room
- Medications are protected from public access
- All hospital units and inpatient and outpatient programs are licensed by the state
- If eligible, the hospital or facility is accredited by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO)
- If sanctioned by JCAHO, the provider has submitted an acceptable corrective action plan
- If eligible, the provider is Medicare approved
- If eligible, the provider is Medicaid approved

IP, RTC, PHP, IOP, 23-Hour Observation Service Standards

- Visitors are required to sign a confidentiality statement prior to entering patient areas
- Provider adheres to written admission criteria
- If services are not provided in a general hospital, arrangements are in place for transporting patients in the event of a medical emergency
- Examination rooms are available for the physical examinations
- Crash carts or emergency boxes are available for medical emergencies
- Clinical staff-to-patient ratios are adequate
- Staff is trained annually in de-escalation techniques

- Treatment is individually tailored to meet the needs of each patient
- Adult and adolescent patients are separated by units or by patient rooms
- Adolescent and child patients are separated by units or by patient rooms
- The Initial Treatment Plan is completed within twenty-four (24) hours of admission
- The History and Physical is completed within twenty-four (24) hours of admission
- The Psychosocial Assessment is completed within forty-eight (48) hours of admission
- The Initial Psychiatric Assessment, including Mental Status Exam and DSM-IV diagnosis is completed within twenty-four (24) hours of admission
- Discharge planning begins upon admission and includes scheduling a post-discharge outpatient appointment within seven (7) days of discharge

Acute Mental Health Units Only Service Standards

- Patients are seen by a MD at least once within any 24-hour period
- Admissions are accepted twenty-four (24) hours per day, seven (7) days per week
- Acute units are locked
- All hallways can be monitored from the nursing station(s) directly or with the use of video equipment
- Patients do not have access to potentially harmful objects
- Shower heads are recessed or do not bear weight (suicide-proof)
- Patient rooms are free from any weight-bearing objects
- Patient rooms are free of electrical cords that are twelve (12) inches or longer in length
- Medically complex patients who are at-risk for suicide and are in rooms that require electrical cords are monitored at least every fifteen (15) minutes
- Light fixtures are recessed or are protected by a non-breakable device
- Windows and mirrors are shatterproof or protected by a non-breakable device
- All objects within the seclusion room are secured
- One piece toilet seats are used in the seclusion area rest room
- Patients in seclusion and in the adjacent bathroom can be viewed by staff at all times
- Staff is trained annually in the use of de-escalation techniques to avoid the use of seclusion unless absolutely necessary
- Ambulatory follow-up appointments are scheduled for patients with a mental health diagnosis leaving the hospital within seven (7) days of discharge from an inpatient unit

Substance Abuse-Only Service Standards

- Patients are seen at least once within any 24-hour period by a licensed practitioner
- If provided, admissions for medical detoxification are accepted twenty-four (24) hours per day, seven (7) days per week
- Beds dedicated to patients admitted for detoxification are nearest to the nursing station
- Staff includes providers with substance abuse certification
- Urine/drug screens are conducted routinely
- An aftercare or relapse prevention program is offered to all patients for a period of at least six (6) months
- Ambulatory follow-up visits for patients admitted with a substance abuse or a dual diagnosis are scheduled for within seven (7) days of discharge

SECTION 4

PRACTITIONER CREDENTIALING AND RECREDENTIALING

All prospective practitioners undergo an evaluation of their professional credentials and experience. The purpose of the credentialing process is to ensure that all APS practitioners meet the criteria established by the APS Credentialing Committee and ensures compliance with state, federal and accrediting bodies (i.e. the National Committee for Quality Assurance [NCQA]).

The initial credentialing process begins with the submission of a signed participation agreement and a complete credentialing application to APS. The complete application is carefully reviewed for completeness and adherence to the APS credentialing criteria. Accepted applications with supporting documents are submitted for primary source verification and review. Once all primary source verifications have been completed, the file is forwarded to the APS Credentialing Committee for peer-review. All applicants are informed in writing of acceptance into or rejection from the APS network.

If the application is incomplete, the credentialing specialist will notify the applicant of missing data elements and secure the required information. If the credentialing specialist is unable to secure the required information, the incomplete application is returned to the applicant.

All participating practitioners undergo a re-examination of his/her credentials at least every three (3) years, or as required by state or federal regulations. The process is initiated one hundred and fifty days (150) prior to the anniversary date of the last credentialing cycle when the recredentialing application is mailed to practitioners. Once the recredentialing primary source verification process is complete, the file is forwarded to the APS Credentialing Committee for peer review. All practitioners under going recredentialing are informed in writing of acceptance into or rejection from the APS network.

Practitioners have the right, during the credentialing process, to review the information in support of their credentialing application, the right to be notified of any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner, the right to correct erroneous information, and the right to confidentiality of all information obtained in the credentialing process except otherwise provided by law.

The Credentialing Committee is co-chaired by the Corporate Director of Credentialing and the Corporate Medical Director, and also includes a multidisciplinary panel of practitioners from our participating provider network. The Credentialing Committee reviews practitioners' credentials and gives recommendations regarding the practitioners' ability to deliver care.

Primary Source Verification (PSV)

Application: All applications must be received in within thirty (30) days of the signature date and all requested documents must be attached and current. This will help facilitate APS in meeting industry standards for credentialing timeliness. All applications must be signed—stamped signatures are not accepted—and dated by the practitioner.

License Verification: is conducted through the appropriate state licensing board; orally, in writing, or via the direct state board Internet websites. All active licenses reported by the practitioner are verified. Participating practitioners must notify APS immediately of licensure status changes.

Professional Liability Insurance: must be active and meet minimum coverage required (\$1 million/3 million for, M.D. and D.O. and \$1 million/\$1 million for Ph.D. and MSW). Positive history of claims requires written explanation from the practitioner. Participating practitioners must notify APS immediately with respect to any changes in the amount or status of any such insurance coverage.

Hospital Privileges: practitioners (MD and DO) must attest to privileges, if applicable. If a practitioner does not have privileges he/she must submit documentation regarding the procedure used if a member needs to be admitted.

Board Certification: is not required. If a practitioner is board certified verification is completed through the American Board of Medical Specialties (ABMS).

NOTE: If not Board Certified then residency is verified orally, in writing, or from the appropriate state licensing board.

Curriculum Vitae (CV): must contain a minimum of five (5) years work experience as a health professional. Any gaps over six (6) months need to be explained in writing. The CV is verified only at initial credentialing.

Education: is verified at the highest level; orally or in writing from the institution issuing the diploma. It can also be verified through the appropriate license board, if the license board primary source verifies education. APS queries all license boards annually to determine if it primary source verifies education prior to issuing licenses. Education is verified only at the time of initial credentialing.

Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) Registration: a copy of a valid certificate (if applicable).

National Provider Data Bank (NPDB): an inquiry is completed for all practitioners in order to review malpractice claims history, Medicare/ Medicaid sanctions, and licensure sanctions.

Medicare/Medicaid Sanctions: is queried through the NPDB.

On-going Monitoring

All participating practitioners undergo an on-going monitoring process. Continuously, APS reviews

- Complaints received about the practitioner
- Quality of care issues
- Licensure Sanctions
- Medicare/Medicaid Sanctions.

APS monitors quality performance indicators of practitioner and provider care and service, including complaints. APS monitors complaints received from, but not limited to, members, client organizations, or APS staff. Complaints are weighted according to the seriousness of the complaint.

In certain instances when, either because of the number of complaints or the seriousness of the complaint, the practitioner or provider file will be reviewed by the Credentialing Committee that will make recommendations regarding the network status of the practitioner or provider, as well as regarding actions to be taken by APS. All case and peer review information is held as privileged and confidential by all APS Staff and providers involved in the process.

Quality of Service Complaints

Quality of service complaints are any concerns raised about the services a member received as distinguished from the behavioral health care treatment received. Quality of service complaints include, but are not limited to, concerns about access to care/services, billing practices, and practitioner and provider/staff professionalism.

Quality of service complaints are processed by the Complaint and Appeals Department. In most instances, APS will work with the practitioner or provider to educate them (in cases where a lack of information is found), or develop a corrective action plan. When a practitioner or provider is placed on a corrective action plan, the circumstances and any outcomes to date are reported to the Credentialing Committee.

A practitioner or provider may be suspended or terminated from the network as a result of the Credentialing Committee's review. Actions that can be taken by APS, include, but are not limited to, consultation, written warning, monitoring, suspension, or termination.

Practitioners and providers who are unwilling to respond to requests to resolve a Quality of Service may face sanctions or termination.

The practitioner or provider may appeal such termination or any sanctions by submitting a written statement within 30 days of the determination. The written statement must include the reason(s) for lack of concurrence with the determination and include any supporting documentation. The written appeal request is presented to the Credentialing Committee for review.

Quality of Care Complaints

Quality of care complaints are concerns about the quality of behavioral health care/treatment a member received. All complaints about quality of care are reviewed under the direction of APS' Corporate Medical Director, and prioritized according to their clinical urgency. These complaints are researched and any necessary corrective action plans are developed and monitored by the Office of Clinical Resources department. When a practitioner or provider is placed on a corrective action plan, the Corporate Medical Director, or designee reports the circumstances and any outcomes to date to the Credentialing Committee.

A practitioner or provider may be suspended or terminated from the network as a result of the Credentialing Committee's review. Possible actions which can be taken by APS include, but are not limited to, site reviews, treatment record reviews, suspension, or termination from the network.

Practitioners or providers who are unwilling to respond to requests to investigate Quality of Care complaints and/or modify performance or inappropriate practices may face termination.

The practitioner or provider may appeal such termination or any sanctions by submitting a written statement within 30 days of the determination. The written statement must include the reason(s) for lack of concurrence with the determination and include any supporting documentation. The written appeal request is presented to the Provider Appeals Subcommittee for review.

Peer Review

APS utilizes established criteria to determine the severity of quality of care complaints. When the criteria are met, the peer review process is implemented and the case is reviewed by an objective health care professional/s with the appropriate expertise for the case in question. This process assures that any quality of care complaints that meet the established criteria are reviewed with a higher level of scrutiny by a peer of the practitioner or provider under review.

An APS Corporate Medical Director, or designee, triages quality of care complaints against the peer review criteria¹. For those that meet peer review criteria, a letter is sent to the practitioner or provider requesting additional case information be sent to APS within fourteen (14) calendar days. If the case requires a chart review the chart is requested in the same letter.

If a chart review is required, a designated peer reviewer reviews all relevant materials. The peer reviewer may recommend that the involved practitioner/provider be placed immediately in "suspend" status until the Credentialing Committee convenes.

If a chart review is not required, a Quality Improvement Manager forwards the practitioner or provider information and the peer review form to the Medical Director, or designee, and the APS Credentialing Director.

The Credentialing Committee is responsible for determining any appropriate corrective action. All corrective action plans include timelines for completion and methods for monitoring progress.

The Credentialing Committee is also responsible for deciding if the provider is to enter and/or continue in “Suspend” status.

Within one (1) week of the Credentialing Committee’s decision, the Corporate Medical Director will send a letter to the practitioner or provider detailing any corrective action requirements and/or changes in the provider’s level of participation.

Providers who are unwilling to respond to requests to modify performance or inappropriate practices may face termination.

The practitioner or provider may appeal such termination or any sanctions by submitting a written statement within 30 days of the determination. The written statement must include the reason(s) for lack of concurrence with the determination and include any supporting documentation. The written appeal request is presented to the Provider Appeals Committee for review.

APS reserves the right to suspend or terminate a practitioner or provider immediately. In all cases, APS will notify the practitioner or provider in writing that these actions have or are about to occur, inform them of the reasons for these actions, and offer the right to appeal the decision and review APS documentation.

Credentialing/Re-credentialing and Quality Review Appeal Rights

Practitioners and providers are notified in writing if a determination is made to alter privileges or implement sanctions. Information on how to appeal this decision will be included with this written notification.

Reporting Termination Decisions

In accordance with Federal Law, the NPDB and the State Licensing Agency shall be informed of APS’s decision to terminate a practitioner or provider. APS will report to the NPDB and the appropriate licensing agencies all practitioners or providers who have been terminated for quality of care issues.

The practitioner or provider is apprised during the sanctioning process that a report may be sent to the licensing agencies and boards. The practitioner or provider will then be afforded the opportunity to further clarify issues and provide additional relevant information. In all cases, they will be given the right to appeal any change in status or re-credentialing decisions. Providers whose initial application for network participation is denied by the Credentialing committee are not afforded appeal rights by APS.

Additional Termination Events

Notwithstanding any other provision in the Provider Service Agreement, APS may terminate said Agreement at any time upon notice to the practitioner of the occurrence of any of the following events:

- Practitioner's failure to maintain membership on the Medical Staff of his/her primary admitting facility (Physicians only) or failure to maintain adequate malpractice or general liability insurance
- Practitioner's conviction of a felony or misdemeanor or crime involving moral turpitude
- Practitioner's failure to comply with quality improvement and utilization review procedures and standards, as established by APS, including, but not limited to:
 - appointment availability, billing practices, utilization, provision of services, and
 - failure to meet timeline requirements of the credentialing program
- Practitioner's loss or suspension of the licenses required to fulfill the Agreement
- Practitioner's failure to provide satisfactory personal and professional references and credentials, or to provide verifiable information regarding past employment, training, hospital affiliation, or professional licensing for him/herself, or any paraprofessional under his/her supervision.

Section 5

PRIVACY POLICIES

Summary of APS Privacy Policies

APS and its subsidiaries and affiliates are committed to ensuring that privacy practices regarding individually identifiable health information comply with industry best practices, covenants given to its clients (“Covered Entities and Business Associates”) and, as applicable, all federal and state laws and regulations including, but not limited to, the Standards for Privacy of Individually Identifiable Health Information promulgated pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”) (“the HIPAA Privacy Rule” or “the Privacy Rule”).

The APS Chief Privacy Officer is responsible for the development and implementation of APS privacy policies and procedures.

A summary of APS privacy policies can be viewed on the APS Web site at www.apshealthcare.com. (Once at the site click on “Provider Information”, then “Behavioral Health Providers.”) You can also request a paper copy of these materials be mailed to you by sending an email to qualityteam@apshealthcare.com, or by calling 1-800-305-3720, extension 3420.

Practitioner and Provider Requirement to Protect Privacy

All APS network practitioners and providers are contractually and professionally obligated to safeguard the confidentiality of member/family individually identifiable Personal Health Information (PHI). Furthermore, APS providers are required to conform to APS’ policies and procedures regarding PHI. Failure of any APS provider to comply with this policy is subject to disciplinary action, up to and including immediate termination from APS’ network. Electronic treatment records, hard copy clinical records, facsimile mail, and electronic mail are covered by the APS privacy policies.

APS’ provider contracts include requirements on maintaining confidentiality of member individually identifiable health information. Compliance with APS’ policies and procedures on confidentiality is assessed as part of provider site visits and treatment record documentation audits.

Protection of Information

A. Provider offices and sites of care guard against unauthorized or inadvertent disclosure of confidential information. Such measures include having a written policy regarding confidentiality, keeping files/computer records locked and maintained in a safe, confidential setting, systems for maintaining phone/message confidentiality, and keeping appointment schedules out of public view.

- B. Provider offices and sites of care maintain member records/information in a locked and secure manner (e.g., secured paper and/or electronic storage areas) made available only to designated staff which have authority, by virtue of their assigned duties, to access the information.

- C. APS providers should have a method of alerting themselves about the need to update the consent forms signed by the members.

Section 6

UTILIZATION MANAGEMENT

APS Philosophy

APS was founded upon the belief that quality and successful outcomes in behavioral healthcare are achieved by *providing access to the most appropriate care, at the right time, and in the least restrictive setting*. In order to accomplish this goal, APS maintains an experienced staff of licensed clinicians on-site Monday through Friday from 8 a.m. to 6 p.m., with availability 24 hours a day, seven days a week, for urgent or emergent clinical situations. These clinicians bring to APS significant mental health and substance abuse (MH/SA) inpatient and outpatient experience gained in the field, together with a successful history of managing the utilization of behavioral healthcare services for our members.

The APS Utilization Management (UM) process begins with a comprehensive clinical intake, including risk assessment. Fulfilling more than the traditional role of determining medical necessity, we design our systems to serve as a resource to patients, families, and providers. Further, our clinical staff is always looking for opportunities to develop and implement alternatives to the more typical adversarial utilization review.

The APS Clinical Triage Tool system provides active, next day follow-up for all members who have been identified through triage as “Urgent” or “Emergent”. Using our *Utilization Management Guidelines*, written Medical Necessity Criteria, consistent with national practice standards, our Care Managers work pro-actively with both the patient and the provider to build consensus around the appropriate level of care, treatment plan, and goal. A copy of the most current APS Medical Necessity and Level of Care Determination Criteria is included in **Appendix A**. An additional copy of these criteria is available by calling Provider Operations at 800-305-3720 or via the APS website www.apshealthcare.com (Once at the site click on “Provider Information”, then “Behavioral Health Providers.”)

Utilizing a full continuum of care consisting of network providers who have been credentialed to National Committee for Quality Assurance (NCQA) standards, our Care Managers monitor the quality of care and provide ongoing clinical review of a member’s treatment, in collaboration with our provider partners, throughout the entire process. In those instances when Care Managers and providers have difficulty determining the proper diagnosis, course of treatment, or proper level of care, our physician advisors are available to offer assistance.

Affirmative Statement Regarding Incentives

Utilization Management (UM) determinations made by APS clinical staff, medical directors, and physician advisors are solely based upon the appropriateness of the behavioral healthcare and/or services for the individual member, within the benefits available to the member. APS does not provide financial incentives for providers, consultants and/or staff members based upon the opinions they render during the UM review process. It is the goal for APS to provide the most appropriate care for the individual member that will result in cost-effective treatment outcomes.

Utilization Management Criteria

Under the direction of the Corporate Medical Director, APS conducts annual reviews and updates of its Utilization Management (UM) Criteria. The UM Criteria form the basis for decisions made by APS about the medical necessity of proposed (or rendered) behavioral healthcare treatment. The annual process involves input from actively practicing practitioners who serve as members of the APS Provider Advisory Group.

How to Get the Criteria

The current Medical Necessity Criteria set can be downloaded from the APS website at: www.apshealthcare.com. (Once at the site click on “Provider Information”, then “Behavioral Health Providers.”) You can also request a paper copy of the criteria be mailed to you by sending an email to qualityteam@apshealthcare.com or by calling 800-305-3720, ext 3420.

Scope of Utilization Management Program

The scope of the APS Utilization Management Program includes all of the activities listed in the following paragraphs. **Please note however, that “Research” is not included among these categories and is not reimbursed by APS.**

Referral and Authorization Procedures

APS maintains a twenty-four (24) hour, toll free 800 telephone line which members, their families, primary care physicians, and practitioner/providers can call to request urgent treatment and/or authorization for such treatment. Routine referrals for behavioral health care services may be requested between 8:00 A.M. and 6 P.M. EST Monday through Friday. Members are not required to obtain a referral from a PCP to access behavioral health services, though APS will work with a PCP to obtain a referral should the occasion present itself.

Initial/Concurrent Review

An APS Member Referral Coordinator processes member requests for routine referrals during normal business hours. An APS Member Referral Coordinator verifies eligibility, updates demographic information, and educates members regarding their benefits. In most instances, these calls are received from the member actually seeking treatment. However, APS will work with PCPs or family members with the permission of the member seeking treatment.

The Member Referral Coordinator conducts a very brief, objective screening to ensure that the member's situation is non-urgent. Any suspected urgent situation is transferred to a Care Manager to handle the call. Once this is established, the Member Referral Coordinator searches the network for a practitioner who offers services that best match the member's clinical needs. The member is given the name and telephone number of a geographically accessible network practitioner and then instructed to contact the practitioner to schedule an appointment. If a member is referred to a practice group, we inform the member to request an APS-credentialed practitioner within the group at the time the appointment is made.

The APS Member Referral Coordinator enters an authorization number into the APS data system, linking the practitioner with the member's record. The authorization number, co-payment or coinsurance requirements are automatically faxed to the practitioner. For those practitioners who do not have fax numbers, the authorization notice is mailed to the practitioner.

Medication Management Referral Process for Non-MD Practitioners

APS has made it easier for non-MD practitioners to obtain a referral for their members to have Psychiatric medication evaluations. This change reflects APS' commitment to supporting its practitioners in appropriate continuity and coordination of care. With a member's permission, practitioners may contact APS to obtain referrals and authorizations to a psychiatrist on their patient's behalf. Practitioners should contact APS' Member Referral Department to obtain a referral and authorization to see a psychiatrist. As always, members may continue to contact APS themselves to obtain a psychiatric referral.

Hospital and Program Services

When a member demonstrates a need for admission to an inpatient facility, a partial hospitalization program, an intensive outpatient program, or an evaluation for these or any other services, a call to APS must be made to request authorization for services or to schedule an evaluation to determine the most appropriate level of care. All hospital and program admissions must be pre-authorized, unless there is a life-threatening medical emergency (see Emergency Services below).

The Care Manager will schedule an evaluation based on the information provided by the caller. The Care Manager, in conjunction with the hospital or program's attending physician or designee, will review the clinical information to determine the type and intensity of treatment that would most benefit the member. The decision to authorize an admission to a hospital or a program will be based on medical necessity presented after an evaluation has been completed by a mental health professional. When a Care Manager authorizes an admission, a preliminary treatment plan is formulated and the authorized length of stay or number of sessions is communicated to the hospital or program. When additional sessions or days are required, the attending physician or designee is to call APS to discuss further treatment prior to the last day of authorized services.

Emergency Services

By accepting a referral from APS, network practitioners accept the responsibility of providing twenty-four (24) hour urgent and emergency services for our members. Patients in active treatment should be given instructions on how to contact their provider or a covering provider in the case of an emergency.

Members who have behavioral health care benefits that are managed by APS are instructed to go to an emergency room only when the member, by acting reasonably, believes that an emergency condition exists. As stated previously, it is expected that answering machine messages and/or answering services provide patients with a number to contact the practitioner in an emergency. A message that states that the patient should go to the emergency room is not acceptable.

Emergency services are delivered by a practitioner in cases when the practitioner has conducted a clinical diagnostic interview sufficient to determine that the patient is harmful to self or others and in need of immediate intervention to ensure member safety. Intervention may include safe transport and any of the following: inpatient evaluation, a 23-hour observation bed, inpatient admission, or inpatient detoxification. The patient is the clinical responsibility of the practitioner who arranges transportation and provides clinical support while continuously monitoring the patient to prevent harm to self or others. Intervention should be immediate and constant until the clinical situation is de-escalated.

Once an emergency intervention is completed and the patient is stabilized, the practitioner is requested to call the Care Manager within two (2) hours to report the outcome and review the next level of care requirements for pre-certification. If a colleague or office staff member is available, contacting the Care Manager immediately for authorization and assistance is recommended.

The patient's behavioral health care practitioner is expected to triage all other urgent and emergency situations. APS Care Managers are available through our toll-free number twenty-four (24) hours per day to assist providers with emergency cases. Contact a Care Manager whenever an member requires emergency attention.

When a patient who is in need of an outpatient emergency intervention contacts a practitioner, the practitioner is to call APS to obtain authorization. If the member requires a service that the practitioner cannot offer, the practitioner is to contact the Care Management Department to arrange for the required intervention.

Discharge Planning

Discharge planning should begin at the initiation of all hospital and program services. It includes preparing the patient and the family for the next level of care and arranging for placement or provision of additional services. APS has developed timeliness standards for follow up appointments after discharge from acute levels of care to increase patient compliance with aftercare treatment and to reduce the likelihood of re-admission. Patients with follow up mental health treatment are expected to have an appointment scheduled with a network practitioner or provider **within seven (7) days of discharge**. It is expected that all APS patients be discharged with a comprehensive aftercare plan that is in compliance with these standards. APS Care Managers will work with hospitals and programs to assure a smooth transition and the use of participating practitioners and providers for follow up care.

Referrals to Other Providers

One of APS Health Care's highest priorities is to offer our members a fully integrated system of care. We strive to develop networks of practitioners and providers who offer a spectrum of behavioral health care services and specialties available today. When a practitioner recognizes that a member would benefit from additional behavioral health care services, such as group therapy, a medication evaluation, or an intensive outpatient program, the practitioner should contact the APS Care Management Department and request an authorization to another APS practitioner or provider. In cases where a referral is obtained for additional behavioral health care services, it is expected that the referring practitioner obtain a signed Release of Information from the member in order to coordinate treatment planning with these other practitioner or providers. Referrals for medical/surgical services are to be coordinated through the member's medical plan and/or Primary Care Physician.

Consultation Liaison Services

Psychiatric consultations for members who are hospitalized on a non-psychiatric unit can be arranged by APS, although the physician attending the member often arranges them. Frequently, these situations are emergencies and require the psychiatrist to respond very quickly. APS asks that network psychiatrists who conduct these types of psychiatric consultations obtain certification within 72 hours of the evaluation. Up to two (2) visits will be authorized at that time. Certification for additional follow up visits can also be obtained at that time. Consider the follow up care that the member will need after discharge and make the appropriate arrangements.

Continuity and Coordination of Care/Exchange of Information Requirements

It is the policy of APS Healthcare to require the appropriate, confidential, and timely exchange of information between practitioners and providers to achieve the safest and most effective coordination of care. This policy addresses APS' specific requirements for:

- Exchange of information across all levels of behavioral healthcare and between all behavioral healthcare provider types
- Exchange of information between behavioral healthcare providers and medical/surgical providers including primary care physicians (PCPs)

1. Exchange of information requirements across all levels of behavioral health care and between all behavioral health care provider types

Table 1

From	To	Conditions that Require Exchange	Minimum Information to be Exchanged	Timeliness/Frequency of Exchange
Behavioral health provider (inpatient, residential, PHP, IOP facilities)	Other behavioral health provider (inpatient, residential, PHP, IOP, outpatient)	When treatment is directly transitioned to a different behavioral health provider	Discharge summary to the behavioral health provider providing the next phase of	Within 7 calendar days of the discharge date
Behavioral health practitioner	Other behavioral health practitioner	When making or receiving a referral or when the member is in treatment with another behavioral health practitioner	Diagnosis Medication(s) prescribed (<i>Psychiatrists and other prescribing practitioners only</i>) Any significant risk status or issues Stress-related factors Severity of problem Frequency of treatment Treatment recommendations/plan	Within 30 calendar days of the initial assessment. Annually if concurrent care continues for > 12 months When medication is started or changed When there is a change in level of care When there is a change in risk status
Testing psychologist	Other behavioral health practitioner	When receiving a referral for psychological testing	Summary report on test results and treatment recommendations to referring practitioner	Within 30 calendar days of completing the testing

2. Exchange of information requirement between behavioral health providers and other medical providers.

Table 2

From	To	Conditions that Require Exchange	Minimum Information to be Exchanged	Timeliness/ Frequency of Exchange
Behavioral health practitioner	Primary care practitioner (PCP)	When a member: Utilizes behavioral health treatment and has a PCP Initiates or changes the dose of medication Has a recent inpatient admission Is a danger to self or others Has suspected medical conditions Shows indications of drug interactions Has substance abuse	Diagnosis Medication(s) prescribed (<i>Psychiatrists and other prescribing practitioners only</i>) Any significant risk status or issues Stress-related factors Severity of problem Frequency of treatment Treatment recommendations/ plan	Within 30 calendar days of the initial assessment Annually if care continues for > 12 months, or more frequently if the member's clinical condition or treatment changes significantly Within 7 days of medication changes, indication of drug interactions, dx. of substance abuse or indication of a medical condition
Behavioral health practitioner	Other medical practitioner	When a member: Utilizes behavioral health treatment Is currently being treated for a significant medical condition by a non-PCP medical practitioner	Diagnosis Medication(s) prescribed (<i>Psychiatrists and other prescribing practitioners only</i>) Other significant coordination of care issues/medical compliance issues	Within 30 calendar days of the initial assessment
Behavioral health practitioner	Medical provider (e.g. hospital, skilled nursing facility)	Not required unless the medical provider has requested a consult from the behavioral health practitioner. The behavioral health practitioner may exchange information if they feel it has significant impact on the outcome of treatment with the medical provider.	Not required	Not required
Testing psychologist	Primary care Practitioner (PCP) or other medical practitioner	When receiving a referral for psychological testing	Summary report on test results and treatment recommendations.	Within 30 calendar days of completing the testing
Behavioral health provider (inpatient, residential, PHP, IOP facilities)	Primary care practitioner (PCP)	When a member: Receives treatment from a behavioral health provider Has a PCP	Discharge summary Other significant coordination of care issues/medical	Within 7 calendar days of the discharge date from the behavioral health provider

From	To	Conditions that Require Exchange	Minimum Information to be Exchanged	Timeliness/ Frequency of Exchange
Behavioral health provider (inpatient, residential, PHP, IOP facilities)	Other medical practitioner	When a member: Utilizes behavioral health treatment Is currently being treated for a significant medical condition by a non-PCP medical practitioner, and does not have a PCP	Discharge summary	Within 7 calendar days of the discharge date from the behavioral health provider
Behavioral health provider (inpatient, residential, PHP, IOP facilities)	Medical provider (e.g. hospital, skilled nursing facility)	When treatment is directly transitioned to a medical providers	Discharge summary to the medical provider	Within 7 calendar days of the discharge date from the behavioral health provider

3. Member Consent and Confidentiality

All member identifiable information involved in exchange of information is confidential (see Policy & Procedure, Restrictions on Protected Health Information, L.005). APS requires that the behavioral health provider procures a written and signed release of information prior to exchanging the information required by this policy. If a member refuses to release information for coordination of care, this should be documented in the member’s treatment record. The provider should weigh the risks of failure to communicate even without the patient’s consent, especially in those instances when the patient is a suicidal/homicidal threat, or when the patient is on medication that could potentially be harmful if combined with other medication. This documentation will be seen as fulfilling the practitioner or provider’s requirement to facilitate the required exchange of information and the case will be considered as “not applicable” toward any monitoring denominators.

Access to a Psychologist for Psychological Testing

In those instances where a non-psychologist practitioner has evaluated a patient and requests that the patient be evaluated for psychological testing, APS requests that the evaluating practitioner contact APS to request an evaluation for psychological testing.

The APS Member Referral Coordinator or Clinical Care Manager then locates a network psychologist who specializes in psychological testing to evaluate the member for testing. The appointment with a psychologist for evaluation for testing must be available within 10 working days, unless it is deemed to be clinically urgent in which case it must be available within 48 hours.

Clinical Practice Guidelines

APS adopts clinical practice guidelines that help practitioners and members make decisions about appropriate behavioral health care for specific clinical circumstances. Guidelines are developed based upon the identified needs of APS' membership. The clinical practice guidelines are based on scientific evidence and current knowledge of the best practices for treating behavioral health disorders.

The guidelines are developed with input from practitioners, members, and community agencies, as appropriate. APS reviews its clinical guidelines no less than every two years and revises them as necessary. Member education, utilization management decision-making, interpretation of covered benefits, and other areas applicable to the clinical guidelines are reviewed for consistency with the guidelines. APS only adopts guidelines which are evidence-based and published by nationally recognized professional organizations.

Annually, APS monitors practitioner/provider adherence to at least two important aspects of two of the clinical guidelines. Monitoring methods include treatment record review, claims data review, encounter data review, or a combination of these. APS' Office of Clinical Resources tabulates results from these monitoring activities. Individual and organization-wide results are shared with practitioners/providers, as appropriate.

APS' current clinical practice guidelines include the following, which can be accessed through the Provider Tools section of the APS website:

American Academy of Child and Adolescent Psychiatry

- Assessment and Treatment of Children and Adolescents with depressive disorders
- Assessment and Treatment of Children and Adolescents with substance abuse disorders

American Academy of Pediatrics

- Diagnosis and evaluation of the child with attention deficit/hyperactivity disorder

American Psychiatric Association

- Treatment of patients with major depressive disorder
- Treatment of patients with bipolar disorder
- Treatment of patients with eating disorders
- Psychiatric evaluation of Adults
- Treatment of patients with substance abuse disorders
- Treatment of patients with Schizophrenia

If you would like a paper copy of any of these clinical practice guidelines, you can email qualityteam@apshealthcare.com or call 1-800-305-3720, extension 3420.

Utilization Management Criteria

APS, its Board of Directors, clinical staff, administration, employees, and network are committed to conducting business in an ethical manner, consistent with its mission, core values, strategic plan, regulatory requirements, and policies. In addition, APS clinical staff and network practitioners are required to comply with the ethical standards of the associations that represent their professional discipline.

APS HealthCare believes that patients are best treated in the least restrictive environment consistent with the patient's symptoms, supports, and safety requirements. The goal of treatment is the restoration of the patient to optimal functionality and independence. This document is intended to be a starting point and common reference for clinical discussion and is based on a literature review of scientific evidence. As such, it focuses on the patient's clinical history, presenting symptoms, and available resources to recommend a level of care. The APS clinical staff who review the clinical information must consider the following issues when applying the criteria to a given individual: age, co-morbidities, and complications, progress of treatment, psychosocial situation, and home environment. In those cases when the above factors indicate that the APS UM Criteria are not appropriate for an individual patient, the APS clinician should obtain supervision with either their direct supervisor or the Medical Director.

APS also recognizes that resources for the full continuum of care do not exist in all parts of the local delivery systems. In those cases, APS may recommend a higher level of care than medically necessary in to assure that the member receives safe and effective treatment. "Medical Necessity" is used in this context to define care which is determined to be effective, appropriate, and necessary to treat a given patient's disorder.

Each level of care is indicated as either Psychiatric or Substance Dependence (except for the outpatient level of care which subsumes both)---and reviews for level of care determination proceed in a logical progression to confirm:

- the presence of a properly diagnosed mental health or substance abuse disorder amenable to treatment
- symptoms of sufficient severity to meet the required criteria for admission
- the clinical condition is likely to demonstrate measurable improvement through medically necessary and appropriate care delivered at the level of care requested
- Clinical requirements for continuing care at that level

APS' Medical Necessity Criteria does not include discharge criteria, program content, or specific recommended treatment interventions, because APS does not want to be too prescriptive and preempt clinical discourse. However, when the patient's condition appears to no longer meet the required criteria for continuing care at a given level or intensity of services, discharge to a lower level of care is recommended.

How to Get the Utilization Management Criteria

The utilization management criteria set can be downloaded from the APS website at: www.apshealthcare.com. (Once at the site click on “Provider Information”, then “Behavioral Health Providers”) You can request a paper copy of the criteria be mailed to you by sending an email to qualityteam@apshealthcare.com or by calling 800-305-3720, Ext. 3420

Non-Certification and Appeals Process

If APS UM criteria do not appear to be met for the requested level of care, the APS Care Manager who has been reviewing the treatment refers the case to an APS Physician Advisor (PA). The PA reviews the request for authorization with the treating practitioner or provider. If, after review of the additional clinical information, the PA agrees that the requested level of care does not meet APS UM criteria, a non-certification will be completed. In these cases, the practitioner or provider is referred to the Care Manager to discuss alternative treatment options that will be authorized and facilitated by APS. Notification is provided by phone and in writing to the practitioner and/or provider (if appropriate), and to the member. The non-certification notifications include the principle reason(s) for the determination, instructions for initiating an appeal of the determination, and any possible recommended alternative treatment options. In cases when the patient is in active treatment in any intensive level of care, an expedited appeal will be offered and completed within 24 hours after receipt of all clinical information.

In the review of an appeal to reverse a non-certification determination, APS ensures that a PA not previously involved in the case will be included in the review. Members, providers, or facilities may appeal non-certification decisions through the UM Department and the Appeals Coordinator either verbally or in writing. First-level appeals may be completed on either an expedited or standard basis. An expedited appeal may be requested telephonically when the patient continues to remain in active treatment at a non-outpatient level of care after issuance of a non-certification. A standard appeal may be requested when the patient is no longer in active treatment. The member, or someone acting on behalf of the member, is offered the opportunity to appear in person and participate at this level. APS notifies the practitioner and/or provider, and member of each appeal outcome via telephone followed by written notification, unless requested otherwise. All initial non-certification decisions and decisions to uphold a denial on appeal will contain information regarding any additional appeal options available to the member and/or provider.

For appeals offered by APS, written requests may be sent to:

APS Healthcare
Attention: Appeals Department
P.O. Box 400
White Plains, NY 10601

Independent Review of Appeals

Under certain circumstances, a practitioner, provider, or member may request an independent review of a non-certification decision. The decision will be based on applicable member health plan coverage or a benefit offered by their employer. With very few exceptions, the member does not bear any of the costs of the Independent Review.

Almost every state has enacted a law or regulation that addresses this process. Each state law is different. For example, some states require the member or the practitioner/provider acting on the member's behalf to complete all APS levels of appeal before allowed access to the Independent External Appeal. Other states allow access to the Independent External Appeal at any point during the process. Some avail the Independent External Appeal only for determinations based on medical necessity and others for any type of determination that limits treatment in any way. In every case, the letter or phone call you receive from APS that notifies you of an adverse determination will also notify you of your specific rights and any steps that you need to take to initiate an appeal of any type.

Retrospective Review

Retrospective reviews are conducted after services have been provided to the patient either without authorization or when the pre-certification was outside contractual timelines. The APS Appeals Coordinator facilitates all retrospective reviews.

In the case of a patient who has been discharged from inpatient care and no pre-certification occurred, an administrative/contractual non-certification determination will be made. A review for medical necessity may occur if the written appeal indicates the provider could not determine if the patient had insurance requiring pre-certification. When the patient remains in treatment, an administrative/contractual non-certification is made for the days prior to the call for authorization and a Care Manager begins ongoing reviews of the case with the provider for continuing stay criteria. An administrative/contractual non-certification applies to claims-generated appeals, calls for pre-certifications outside the contractual limitations, and cases when the patient is discharged and the facility subsequently calls APS to request authorization.

When the pre-certification of the patient occurred outside the timelines for pre-certification, the case is administratively/contractually denied. The provider may appeal this decision whereupon he/she is required to submit the complete medical record for review. An initial review of the medical record is completed by the Appeals Coordinator with supervision by a clinician (if necessary) to ensure that there are no medical necessity issues involved that impacted the pre-certification time line. The record is then submitted to administration for a benefits/contract review to ensure the appropriateness of the administrative/contractual denial. In cases when APS chooses to offer a retrospective review, the complete medical records are reviewed by a Care Manager to determine whether APS criteria are met, and authorizes care which is medically necessary. When there is

question as to whether a patient's condition met the criteria for the requested level of care, a physician advisor/peer reviewer is contacted to review the case and to determine if there will be a non-certification of the requested services. In all non-certification cases, APS issues to the provider a clear rationale for the denial of requested services and furnishes instructions regarding the appeals process.

Reporting Adverse Occurrences

Adverse occurrences are defined as completed suicides, completed homicides, and unplanned transfers from a psychiatric unit to a medical unit. The practitioner or provider is to immediately report to APS if an APS member experiences such an occurrence. These cases are reviewed by APS' Corporate Medical Director to identify any risk issues and to assist the provider to identify opportunities for improvement. Notification of APS does not substitute for nor take precedence over state or federally mandated reporting requirements for abuse, neglect, or danger to self or others.

APS Healthcare
Attention: Corporate Medical
Director
P.O. Box 400
White Plains, NY 10601

Ancillary Services

APS members' medical plans typically maintain contracts with laboratory, radiology and other specialty providers. When these services are used in conjunction with an APS member's behavioral health care, the APS practitioner or provider should attempt to coordinate these services with the member's Primary Care Physician (PCP).

Laboratory Services

All lab work must generally be done through these contracted providers. The provider ordering the lab work will not be billed when using the participating laboratory. Use of any other non-contracted laboratory service may be the financial responsibility of the physician who orders the test(s). APS providers should attempt to use the member's medical plan's contracted laboratory provider for all outpatient lab tests. A listing of the medical plan's contracted laboratory locations can be found in the member's Provider Directory. This information may also be obtained by calling the member's medical plan at the number listed on the member's plan identification card.

Radiology Services

For HMO members, radiology services typically require a referral from the member's Primary Care Physician (PCP). Please contact the PCP at the number listed on the member's identification card to coordinate these services. CAT scan and MRI procedures also require prior authorization from the member's PCP.

To utilize radiology services for non-HMO members, the payer should be contacted directly at the number listed on the member's identification card.

Pharmacy Services

Employer health plans and HMO members with a prescription rider to their policy (indicated on their identification card with an Rx) generally can fill prescriptions at any participating pharmacy. A complete listing of participating pharmacies is found in the member's Provider Directory.

To learn whether a medication is a formulary medication for any individual plan, contact the members' medical (or pharmacy) plan at the number on the back of the member's identification card.

Mixed Psychiatric/Medical Protocol

To promote the access and the delivery of quality care for members with both medical-surgical and behavioral health conditions, APS and its customers work together to successfully coordinate member care. Except in cases of medical emergency, APS or the member's medical plan, contacts its counterpart prior to treatment being rendered to coordinate the approval for the required or requested treatment. Medical necessity criteria, level of care criteria and administrative procedures are generally determined by the payer responsible for claims adjudication. Pre-certification and concurrent review requirements are determined by the benefit plan design. If questions arise concerning the coordination of a member's medical-surgical and behavioral health services, APS providers may contact APS Care Management. Members utilizing outpatient laboratory, pharmacy, and other diagnostic service providers should be referred to those providers contracted by the member's medical (or pharmacy) plan. In these circumstances, the APS practitioner or provider is responsible for coordinating these services with the member's Primary Care Physician.

SECTION 7

QUALITY IMPROVEMENT

Information on Quality Activities Available to Practitioners and Providers

APS regularly updates our Web site to provide our practitioners and providers with the latest information on a number of key quality activities. The following information can be obtained in detail at www.apshealthcare.com

Information on Quality Improvement Programs and Results

- An annual report on the results of the APS Quality Program
- A description of the APS Quality Program

Results of Member Satisfaction Measurement Activities

- A summary of results from the latest member survey looks at how APS can improve member satisfaction
- An annual summary of complaints and appeals looks at how APS can reduce complaints and appeals

Results of Availability and Access Studies

- A summary of the annual network report measures the number of providers, how close they are to our members, how we can improve the availability of care, and what actions we will take to do so
- A summary of the annual appointment access report measures if APS is providing members with timely appointments, how we can improve access to care, and what actions we will take to do so

APS Member Rights and Responsibilities Statement

APS is committed to maintaining a mutually respectful relationship with our members. The APS Member Rights and Responsibilities statement provides a structure for cooperation among members, practitioners/providers, and APS.

APS providers should become familiar with the APS Members Rights and Responsibilities (R&R) Statement. **Please see Appendix C for R&R statements for Commercial/Medicare members and for Medicaid members.** A copy of these should either be displayed in your office or given to the member prior to your rendering any services.

Performance on Preventive Behavioral Health Programs

Every year, APS tracks the number of members who took part in our prevention programs and evaluate if the programs helped members. Members can review a short report of how we performed in these areas. All of the materials listed above are available on the APS Web site at www.apshealthcare.com. (Once at the site click on “Provider Information”, then “Behavioral Health Providers.”) You can also request that a paper copy of these materials be mailed to you by sending an email to qualityteam@apshealthcare.com, or by calling 1-800-305-3720, extension 3420.

Provider Satisfaction Survey

In our effort to continually improve our business practices and our relationships with providers, APS will survey network providers bi-annually to determine their level of satisfaction with APS. Providers are contractually obligated to participate in these surveys as well as any other Quality Improvement activities. Corrective actions may be taken by APS to address problems that have surfaced through the surveys to enhance the relationship between providers and APS and to improve the services that APS provides to the network.

Standards for Treatment Records

Initial Evaluation of Treatment Record Keeping Practices

APS has established treatment record keeping standards to assure that its providers maintain well-organized treatment records that facilitate communication, yet maintain patient and family confidentiality. These standards are assessed at the time of a site and/or treatment record review. The standards are:

- Each patient has individual folder/chart filed by name or identification number.
- Treatment records must be kept in a locked and secured location within the practitioner's office.
- Any electronic treatment records are secured by unique password for each staff/practitioner.
- There are policies and procedures related to maintaining treatment records in a confidential manner.
- Treatment records are available to the practitioner at the time of treatment.
- Treatment records are retained upon discharge in accordance with all state and federal laws.
- Records of providers who leave a group practice are completed, promptly filed and retained in safekeeping according to applicable state and federal laws.
- There are policies and procedures related to treatment records.
- Patient consent for release of information or refusal thereof is valid.

An overall score of 80% is required. The lack of compliance with maintaining treatment records in a secure manner (items 2 and 3 above) is a serious breach. During the review process, any office that is found to be out of compliance with these critical elements will be considered non-compliant for record keeping practices, irrespective of the overall score. In these instance, a request for a corrective action plan will be made and a reassessment would be made within six months.

Treatment Record Documentation Standards

In addition to initial on-site reviews, APS may also conduct clinical treatment record reviews of practitioners in accordance with NCQA standards.

APS has established treatment record documentation standards and compliance goals for its practitioners. These are intended to assure that APS practitioners maintain well-documented treatment records that facilitate communication, coordination, and continuity of care to promote efficient and effective care.

APS has established the following standards for treatment record documentation:

1. Each page in the record contains the patient's name or identification number.
2. Each record includes the patient's address, employer or school, home and work telephone numbers, including emergency contacts, marital or legal status, appropriate consent forms (including consent for treatment), and 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.
4. All entries are dated.
5. The record is legible to someone other than the writer and in ink.
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. Assessment of severity and imminence of potential harm to self or others is completed and documented at least once, and then as often as appropriate.²
9. Special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential, are prominently noted, documented, and revised in compliance with written protocols.
10. Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.
11. Allergies and adverse reactions are clearly documented.
12. For children and adolescents, prenatal and prenatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic) are documented.

13. For patients 12 and older, documentation includes past and present use of cigarettes, alcohol, illicit drugs, and prescription medication(s).
14. A mental status evaluation documents the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.
15. A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessments.
16. Treatment plans are consistent with diagnoses and have both objective measurable goals and estimated timeframes for goal attainment or problem resolution.
17. The focus of treatment interventions is consistent with the treatment plan goals and objectives.
18. Informed consent for all prescribed medications and the patient's understanding of the treatment plan is documented (for MDs/DOs only).
19. Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.
20. The treatment record documents preventive services, as appropriate (e.g., relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).
21. Treatment record provides evidence of practitioner attempting to obtain consent to communicate with other behavioral healthcare providers or practitioners when appropriate.
22. Treatment record provides evidence of communication and coordination of care with other behavioral healthcare providers or practitioners if they exist.
23. Treatment record provides evidence of practitioner attempting to obtain consent to communicate with primary care physician (PCP) or other ancillary providers/health care institutions when appropriate.
24. Treatment record provides evidence of coordination of care with primary care provider (PCP) or other ancillary providers/health care institutions when they exist.
25. The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.

Practitioner Communication

APS Treatment Record Documentation Standards and performance goals are distributed to practitioners via the Provider Manual, which providers receive upon commencement of their contract. Practitioners may also be notified of revisions to the standards or policy through newsletters or other direct mailings.

Performance Monitoring

APS reviews a sample of treatment records on a bi-annual basis. Records are selected from APS members who have started treatment with practitioners during the prior year. To ensure the confidentiality of patient information, APS reviewers or vendors use the following procedures:

- Reviewers are licensed healthcare professionals with a contractual and professional obligation to maintain confidentiality
- The provider is given advanced notice of the review
- The records are reviewed in a private area of the office
- The records remain at the provider's office throughout on-site review
- The practitioner is requested to blind all patient identifying information for any records submitted to APS for the purposes of treatment record review

Records reviewed for other APS quality activities are utilized for completing the annual clinical record keeping monitoring. Other quality activities used for this may include:

- Clinical guideline monitoring
- Clinical study data collection
- Investigation of quality of care issues
- Activities monitoring continuity and coordination of care

Practitioners receive written notification of their results within 90 days of the review. They receive their completed tool along with the record keeping toolkit.

Performance Goals

Compliance with the standards requires an overall score of 60%. Compliance with Critical Indicator #8, assessment of severity and imminence of self harm and requires a score of 80%.

Compliance with the following Critical Indicators requires a core of 60% for each item: Critical Indicators #22- 25:

- Treatment record provides evidence of practitioner attempting to obtain consent to communicate with other behavioral healthcare providers or practitioners when appropriate

- Treatment record provides evidence of communication and coordination of care with other behavioral healthcare providers or practitioners if they exist
- Treatment record provides evidence of practitioner attempting to obtain consent to communicate with primary care physician (PCP) or other ancillary providers/health care institutions when appropriate
- Treatment record provides evidence of coordination of care with primary care provider (PCP) or other ancillary providers/health care institutions when they exist

Providers whose scores fall below the acceptable threshold (above) may be referred to the appropriate APS quality committee for further review and follow-up.

Treatment Record Keeping Tools

APS regularly audits practitioners' treatment records for compliance with the APS treatment record documentation standards. As a result of these audits, APS developed several record keeping tools to assist practitioners in achieving compliance with the documentation standards. These include the following:

- Intake Attachment Form for Non-MDs for Allergies and Medical Conditions
- Brief Mental Status Exam Form for Non-MDs
- Child/Adolescent Developmental History Form
- Initial, Brief Treatment Plan Template
- Informed Consent to Treatment
- Behavioral Health Exchange of Information Form

Copies of these tools are included in the next pages of the APS Provider Manual. All of the tools listed above can be downloaded from the APS Web site at www.apshealthcare.com (once at the site click on "Provider Information," then "Behavioral Health Providers").

Brief Mental Status Exam (MSE) Form

Patient Name: _____

1. Appearance	<input type="checkbox"/> casual dress, normal grooming and hygiene <input type="checkbox"/> other (describe)	
2. Attitude	<input type="checkbox"/> calm and cooperative <input type="checkbox"/> other (describe)	
3. Behavior	<input type="checkbox"/> no unusual movements or psychomotor changes <input type="checkbox"/> other (describe)	
4. Speech	<input type="checkbox"/> normal rate/tone/volume w/out pressure <input type="checkbox"/> other (describe)	
5. Affect	<input type="checkbox"/> reactive and mood congruent <input type="checkbox"/> labile <input type="checkbox"/> tearful <input type="checkbox"/> blunted <input type="checkbox"/> other (describe):	<input type="checkbox"/> normal range <input type="checkbox"/> depressed <input type="checkbox"/> constricted <input type="checkbox"/> flat
6. Mood	<input type="checkbox"/> euthymic <input type="checkbox"/> irritable <input type="checkbox"/> elevated <input type="checkbox"/> other (describe):	<input type="checkbox"/> anxious <input type="checkbox"/> depressed
7. Thought Processes	<input type="checkbox"/> goal-directed and logical <input type="checkbox"/> other (describe):	<input type="checkbox"/> disorganized
8. Thought Content	<input type="checkbox"/> suicidal ideation <input type="checkbox"/> None <input type="checkbox"/> passive <input type="checkbox"/> active Y N If Active: Plan <input type="checkbox"/> <input type="checkbox"/> Intent <input type="checkbox"/> <input type="checkbox"/> Means <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> delusions <input type="checkbox"/> phobias <input type="checkbox"/> other (describe)	<input type="checkbox"/> homicidal ideation <input type="checkbox"/> None <input type="checkbox"/> passive <input type="checkbox"/> active Y N If Active: Plan <input type="checkbox"/> <input type="checkbox"/> Intent <input type="checkbox"/> <input type="checkbox"/> Means <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> obsessions/ compulsions
9. Perception	<input type="checkbox"/> no hallucinations or delusions during interview <input type="checkbox"/> other (describe)	
10. Orientation	<input type="checkbox"/> oriented X 3 <input type="checkbox"/> other (describe)	
11. Memory/ Concentration	<input type="checkbox"/> short term intact <input type="checkbox"/> other (describe)	<input type="checkbox"/> long term intact <input type="checkbox"/> distractible/ inattentive
12. Insight	<input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> poor	

Date Completed: _____

Practitioner Signature: _____

**Intake Attachment Form
Medical Conditions**

Informed Consent to Treatment with Medication

Patient I.D., a patient of _____, have received the complete explanation of my medication(s).

Description of Medications: (Check appropriate category)

- | | | |
|---|---|---|
| <input type="checkbox"/> Antipsychotic * | <input type="checkbox"/> Mood Stabilizer | <input type="checkbox"/> Antidepressant |
| <input type="checkbox"/> Antiparkinsonian agent | <input type="checkbox"/> Psychostimulant | |
| <input type="checkbox"/> Anxiolytic agent | <input type="checkbox"/> Cognition Enhancer | |
| <input type="checkbox"/> Hypnotic/Sedative | <input type="checkbox"/> Other: _____ | |

My physician has discussed with me the nature of my psychiatric/behavioral problems for which medication has been prescribed. My physician has discussed with me the reasons why medication may be helpful, including the likelihood of my psychiatric/behavioral problems improving or not improving with medication, and I have been informed of the consequences of my refusing medication. If effective treatment alternatives are available my physician has discussed them with me. I have been informed of the potential side effects and risks reasonable to be expected from this medication. I have decided to accept medication as prescribed for the treatment of my psychiatric/behavioral problems at this time. I understand that I may change my decision to accept medication and that if I change my decision I will contact my physician. It is important to report to my physician the emergence of any side effects.

The symptoms and risks of Tardive Dyskinesia and Neuroleptic Malignant Syndrome have been

Patient	Date
Representative	Date
Relationship to Patient	Date
Person Giving Explanation	Date
Physician	Date

If this consent is for treatment of a minor or for a patient that is unable to give consent, the following information must be provided:

- a.) Name of one or both parents, if known:
- b.) Name of managing conservator or guardian of person, if appointed:
- c.) Date on which treatment is to begin:

Patient Name: _____

1. **Are you allergic to any medications or have you ever experienced adverse reactions to any medications? (Over the counter or prescribed)**
 - Yes; Describe:** _____
 - No**

2. **Do you have any other allergies? (E.g. food allergies)**
 - Yes; Describe:** _____
 - No**

3. **Are you currently under the care of a physician for any medical problems, or are you experiencing any medical problems that you are concerned about?**
 - Yes; Describe:** _____
 - No**
Physician Name: _____

4. **Are you on any type of medication? (Over the counter or prescribed)**
 - Yes; Describe:** _____
 - No**

5. **Have you been treated for any significant medical problems in the past?**
 - Yes; Describe:** _____
 - No**

6. **Does your family have a history of any significant medical illness? (For example-heart disease, asthma, and diabetes)**
 - Yes; Describe:** _____
 - No**

7. **Do you anticipate medical problems or procedures in the next 6 months?**
 - Yes; Describe:** _____
 - No**

Date Completed: _____

Practitioner Signature: _____

Healthcare Exchange of Information Form

APS requires contracted behavioral health practitioners/providers to coordinate treatment with other behavioral health practitioners/ providers, primary care practitioners (PCPs), and other appropriate medical practitioners involved in a member’s care. Please complete this form and send it to the appropriate care provider(s) treating the member.

PATIENT NAME: _____

A. Behavioral Health Practitioner/Provider Information:

Treating Behavioral Health Practitioner Name:	Treating Behavioral Health Practitioner Telephone #:
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B. PCP/Medical Practitioner or Other Behavioral Health Practitioner/Provider/ Information:

PCP/Medical Practitioner or Other BH Practitioner Name:	Address:
(Telephone #:	
FAX #:	

D. Patient Clinical Information:

1. The patient is being treated for the following behavioral health diagnosis(es): _____
2. The patient is taking the following prescribed psychotropic medication/s: _____ _____
3. Expected length of treatment: _____
4. Coordination of Care Issues/Other Significant Information impacting medical or behavioral healthcare: _____ _____

**o DATE FORM MAILED OR FAXED TO OTHER PRACTITIONER/PROVIDER:
(PLACE A COMPLETED COPY OF THIS FORM ON THE PATIENT’S MEDICAL RECORD)**

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section B to release the information contained on this form to the practitioner/provider listed in section C above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last 30 days from the date signed. I understand that I may revoke my consent at any time.

I do not wish to have information shared with:
 my PCP/medical practitioner
 my other behavioral health practitioner(s)/provider(s).

I am not currently receiving services from:
 any PCP
 any other behavioral health practitioner/provider.

Patient Signature

Date

Behavioral Health Practitioner Signature

Date

APS Preventive Behavioral Health Programs

APS has developed and implemented three preventive behavioral health programs. Our practitioners have been previously informed about two of the programs:

- *Education and Treatment Compliance for Adults with Depressive Disorders*
- *ADHD in Children: Parenting Skills Training*

Both of these programs consist of a series of educational newsletters that are mailed to members participating in the programs. Materials for both programs have been updated in 2007 to expand information based on participant feedback.

The newest APS preventive behavioral health program offering is:

- *Education and Awareness of Postpartum Depression (PPD)*

This program consists of a welcome packet mailed to all participating health plan members who are new mothers. The packet includes a welcome letter, demographic survey, a depression scale survey and a brochure on PPD. A member of the APS Case Management Team will contact members who return surveys with positive scores and offer referrals to behavioral health services.

More detailed descriptions of these programs are contained in **Appendix B**

You can access the educational newsletters and program materials on the APS Web site at www.apshealthcare.com. (Once at the site click on “Provider Information”, then “Behavioral Health Providers.”) You can also request that a paper copy of these materials be mailed to you by sending an email to qualityteam@apshealthcare.com, or by calling **1.800.305.3720 ext. 3420**.

SECTION 8

CLAIMS DEPARTMENT

The APS Claims Department is located in our corporate headquarters in Silver Spring Maryland. The Claims Department is comprised of senior-level Claims Examiners and Specialists who are experienced, well trained, and have a commitment to the timely and accurate processing of all claims. The APS claims system is an on-line adjudication system that is fully integrated with all supporting files necessary for validation and extraction of key data elements vital to process quick and accurate claims payment. During the on-line adjudication process, the system is able to automatically access the membership, benefits, authorization, and provider files in a matter of seconds, and that requires manual intervention only if an error situation occurs. In addition, all codes (ICD9, CPT IV, and Revenue Codes) are validated against code file tables to maintain the integrity of the data. Further, the adjudication process edits each claim transaction line against the claims transaction file to detect any possible duplicate transactions. Since all processing occurs in a real time on-line environment, accurate, up-to-the-minute information is available continuously.

REIMBURSEMENT PROCEDURES

Co-payment Collection

Members typically have a co-payment or co-insurance obligation for behavioral health care services. The APS Customer Service Representative will inform the practitioner or provider of the member's co-payment amount when the referral is made. It is the practitioner or provider's responsibility to collect the member's co-payment at the time of service. The remainder of the contracted fee will be reimbursed by APS.

If a member refuses to remit the co-payment to a practitioner or provider, they should contact the Customer Service Department at APS. APS will attempt to resolve the situation so the member may receive services. Members who have questions concerning their financial responsibility in the provision of behavioral health care services should be directed to contact APS's Customer Service Department.

Balance Billing

Under federal law, HMO members cannot be billed for moneys due from an insurer for covered services. By contracting with APS, a practitioner or provider agrees that the collection of the member's co-payment or co-insurance is his responsibility and that he/she will not bill the member in excess of this amount.

The only time you may submit a bill to an APS member is if you have obtained prior written acknowledgment from your client/patient that you will be engaging in a treatment plan either not covered by the employer's benefit plan or not authorized as medically necessary by APS.

Co-payment Waiver

It is APS policy to adhere to our client's non-waiver of co-payment guidelines. As such, APS will not waive a member's co-payment or coinsurance responsibility under any circumstances. We subscribe to the trend in the health care industry toward the consumer's awareness of their own health care expenditures by requiring a shared financial responsibility between members and health care payers. This trend is seen in the shift from employers who provide full health insurance coverage to that of employers purchasing benefit packages in which employees are contributing a larger portion of their health care costs. APS practitioners and providers may independently waive the co-payment or coinsurance responsibility of any member. A decision to waive a member's financial contribution to the services provided is neither sanctioned nor prohibited by APS. In such a case, APS will reimburse the practitioner or provider at the contracted rate for the service provided, less the co-payment or coinsurance amount.

Terminated Members

Authorizations from APS are not a guarantee of payment. APS authorizes services based on benefit eligibility information available at the time the authorization decision is granted. If the member's benefits are terminated between the time an authorization is granted and the date of service, APS will not reimburse the practitioner or provider for services provided (Unless specifically prohibited by law). In this situation, a practitioner or provider may bill the member directly for the services delivered at your usual and customary fee.

If APS determines that a practitioner or provider has been paid for services delivered to an ineligible members, APS reserves the right to collect the amount of the overpayment from the them or to withhold the overpaid amount from future payments.

In instances when a member's benefits are terminated or benefits end for any reason, practitioners and providers are expected to work with APS and the member to transition the member to other care that is appropriate.

Claims Submission

Electronic Data Interchange (EDI) Claims submissions

Please see section 2 page 6 of this manual.

General Claims Submission Guidelines

Always use either a Center for Medicaid and Medicare Services (CMS)- 1500 form or a UB-92 or UB-04 form. UB forms should be used for Inpatient and Outpatient Facility claims.

Practitioners and providers in the former APS Healthcare Houston Service Center networks should submit claims to:

**APS HEALTHCARE
Claims Department
P.O. Box 99
Linthicum, MD 21090-0099**

All other practitioners and providers should send claims forms to the addresses assigned to specific accounts or to:

**APS HEALTHCARE
Claims Department
P.O. Box 99
Linthicum, MD 21090-0099**

Claim forms may be typed or printed. If printed, all entries must be legible. Using pencil or red pen to complete the claims may result in a delayed payment or a rejected claim. White-out may NOT be used on claims forms. If changes need to be made, cross out the incorrect information, initial, and write in the correct information.

- Use one form for each member.
- Separate forms must be used for each rendering practitioner or provider when a member receives treatment from multiple professionals within a group practice.
- Verify that the procedure codes (CPTIV or HCPCS) billed are listed as part of your contract with APS. (Refer to your contract for specifics.) Services billed with procedure codes not on your contract will be denied.
- APS does not reimburse practitioners or providers for any fees charged when a member is a “no show” for a scheduled appointment.
- Claims should be filed as close to the Date of Service as possible. We encourage you to submit claims within ninety (90) days of the Date of Service.
- For specific directions regarding OMHCs, Private Group Practice, and Individual practitioners, see examples at the end of this chapter.

Diagnosis Codes for Mental Health Services

All claims submitted for mental health care services must have an appropriate diagnosis code. Please use only ICD 9 codes. Any claims submitted without a valid ICD 9 code will be denied. V codes are only acceptable for charges for an initial evaluation.

CMS Filing Instructions

- Each Date of Service line service should include a single date
- Block 23 can list a Pre-authorization Number. Inclusion of this number on your claim form is no not required for processing of your claim.
- Block 31 must contain the name of the rendering practitioner or provider. *The name must be printed legibly and include the providers degree level.* For a group practice, this name must be different than the one contained in Block 33.
- Block 33 must reflect the name of the billing entity. For group practices and clinics, this is the group or clinic name. For individual practitioners, this will be the individual's name.
- The billing entity's Tax Identification Number must appear in Block 25.
- The NPI numbers for providers should be displayed in the appropriate fields.

UB-92 and UB-04 Filing Instructions

- There will be strict adherence to assure all required fields are completed, and claims will be denied if not completed accurately.
- Blocks 44, 45, 46 and 51 are unique to Outpatient services.

Coordination of Benefits

Coordination of benefits (COB) guidelines are used by APS to arrange for claims payment when an individual is covered under more than one group health insurance policy. The first determination of the primary insurer is based on the employer-employee relationship. The policy held by a person through their employer is primary for that person. Additionally:

- If the recipient is enrolled in other insurance, an Explanation of Benefits from the other carrier must be attached to the claim.
- If a private carrier denies a level of care, the practitioner or provider must go through the full appeal process with the private carrier. If the final decision by the private carrier is to deny the services, the practitioner or provider should send the claim to the APS claims department. The claim must be sent along with documentation of the private carrier's final decision. The claims will be paid by APS and are subject to a retrospective review.
- If **Medicare** is the primary payor, the claim must first be submitted to Medicare.

- Medicare denial statements must be submitted. Statements from practitioners or providers of an anticipated Medicare denial will not be accepted. All third party resources, such as Worker's Compensation, should be billed first and either payment or denial received prior to billing APS for any portion of the charges.

When dependent children of married parents are covered under more than one policy, APS follows the guidelines of the National Association of Insurance Carriers (NAIC), which recommend using the "birthday rule" to determine primary coverage. This rule states that the policy of the parent, whose birthday falls first in the calendar year, using month and day only, is primary for the children. When both parents have the same birthday, the primary insurance carrier is determined by the policy effective date.

When dependent children of divorced or separated parents are covered under more than one group health policy, the following order is used to determine the sequence in which benefits are paid:

- 1) the policy of the parent with custody of the children;
- 2) the policy of the spouse of the parent with custody of the children;
- 3) the policy of the non-custodial parent;
- 4) the policy of the spouse of the non-custodial parent.

Explanation of Payment (EOP)

- Checks will be accompanied by an Explanation of Payment (EOP) which will identify the member, date(s) of service, the amount charged and amount paid. If a claim is denied or pended there will be a denial or pend code and an explanation of these on the last page of the EOP.
- Practitioners and providers **MUST** "post" the claims paid and denied for proper record keeping. "Post" means reconciling each member's account with the claims listed on the EOP by service and date of service.
- Please remember that you will be paid at your contracted rates regardless of the amount billed. Resubmission of the difference between the contracted and the billed amount will be denied as duplicate submission. APS members may not be billed for the difference between the amount billed and the contracted rate.
- After posting your accounts, any questions concerning your EOP can be directed to APS Health Care Claims Customer Service by calling the behavioral health phone number indicated on the back of the member's ID card.

Member Hold Harmless Provision

Practitioners and providers agree to collect applicable co-payments, if any, from members at the time services are provided. The practitioner or provider shall look only to APS for compensation for Necessary Covered Services. In addition, the practitioner or provider shall under no circumstances, including the termination of the existing Agreement or the insolvency of APS or breach of the existing Agreement, assert any claim for compensation against members or persons acting on their behalf for Covered Services in excess of applicable co-payments.

Providers agree to provide continuation of services until discharge of any members confined in an inpatient facility on the date of insolvency or other cessation of operations or through the premium-paid period for which member has made prepayment, or on whose behalf prepayment has been made. Provider further agrees that this provision shall survive the termination of the existing Provider Agreement regardless of the cause giving rise for termination and shall be construed to be for the benefit of the APS member, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and/or member, or persons acting on their behalf.

Missed Appointments/No-Shows

A patient may not be charged for canceled appointments if the patient has provided at least twenty-four (24) hours notice of cancellation. The office policy of the practitioner or provider on canceling appointments should be communicated to patients at the commencement of treatment. A practitioner or provider may only collect a co-payment from a member who cancels an appointment without twenty-four (24) hours notice or who fails to give any notice at all (no-show). Missed appointments and no-shows do not count against APS member's maximum benefit allowance and APS assumes no liability for the collection of such charges. The collection of charges from members who have benefit plans that are not managed by APS is determined by the payor. The payor's telephone number, listed on the member's identification card should be called to determine reimbursement in these cases.

Section 9

CUSTOMER SERVICE

The APS Customer Service Departments' primary mission is to provide excellent service to members and providers. The Customer Service Team is committed to providing quick and accurate resolution to both provider and member inquiries regarding:

- Eligibility and benefits
- Authorizations
- Claims inquiries
- Claims submission assistance
- Check replacements
- Credentialing, recredentialing and provider updates and changes
- Fee schedules
- Complaints and appeals

You can contact Customer Service by calling the behavioral health phone number indicated on the back of the member's ID card and we will be happy to assist you.

Note: Prohibition against Retaliatory Action

APS Health Care (APS) is prohibited from retaliating against a Group or any member, including refusing to renew or canceling coverage under the existing Agreement, because Group or member, or a person acting on behalf of Group or member, reasonably filed a complaint against APS or appealed a decision of APS relating to the member, including, but not limited to, a medical necessity determination. APS also is prohibited from retaliating against a Participating Practitioner or Provider for reasonably filing a complaint against APS or appealing a decision of APS for issues pertaining to himself or herself or on behalf of a Group or member.

ONSITE REVIEW TOOL CREDENTIALING

Practitioners must score a total of at least 80% on the site visit score (80%) on both critical indicators:

Files are kept in a locked cabinet

Electronic treatment records are secured by unique staff/practitioner.

Practitioner Name	Degree
Address	Suite
City	State
Phone	Fax

Office Type (fill in one)

- Office Building Home Office
- Medical Center/Hospital Community Mental Health Center Academic Medical Center
- Other (specify) office staffing

Indicators	Y	N	Comments
Parking Available			
Office accessible to the disabled (i.e. wheelchair ramps, wide doors)			
Elevator if above the first floor			
Well maintained office (clean and in good repair			
Courteous staff			
Adequate seating in waiting room			
Equipment/toys are clean and in good repair			
Adequate lighting			
Designated space for private interviewing			
Restroom available/ accessible to disabled			
Restroom clean and in good repair			
Emergency room phone numbers are available			
Smoke detectors/fire alarm/sprinkle/fire extinguisher			
Fire/Emergency exits and plans clearly visible			
Written Member Rights & Responsibility			
Degree and license posted in public view			
Emergent life-threatening appointments available immediately			
Emergent non-life threatening appointment available within 6 hours			
Urgent appointments available within 8 hours			
Routine appointments available within 10 business days			

Indicators	Y	N	Comments
Answering service/beeper for after hours calls			
Evidence of alternate provider coverage			
Evidence of procedures for psychiatric/ medical emergencies			
Each patient had individual folder/chart filed by name or identification number			
Treatment records are kept in a locked and secured location within the practitioner's office. (CRITICAL INDICATOR)			
Any electronic treatment records are secured by unique password for each staff/practitioner. (CRITICAL INDICATOR)			
There are policies and procedures related to maintaining treatment records in a confidential manner.			
System in place for maintaining telephone calls/messages confidentially			
Treatment records are available to the practitioner at the time of treatment			
Treatment records are retained upon discharge in accordance with all state and federal laws.			
Records of providers who leave a group practice are completed, promptly files and retained in safekeeping according to applicable state and federal laws.			
There are policies and procedures related to treatment records			
Patient consent for release of information or refusal thereof is valid.			

APS HEALTHCARE
Preventive Behavioral Health Program
Attention Deficit Disorder: Parenting Skills Training
Information for Providers

APS Healthcare (APS) offers a preventive health program for parents of children who are being assessed for, or have been diagnosed with, Attention Deficit Hyperactivity Disorder (ADHD). This program is designed to improve clinical outcomes for both children and their parents by educating parents about the disorder and how to work more effectively with their children.

This educational program complements the care that you provide. Together with your support, APS can help parents recognize the effect of ADHD on their lives, and the lives of their children. This program can help teach parents to take active steps to foster communication, help modify problem behaviors in the home, and reduce the distress that they and other family members may experience in caring for a child with ADHD.

Information about the program follows along with a description of what you can do to assist us in this important preventive health initiative which we believe will have a positive benefit for the children in your care. Additionally, copies of the newsletters are attached for your review.

Why has APS implemented this program?

Attention deficit and disruptive behavior disorders are among the top diagnoses for children (ages 0-12 years) whose behavioral health care is managed by APS. Care for children with ADHD extends beyond medication management and behavioral therapy with the child. Important in helping children with ADHD is the development of a family environment in which the child can prosper and feel supported. In treating a child with ADHD, the role of the parents in helping their child is critical. This program helps parents learn how they can shape their child's behaviors and how they can provide an emotionally supportive and productive environment for their child with ADHD.

Parenting a child with ADHD can be an exhausting and frustrating experience, one often leaving a parent feeling helpless and without support or understanding. Such parents may be strained or unable to meet the special demands which parenting a child with ADHD requires. Empowering parents through education and training can be an effective way to help parents learn to cope. Teaching parents skills, which translate into parenting approaches appropriate to the unique needs of children with ADHD, can help restore a sense of capability and confidence for parents and can help their child become more focused and productive.

What are the goals of APS' program?

The goals of this program are to

- Educate parents about ADHD.
- Help parents develop more effective ways of relating, rewarding and disciplining their children.
- Help parents cope with the emotional toll which parenting a child with ADHD can have.

What are the criteria for inclusion in this program?

This program is directed at parents of children age 12 and younger who have been diagnosed with Attention Deficit Hyperactivity Disorder (DSM-IV codes 314.00; 314.01 and 314.9) as a primary or secondary Axis I diagnosis.

What interventions does the program include?

This program consists of several educational modules, which will be mailed to parents of children who have recently received authorization for evaluation or treatment of ADHD.

The first module helps educate parents about ADHD and suggests ways in which they might begin to assess how ADHD affects their child's life. The second module educates parents about effective ways to think about their child's experience. It teaches parents how to communicate with their child and how to use structure reinforcements and discipline in an optimal way. Finally, because parenting a child with ADHD can be difficult and stressful, the third and last module addresses ways parents can take better care of themselves by suggesting ways they can creatively cope with the stress that they may experience.

How will this program be made available to members?

At least annually, APS will inform its members about this preventive behavioral health program through member newsletters, materials mailed along with authorization letters or by asking you to make materials available in your office. Additionally, members will be identified via diagnoses that are submitted on claims forms. Parents of children who meet diagnostic eligibility criteria based on authorization and treatment plan data will automatically receive an introductory letter describing the program, a copy of the first newsletter, and information on how to opt out of the program if they desire. Members who learn of the program via newsletters or handouts will be encouraged to take advantage of the program and will be told how to obtain the materials.

The educational modules described above will be mailed out to participating members. Following the introductory letter, newsletters will be mailed out approximately every two to three weeks. If members choose not to participate in the program or wish to have the newsletters sent to a different address they could call a toll-free number.

How will this program be evaluated?

Assessing the effect of this program is important for improving and further developing materials and services offered through APS. Included with the final newsletter is a copy of a survey questionnaire and stamped envelope for members to assess the perceived benefit of the overall program.

What can you do as a provider?

This prevention program is designed to increase parental knowledge of how to more effectively work with, and cope with, the problems their child faces. Helping parents develop effective skills can have a more positive clinical outcome for the child whom you have evaluated or to whom you may be providing services.

Your support for this program is important to us. While APS will contact members automatically through the identification processes discussed above, you are encouraged to inform parents of children with ADHD about the program and to call us at 800-305-3720 Ext 3241 with the name of any member who meets inclusion criteria.

Participating parents may have questions or may seek further information from you regarding issues discussed in the educational materials. We believe the educational materials will help parents understand the basics upon which you can build to help them further develop or practice the skills necessary for effectively parenting a child with ADHD.

Included with this program description are copies of the introductory letter and the three educational newsletters that will be mailed to members participating in the program. Please take time to read these materials and give us your feedback. It is our hope that you find these materials a valuable addition to the care you provide.

Should you have any questions or concerns, we would be pleased to address them. To discuss the program, please contact Robert Sack, MD, APS Corporate Medical Director, at 1-800-305-3720 ext. 3009.

APS Healthcare Preventive Health Program

“Education and Treatment Compliance for Adults with Major Depressive Disorder”

APS Healthcare (APS) offers a preventive health program for individuals who have recently been diagnosed with Major Depressive Disorder (MDD) and are being treated with psychotherapy and/or antidepressant medication. This program is designed to improve clinical outcomes for these individuals by educating them about depression and its symptoms, available treatments, the course of recovery, and by helping them understand critical aspects of their own role in the treatment process.

PURPOSE

Depression is the most common diagnosis among adults between the ages of 18 and 64 among APS’ membership. Antidepressant medications are now frequently prescribed alone, or in combination, as a first line treatment for depression. Many individuals also participate in psychotherapy for depression. For both of these treatment approaches, compliance issues and patient behavior in relation to the treatment can pose major barriers in an otherwise highly effective treatment regimen. APS views the role of educating patients about the treatment process, helping them understand their experience of treatment, and encouraging them to assume an active role in their treatment as factors critical to ensuring effective treatment and preventing relapse.

CRITERIA

This program is designed for members ages 18 and over who have been diagnosed with a depressive disorder (DSM-IV codes: 296.2x, 296.3X, 300.4X, and 311 .XX) as a primary or secondary Axis I diagnosis and who have been prescribed antidepressant medications and/or are being treated with psychotherapy. This program is not intended for individuals who have been diagnosed with Bipolar disorders and other mood disorders not indicated by the codes listed above.

INTERVENTIONS

This program consists of 3 educational newsletters, which will be made available to members for whom a claim is received for medication management and/or psychotherapy, and for whom claims data indicate a diagnosis of a depressive disorder.

**APS Healthcare
Preventive Behavioral Health Program**

*Education and Identification Program of Newly Delivered Members with
Postpartum Depression*

Information for Provider

APS Healthcare (APS), in collaboration with its Health Plan partners for administering behavioral health, offers a preventive health program, “*Identification of Post Partum Depression*”, for mothers of newborns who may be experiencing symptoms of Post Partum Depression (PPD). This program is designed to identify new mothers who may be suffering from post partum depression by educating them about PPD and asking them to complete a depression survey that specifically measures post partum depression.

The “*Identification of Post Partum Depression*” program was developed in collaboration with several health plan partners who were concerned that new mothers who were experiencing post partum depression:

- Might not be aware of the prevalence of this condition,
- The symptoms they are experiencing can be treated, or
- Of the help that is available through APS.

Together, we have devised a program that should help to improve the identification of post partum depression earlier and assist these women to obtain the treatment they need.

APS would like our provider network to be aware of this program so that, should you be referred one of these women, you would be aware of the materials they have received and how the members were identified. Included in the mailing to every new mother of all participating health plans, within three (3) to five (5) weeks of delivery are:

- A copy of the “welcome” letter to the new mother that describes the program and the rest of the materials in the package;
- A copy of the brochure on post partum depression that provides an overview of the symptoms, the potential risks of failing to treat the depression, recommendations about seeking treatment, and additional sources of information about PPD. The brochure also provides an emergency number that the member can call to obtain immediate help;
- A copy of the Edinburgh Depression Scale, a valid and reliable tool that was designed specifically to measure PPD severity; and,
- A copy of the “Demographic Information” questionnaire that the new mother is asked to complete.

The new mother is asked to complete the Edinburgh Depression Scale and the Demographic Information questionnaire and mail it to APS in the envelope that is enclosed in the packet. Once the information is returned to APS, an APS staff member scores the Edinburgh Depression Scale. If the score is 8 or above, the member is contacted by a licensed behavioral healthcare clinician employee of APS who assesses the member over the phone for risk and assists the member with a referral.

Why has APS implemented this program?

Any woman who has had a baby within the last year, miscarried, or recently weaned a child from breast-feeding is at risk for PPD. About 20 to 40 percent of women report some emotional disturbance or cognitive dysfunction in the postpartum period. Many experience postpartum blues or “baby blues”, a normal state of sadness, dysphoria, frequent tearfulness, and clinging dependence. Those feelings, which may last several days (3-7), have been ascribed to the woman’s rapid change in hormonal levels, the stress of childbirth, and her awareness of the increased responsibility that motherhood brings. Many women feel especially guilty about having depressive feelings at a time when they believe they should be happy. They may be reluctant to discuss their symptoms or their negative feelings toward the child.

Should these feelings persist longer than a week, the mother may be experiencing post partum depression. Aside from the typical “blues”, these mothers may also be coping with suicidal ideation, obsessive thoughts regarding violence to the child, inability to concentrate,, and psychomotor agitation. Should the symptoms of PPD go untreated, the mother is at risk for postpartum psychosis.

Postpartum psychosis is most often characterized by depression, delusions, and thoughts by the mother of harming either the infant or herself. Suicidal ideation or infanticide must be carefully monitored, since some mothers have acted on those ideas. The incidence of postpartum psychosis is about 1 per 1,000 births, although some reports have indicated that the incidence may be as high as 2 per 1,000 births.

What are the goals of APS’ program?

The goals of this program are to:

- Educate members about postpartum depression.
- Help patients identify symptoms and to seek treatment.
- Instruct members in ways they can get treatment for postpartum depression.

What are the criteria for member inclusion in this program?

The only criteria for inclusion in this program are that the new mother be a member in the APS partner health plan. There are no age limitations.

How will this program be made available to members?

Besides the mailing to all new mothers after delivery, the health plans will inform its members about this preventive behavioral health program. This information will be communicated to members through Member Newsletters. Members will be encouraged to take advantage of the program and will be told how to obtain the materials.

In addition, APS will educate all participating health plan members who used APS services within the last year, of the availability of the program. Information about the program and methods of obtaining more information will be included in the APS Member Newsletter.

What can you do as a provider?

Included with this program description are copies of the “*Identification of Post Partum Depression*” Program packet that will be mailed to members participating in the health plan. Please take the time to read these materials and give us your feedback.

APS is pleased to offer this program to our health plan partners. Should you have any questions about this program, please contact Robert Sack, MD, APS Corporate Medical Director at 1-800-305-3720 ext. 3009.

MEMBER RESPONSIBILITIES

I have the responsibility to:

1. Receive information about APS', including its services, practitioners and providers, and clinical guidelines and member rights and responsibilities.
2. Be provided care and treatment with dignity and respect.
3. Be treated as an individual with personal needs, feelings, preferences, and requirements.
4. Non-discriminatory care, services, and access to treatment, regardless of race, religion, gender, ethnicity, sexual orientation, age, or disability.
5. Privacy in my treatment.
6. Communicate with APS staff and providers in a language I understand. If necessary, interpretation services will be provided, free of charge to me.
7. A candid discussion of all services available or that might be appropriate regardless of whether those services are covered by my benefits. I have the right to know my treatment options regardless of the cost and whether they are covered services.
8. Be provided with and involved in the development of a plan for my treatment that is individualized to me.
9. Be fully informed of any rules and regulations that may govern my participation in treatment. (i.e., Whether I can be charged if I do not attend my appointment or whether I have to pay any costs in addition to that covered by my benefits.)
10. Be fully informed about any procedures, medications, including the benefits and risks, and any research projects that I may be involved in before they are started.
11. Refuse any treatment without losing access to other services to the extent permitted by law, and to be informed of the consequences of this refusal. However, my provider has the right to discontinue treatment with me if he/she feels that my refusal of treatment make reasonable and responsible treatment impossible.
12. Continuous care with the same provider(s) as long as I remain eligible for services. If it becomes necessary to transfer my care to another provider, I will be given advance notice including the reasons for transfer, any alternatives, and a plan for the transfer unless an emergency situation exists.
13. Voice my opinions, recommendations, complaints or appeals to APS about their policies, decisions, their member rights and responsibilities statement and policy, or my care without fear of discrimination or reprisal.
14. Be free from physical, chemical and mental abuse in the course of my treatment.
15. Confidential treatment of my treatment records. Any information from my records will not be released without my prior consent, except in an emergency, or as required by law.
16. Refuse to perform any services for any program where I am receiving treatment, unless they are a part of my treatment plan.
17. Request the opinion of a consultant at my own expense.
18. Receive information about the processes that APS uses to make decisions about whether my care will be covered, benefit plan eligibility, benefit plan services included and excluded, co-payments, the providers who are available for my care, preventive health programs available, and how to file a claim and appeal.
19. File an appeal with APS or the appropriate governmental agency when a decision has been made to deny treatment and that a doctor who was not involved in the original decision review my request for an appeal.
20. The appropriate assessment and management of any pain that I experience.
21. Get information about my rights.
22. Receive care with dignity and respect.
23. Be treated as an individual.

24. Get care regardless of my race or religion.
25. Get care regardless of my gender or sexual preference.
26. Get care regardless of my age or disability.
27. Privacy when I'm getting care.
28. Speak with APS in my own language. If I need it, APS will get me a translator for free.
29. An honest talk about all treatments that might help me even if Medicaid doesn't pay for it.
30. Be involved in making my own care plan.
31. Be told the rules about participating in my care.
32. Be told the good and bad about procedures or medications that might help me before I get them. Be told the good and bad about any research projects that I might take part in before I start.
33. Be allowed to refuse any care or treatment. My doctor may not treat me anymore if they believe that my refusal is dangerous for my health.
34. Stay with the same therapist or doctor as long as I'm getting Medicaid. If I have to switch to a new doctor or therapist, I will be told ahead of time. If I have to switch to a new doctor or therapist, I will be told the reasons. If I have to switch to a new doctor or therapist, I will be told about my other choices. If I have to switch to a new doctor or therapist, I will be told what to do in an emergency.
35. Tell APS my opinions and complaints about their policies. If I complain, I will not have to worry about being "punished."
36. Not be abused physically, mentally, or chemically.
37. Have my treatment records kept private. No information about me will be given out unless I give permission.
38. Request the opinion of another provider.
39. Receive information about the processes that APS uses. Receive information about my Medicaid benefits. Receive information about how much I have to pay for care. Receive information about preventative health programs. Receive information about how to file an appeal.
40. Ask APS to review a decision to deny care. A doctor who was not part of the first denial will review this.

MEMBER RESPONSIBILITIES

I have the responsibility to:

1. Provide, to the extent possible, information that APS and its practitioners and providers need in order to care for me.
2. Follow the plans and instructions for care that I have agreed upon with my practitioner(s).
3. Participate, to the degree possible, in understanding my behavioral health problems and to work with my practitioner or provider to develop mutually agreed-upon treatment goals.
4. Follow the terms of my benefit plan.
5. Give APS and its doctors and therapists the information they need to properly care for me.
6. Follow the plans and instructions for care that my doctor or therapist gives me.
7. Work with my doctor or therapist to develop goals for my care.
8. Follow the terms of my benefit plan.

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