



Hawai`i Community Care Services  
(CCS) program  
2009

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# SECTION 1

## PROVIDER OPERATIONS

### Provider Operations Area

The Provider Operations Area acts as a liaison between 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 and providers in the following ways:

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

### Provider Operations Department

APS maintains a team to answer provider questions through toll free numbers. The phone lines are open from 8:00 a.m.- 5:00 p.m. Eastern or, as appropriate, Central Standard Time Monday - Friday. **The telephone number for APS' service center is 808-845-7771.** Please note that all Credentialing-related inquiries are handled in APS' Brookfield, Wisconsin office.

### 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- Information that is no longer valid
- Tax identification number of the address that is no longer valid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](http://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: 262-787-2364 Attn: Provider Updates. Demographic updates may also be mailed to:

APS Healthcare, Inc  
P.O. Box 991  
Brookfield, WI 53008-0991  
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](mailto:provideraddressupdates@apshealthcare.com), Fax-262-787-2364 or mail to:

APS Healthcare, Inc  
P.O. Box 991  
Brookfield, WI 53008-0991  
Attn: NPI Update

## **Provider Network**

All services must be rendered by participating, credentialed and contracted APS Network providers. APS' provider network includes, but is not limited to:

- Licensed psychiatrists
- Licensed psychologists
- Licensed social workers
- Licensed marriage & family therapists
- Licensed mental health counselors
- Licensed psychiatric nurse
- Mental health clinics
- Community based substance abuse programs
- Community mental health centers
- Acute care facilities
- Other community services
- Care Coordination/ Case Management Agencies

## **Access to Services**

Members in CCS have access to behavioral health services through any of the following five sources:

- Self referral/Directly contacting Community Care Services
- Their Care Coordinator
- Their PCP (but is not a requirement)
- Their Therapist/Behavioral Healthcare Practitioner (BHP)

## **CCS Mental Health and Substance Abuse Benefits**

Outpatient psychotherapy and care coordination services for CCS members do not require preauthorization. All other services, including electroconvulsive therapy and psychosocial rehabilitation, must be pre-authorized. Psychological testing, imaging studies (MRI, CAT, PET), and other Behavioral Health diagnostic procedures must also be pre-authorized/pre-certified.

CCS members' behavioral health benefits are based on medical necessity and include an array of services. Utilization of these services is guided by APS Healthcare's Medical Necessity Criteria and the *American Society of Addictions Medicine (ASAM) Criteria*.

- Inpatient
- Residential
- 24 hour Crisis Response
- Crisis Beds
- Partial Hospitalization

- Intensive Outpatient
- Outpatient
- Psychosocial Rehabilitation
- Medications
- Transportation – only when necessary to address a goal in the care plan and/or when no other reasonable transportation options exist
- In-Community Stabilization
- Translation Services
- Care Coordination Services
- Diagnostic Services
- TDD linkage or interpretation services for persons with vision or hearing impairments

Every CCS member chooses or is assigned a Behavioral Health Practitioner (BHP). The BHP is responsible for overseeing the member's behavioral health treatment plan.

## **On-Call Coverage/Covering**

Practitioner's/providers are responsible for arranging adequate coverage during the practitioner's absence. APS must be notified of all coverage arrangements. Covering should also be participating APS providers and must adhere to all APS administrative requirements, including, but not limited to: authorization procedures and accessibility standards. The covering practitioner must be of equivalent licensure level and must accept the APS Fee Schedule allowance.

are not required to work with a participating APS practitioner in an emergency. However, if the covering practitioner does not participate 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**

When treating an APS member on an outpatient basis, it is expected that the member understands the process for accessing therapeutic assistance outside of your normal business hours. State requirements mandate that individuals have access to care at any hour should the need arise.

## **Suspending Referrals**

When a practitioner/provider 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 and providers. The newsletters update 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](http://www.apshealthcare.com).

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# **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.

### **Case Rate Care Coordination Agencies**

For agencies receiving case rate payments for care coordination, a monthly payment will be made if all of the following are met for a member assigned to the agency for care coordination only if:

- a) The member is enrolled in CCS
- b) A completed Service Invoice is submitted
- c) An Updated Care Plan has been submitted to CCS
- d) The member has been seen face to face at least once in the month or at least 4 non-face-to-face attempts were made to contact the member

*\* If after 60 days no contact is made with a member, the care coordination agency should contact its CCS assigned representative for review of member's possible disenrollment.*

Invoices should be submitted to:

APS Healthcare, Inc.  
1600 Kapiolani Blvd, Suite 920  
Honolulu, HI 96814  
Attn: Accounts Payable

Chart Reviews. Once a month, CCS Utilization Management staff will audits a sample of charts to ensure that quality of care standards are being met. The results of these audits will be shared with the Care Coordination Agency.

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# SECTION 3 PRACTITIONER AND PROVIDER STANDARDS

## Access Standards

It is expected that the practitioner or provider will be able to offer an appointment or to arrange appropriate care for 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

New referrals from APS must be accepted without regard to race, religion, gender, sexual orientation, place of residence, national origin, age, or physical or mental health status.

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

APS Healthcare, Inc  
P.O. Box 991  
Brookfield, WI 53008-0991

## **On-Site Evaluation Process**

### *Practitioner/Practitioner Groups*

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

Reviews will be scheduled in advance and conducted by a Provider Operations staff member. APS policies and procedures will be reviewed and the practitioner's adherence to APS standards will be evaluated. The evaluation may also include 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 time frame to complete the action plan.

## **General Service Standards**

### **The following service standards apply to all and Providers:**

APS Network Practitioner and Providers are responsible for assessing the behavioral health needs of the CCS member, and coordinating care with the member's Case Management Team and other behavioral health providers. The Behavioral Health Provider (BHP) will be responsible for overseeing the Care Plan and is generally the individual who provides the majority of the member's clinical behavioral health services.

*The BHP will be expected to:*

- Assess and document the member's behavioral health care needs in the clinical record for the member.
- Develop and maintain an individualized treatment plan and submit this plan to CCS within 30 days after enrollment for a new patient and every six months for an established patient.
- Participate in CCS's protocols for pre-authorization/pre-certification of benefits, utilization management, and reporting requirements.

- Work with each member's CCS Case Manager (Team Leader) or Care Coordinator to:
  - Determine appropriate treatment services.
  - Maintain current treatment progress reports on each member.
  - Inform the Care Coordinator of any change in member's status such as divorce, impending homelessness, loss of financial assistance, incarceration, etc. which affects the need for or the intensity of care coordination and support services.
  - Inform care coordinator of missed appointments by member.
- Refer member to appropriate treatment providers when the scope of therapy is outside the BHP's scope of license and expertise.
- Ensure there is at least one staff member available for patient intake during business hours.
- 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.
- are trained in de-escalation techniques.
- Patient education materials are distributed routinely.
- are trained and/or experienced in working effectively with Managed Behavioral Health Care Organizations.
- 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**

Provider standards refer to the inpatient, residential, detoxification, crisis shelter 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 and prescription pads 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), Commission on Accreditation of Rehabilitative Facilities (CARF), Utilization Review Accreditation Commission (URAC) and National Committee for Quality Assurance (NCQA) as applicable.
- If sanctioned by an accrediting body, the provider has submitted an acceptable corrective action plan
- If eligible, the provider is Medicare approved
- If eligible, the provider is Medicaid approved
- If eligible, the provider is QUEST 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
- The service expectation for IOP is a minimum of three (3) hours of service per day at least three (3) days per week.
- The service expectation for partial hospitalization is a minimum six (6) hours of service per day on a continuous basis.

- 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

### **Care Coordination**

Care Coordination Agencies (CCA) roles and responsibilities include providing adequate level of ongoing case monitoring and service coordination to meet the member's needs. A measure of this is to provide at least the required contacts per Acuity Level and to maintain timely assessments and care plans (refer to Section XIII for description of Acuity Levels).

Non-licensed, non-degreed staff providing care coordination to CCS members will be supervised by a licensed and appropriately credentialed human service/health professional. Supervision must be documented.

Claims for care coordination services are submitted on HCFA 1500 forms.

Other responsibilities:

- CCAs must complete a face-to-face intake session with the member within 10 business days of having the member assigned. Within 30 days of the referral to the agency, the CCA must complete:
  - A care coordination assessment using the *CCS Care Coordination Initial Assessment* form,
  - A care coordination plan using the *CCS Care Coordination Plan* form,
  - the *CCS Care Management Profile* form
  - The Member's Crisis Plan
  - The Member's Informed Consent to Treatment
  - The Orientation Checklist

The CCS Assessment for Continuing Care form and an updated Care Plan should be submitted at least every six months. Care plans may be updated more frequently as clinically appropriate.

- Each CCA should have members sign '*Consent to Treat*', '*Member/Client/Patient Rights*', and '*Release of Information*' forms. (It is recommended that '*Release of Information*' forms be signed for all of the member's Health Care Providers, as well as for the agency providing after-hours crisis intervention services (if different from CCS or own agency).
- Provide informed crisis response services to assigned members 24 hours per day. If inpatient hospitalization is requested, agency must coordinate with CCS Team Lead for admission authorization.
- Provide CCS Liaison with weekly member summary report. Other coordination for members in crisis with CCS Liaison as needed.

- Assist member with maintaining their physical health including help in making/keeping PCP appointments, and maintaining an updated physical and TB exams.
- Assist member with obtaining available and necessary Social Services Benefits.
- Participate with the member and BHP in developing Care Plans.
- Working collaboratively with the members BHP and other treatment team professionals.
- Participate in referral, admission, assessment, and/or discharge planning when a member is hospitalized or admitted into a structured program.
- At disenrollment from CCS or discharge/transfer from agency, complete the *CCS Disenrollment/Transfer Summary* form and submit to CCS within ten (10) business days.
- Complete other forms and reports as required by CCS.

### **In-Community Stabilization for Adults**

In-Community stabilization does not offer 24-hour on-site supervision or on-site treatment.

### **Requirements**

In-community stabilization services may be provided by agencies that have a CCS contract with APS.

Four levels of in-community placement are commonly used:

- **Transitional Living** - provides 8-16 hours of on-site supervision, on-site treatment but some psychosocial rehabilitation services, the member is unable to pay, the member is able to engage in self-directed activities of daily living but has some degree of functional disability secondary to an acute exacerbation of a psychiatric illness that impairs functioning outside a structured living setting.
- **Supportive Living** - provides up to 8 hours per day on-site, no on-site treatment, but some psychosocial rehabilitation services, the member is unable to pay, the member is able to engage in self-directed activities of daily living but has some degree of functional disability secondary to an acute exacerbation of a psychiatric illness that impairs functioning outside a structured living setting. Often utilized as a step down from Transitional Living.
- **Respite Care** - provides supervision and close oversight of member's activities with re-directions as needed. Provides individualized services which have been assessed to be necessary in order to maintain the CCS member at their present level of functioning.
- **Temporary Placement** - no supervision, no treatment, short-term, the member is unable to pay.

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## **SECTION 4**

# **PRACTITIONER CREDENTIALING AND RE-CREDENTIALING**

All prospective providers undergo an evaluation of their professional credentials and experience. The purpose of the credentialing process is to ensure that all APS providers 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 providers 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. Once the recredentialing primary source verification process is complete, the file is forwarded to the APS Credentialing Committee for peer review. All providers under going recredentialing are informed in writing of acceptance into or rejection from the APS network.

Providers 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 providers from our participating provider network. The Credentialing Committee reviews' credentials and gives recommendations regarding the 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:** (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, and 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 criteria<sup>1</sup>. 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’ 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.

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## 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](http://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](mailto:qualityteam@apshealthcare.com), or by calling 1-800-305-3720, extension 3420.

### Practitioner and Provider Requirement to Protect Privacy

All APS network 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 staffs 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.

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## 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 5 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](http://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 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](http://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](mailto: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 hotline 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 4:45 P.M. HST 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.

Oahu: 845-7771

Big Island: 1-808-935-3481

Neighbor islands (not including the Big Island): 1-800-947-8881

## Initial/Concurrent Review

The member’s assigned Care Coordinator and/or Case Manager assists the member in the selection of the provider and in completing the necessary paperwork.

## Medication Management Referral Process for Non-MD

APS has made it easier for non-MD to obtain a referral for their members to have Psychiatric medication evaluations. This change reflects APS' commitment to supporting its in appropriate continuity and coordination of care. With a member's permission, may contact APS to obtain referrals and authorizations to a psychiatrist on their patient's behalf. 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 Case Manager (Team Lead) will schedule an evaluation based on the information provided by the caller. The Case Manager (Team Lead), 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 Case Manager (Team Lead) 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 accepts 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 Case Manager (Team Lead) 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 Case Manager (Team Lead) 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 Case Managers (Team Lead) are available through our After Hours Hotline twenty-four (24) hours per day to assist providers with emergency cases. Contact a Case Manager (Team Lead) whenever a member requires emergency attention.

Oahu: 845-7771

Big Island: 1-808-935-3481

Neighbor islands (not including the Big Island): 1-800-947-8881

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 Case 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 Case Managers (Team Lead) will work with hospitals and programs to assure a smooth transition and the use of participating 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 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 Case 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.

### **For pre-authorization of inpatient psychiatric consultation contact:**

Oahu: 845-7771

Big Island: 1-808-935-3481

Neighbor islands (not including the Big Island): 1-800-947-8881

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 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 healthcare provider types**

**Table 1**

To	From	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 treatment treatment.	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 only</i> )  Any significant risk status or issues  Stress-related factors  Severity of problem  Frequency of treatment  Treatment recommendations/plan significant coordination of care issues	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 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 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

<b>From</b>	<b>To</b>	<b>Conditions that Require Exchange</b>	<b>Minimum Information to be Exchanged</b>	<b>Timeliness/Frequency of Exchange</b>
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 Care Coordinator or Case 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 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 , 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 /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 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](mailto: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 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.

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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](http://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](mailto: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 Case Manager (Team Lead) 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.

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 Case Manager (Team Lead) 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 Case Manager (Team Lead) to determine whether an APS criterion are met, and authorizes care which is medically necessary. When there is a 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: Adverse Occurrences  
1600 Kapiolani Blvd, Suite 920  
Honolulu, HI 96814

## **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***

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

***Pharmacy Services***

All CCS members generally can fill behavioral health related prescriptions at any participating pharmacy. A complete listing of participating pharmacies is found in the member's Provider Directory.

**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 Case 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.

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# SECTION 7

## QUALITY IMPROVEMENT

### Information on Quality Activities Available to and Providers

APS regularly updates our Web site to provide our 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](http://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, /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 Medicare members and for QUEST members.** A copy of these should either be displayed in your office or given to the member prior to your rendering any services.

### 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 this 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 in accordance with NCQA, URAC and/or Medicaid standards.

APS has established treatment record documentation standards and compliance goals for its . These are intended to assure that APS 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 with start and end times.
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.<sup>2</sup>
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. A mental status evaluation documents the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.

13. A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessments.
14. Treatment plans are consistent with diagnoses and have both objective measurable goals and estimated timeframes for goal attainment or problem resolution.
15. The focus of treatment interventions is consistent with the treatment plan goals and objectives.
16. Informed consent for all prescribed medications and the patient's understanding of the treatment plan is documented (for MDs/DOs only).
17. Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.
18. The treatment record documents preventive services, as appropriate (e.g., relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).
19. Treatment record provides evidence of practitioner attempting to obtain consent to communicate with family/significant others, behavioral healthcare providers, the primary care physician (PCP), and/or other providers/health care institutions as appropriate.
20. Treatment record provides evidence of communication and coordination of care with other behavioral healthcare providers or if they exist.
21. Treatment record provides evidence of coordination of care with primary care provider (PCP) or other ancillary providers/health care institutions when they exist.
22. 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 via the Provider Manual, which providers receive upon commencement of their contract. 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 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 when appropriate
- Treatment record provides evidence of communication and coordination of care with other behavioral healthcare providers or 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
- Treatment record provides evidence of practitioner attempting to obtain consent to communicate with family/significant others, behavioral healthcare providers, the primary care physician (PCP), and/or other providers/health care institutions as appropriate.

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

## **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**

CCS members do not have co-pays and APS' payments will constitute payment in full.

### **Balance Billing**

Under federal law, QUEST members cannot be billed for moneys due from an insurer for covered services. By contracting with APS, a practitioner or provider agrees that APS' payment will constitute payment in full. Co-payments do not apply.

### **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 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, 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 7 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.

and providers should send claims forms 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 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, 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, 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 is used by APS to arrange for claims payment when an individual is covered under more than one group health insurance policy.
- If **Medicare** is the primary payor, the claim must first be submitted to Medicare.
- Medicare denial statements must be submitted. Statements from 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.

## 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 Healthcare Claims Customer Service by calling the behavioral health phone number indicated on the back of the member’s ID card.

## Case Rate Agency Invoices

In addition to claims, contracted Case Rate Agencies must submit monthly invoices to include the name of the organization, billing address, tax ID number and the name of each member serviced. Invoices should be sent to:

APS Healthcare  
1600 Kapiolani Blvd, Suite 920  
Honolulu, HI 96814  
Attn: Accounts Payable

Invoices will be paid upon verification that appropriate services were rendered.

## Member Hold Harmless Provision

Practitioners cannot charge members co-payments. 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 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**

CCS members may not be charged for cancelled or missed appointments.

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## 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
- 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**

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

1. Files are kept in a locked cabinet
2. Electronic treatment records are secured by unique staff/practitioner.

<b>Practitioner Name</b>	<b>Degree</b>
<b>Address</b>	<b>Suite</b>
<b>City</b>	<b>State</b>
<b>Phone</b>	<b>Fax</b>

**Office Type (fill in one)**

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

<b>Indicators</b>	<b>Y</b>	<b>N</b>	<b>Comments</b>
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			

## MEMBERS' RIGHTS AND RESPONSIBILITIES

Please read the following statements and ask your Case Manager about any items you do not understand. Your basic rights and responsibilities as a member of the CCS program are also described in your member handbook.

### Your Rights

- Right to be treated with dignity and respect.
- Right to have treatment and services provided:
  - ✓ without regard to race, ethnicity, religion, gender, sexual orientation, age, handicap, or disability,
  - ✓ That are culturally appropriate
  - ✓ That encourage family participation
  - ✓ that are free from physical, chemical, and mental abuse,
  - ✓ in the least restrictive manner and by qualified, competent staff.
- Right to confidentiality. Your prior consent is required to release information except in an emergency or as required by law.
- Right to be clearly informed about:
  - ✓ Your treatment and condition,
  - ✓ All options regarding treatment and services,
  - ✓ The availability of providers,
  - ✓ Clinical guidelines used in providing or managing your treatment or care,
  - ✓ Your rights and responsibilities as a CCS member,
  - ✓ State and federal laws that relate to your rights and responsibilities,
  - ✓ The complaint, grievance, and appeal procedures,
  - ✓ When audio or video recording devices will be used for activities that will involve you,
  - ✓ Non CCS personnel visiting CCS premises, or CCS affiliates' premises,
  - ✓ Your right to refuse treatment and the consequences for refusing treatment and services,
  - ✓ Information in your clinical record and the right to request copies of your clinical record
- Right to provide input:
  - ✓ In your treatment planning,
  - ✓ On CCS policies and services,
  - ✓ On CCS members' rights and responsibilities.

### Your Responsibilities

- To treat those who provide care and services with dignity and respect.
- To inform providers:
  - ✓ When the treatment or care coordination plan no longer works,
  - ✓ About changes in status such as marital, health insurance, address, telephone, and income,
  - ✓ About changes in medications, including medications given by other providers.

- To actively participate in developing and implementing a care coordination or treatment plan.
- To avoid threats or actions that could harm CCS employees or its affiliates' employees including CCS employees, providers and other members.
- To keep appointments with providers and cancel appointments when unable to keep them.
- To ask providers questions in order to understand your care and their role in that care.
- To follow all reasonable instructions, guidelines, or plans regarding treatment and services as a part of the CCS program.

## **Forms – Case Rate Agencies**

### **REQUIRED FORMS:**

Authorization for Release of Records or Information

Individual Care Management Profile

Case Management Plan

Care Coordination Continuing Care Assessment

Care Coordination Initial Assessment

Member's Crisis Plan

Discharge/Transfer Summary

Member's Informed Consent to Treatment

Members' Rights and Responsibilities

Notice of Privacy Practice

Orientation Checklist

### **OPTIONAL FORMS:**

Daily Activity Log

Acuity Level Review/Care Coordination Response

Unable to Contact Nimitz SAMPLE



**AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION**

\_\_\_\_\_, hereby give permission  
(Print name of patient/client) (Social Security Number)

APS Healthcare Inc. (APS); its subsidiaries; affiliates or subcontractors, and the clinician(s) performing services on behalf of APS in connection with my treatment to:

DISCLOSE information to: AND/OR  OBTAIN information from:

\_\_\_\_\_  
(Name of agency, attorney, school counselor, therapist, etc)

\_\_\_\_\_  
(Address, city, state, and zip code) (Phone) (Fax No.)

**INFORMATION TO BE DISCLOSED/OBTAINED**

- MY MENTAL HEALTH RECORD IN ITS ENTIRETY; OR
- MY SUBSTANCE ABUSE RECORD IN ITS ENTIRETY; OR
- ONLY the following information: **(PATIENT MUST INITIAL EACH ITEM TO BE DISCLOSED/OBTAINED)**
  - \_\_\_\_\_ Substance Abuse Evaluation
  - \_\_\_\_\_ Treatment Recommendations
  - \_\_\_\_\_ Expected Length of Treatment
  - \_\_\_\_\_ Attendance Records Only
  - \_\_\_\_\_ **Other (specify): Levels of care authorized & medications**
  - \_\_\_\_\_ **Diagnosis/Assessment as shown on DHS referral to CCS**
  - \_\_\_\_\_ Treatment Plan
  - \_\_\_\_\_ **Treatment Provider's name, address, & phone number**
  - \_\_\_\_\_ Progress Report on my Treatment

Form in which information should be released:  Verbal  Photocopied  
 Written  Other \_\_\_\_\_

The PURPOSE for such disclosure is:  
 to permit continuity of care  
 to permit case management (including reimbursement determinations) and processing of benefit claims  
 Other (specify): \_\_\_\_\_

I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this consent will expire on (1) year after I have terminated treatment with all providers affiliated with APS and its CCS Program.

\_\_\_\_\_  
Signature of member/client  
\_\_\_\_\_  
Date  
\_\_\_\_\_  
Signature of parent, guardian, conservator, or Authorized representative (when required)  
\_\_\_\_\_  
Witness

**NOTICE TO RECIPIENT OF INFORMATION**

This information has been disclosed to you from records, the confidentiality of which may be protected by Federal and/or state law. If the records are so protected, Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

## INDIVIDUAL CARE MANAGEMENT PROFILE

**Mem #:** \_\_\_\_\_ **Date of Enrollment:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Member Name:** \_\_\_\_\_  
(Last, First, M.I.)

**Address:** \_\_\_\_\_  
(Mailing Address)

\_\_\_\_\_ (Physical Residence Address) (date of most recent address change)

**Home Phone No.:** \_\_\_\_\_ **Alternate Phone:** \_\_\_\_\_

**Male** \_\_\_\_\_ **Female** \_\_\_\_\_ **DOB/Age:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_ **Religion:** \_\_\_\_\_

**Housing Arrangement:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_  
(Name) (Relationship)

**Emergency Contact:** \_\_\_\_\_  
(Address) (Telephone)

**Insurance Plan:** Quest Plan \_\_\_\_\_ **Medicaid** \_\_\_\_\_ **Medicaid/Medicare** \_\_\_\_\_

**PCP:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Psychiatrist:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**BHP:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Date of Annual Medical Exam:** \_\_\_\_\_ **Date of TB Test:** \_\_\_\_\_

**Seizure Disorder:** NO  YES  **Date of last seizure:** \_\_\_\_\_

**Allergies (in red ink):** \_\_\_\_\_

**Diagnostics (DSM/IV):**

	Date	Diagnosis	Date	Diagnosis
Axis I				

Axis II  
Is Axis II the member's primary diagnosis?  Yes  No

Axis III

Axis IV

Axis V

**Legal/Forensics:** Advance Directive?  Yes  No      Psych Advance Directive  Yes  No

**Guardianship:** \_\_\_\_\_  
(Name/Address/Phone No.)

**Probation/Parole Officer:** \_\_\_\_\_  
(Name/Phone No.)

**CPS Social Worker:** \_\_\_\_\_  
(Name/Phone No.)

**Power of Attorney:** \_\_\_\_\_  
(Name/Phone No.)



## CASE MANAGEMENT PLAN

**Initial**       **Continuing**      Member ID:

**Consumer Name:**

**List Problem by Priority**

**1. Problem:**

**Date Added:**

**Target Date:    Goal:**

**Goal Type:    Goal Met:    Achieved I**  
 Short Term     No  
 Long Term     No

**Goal Category:**     Resource Development;  
 General Health Maintenance;  
 Formation of a Healthy Lifestyle;  
 Managing Psychiatric Symptoms;  
 Addressing Substance Abuse Issues;

Crisis Mgmt/Risk of Harm Reduction;  
 Resolving Current Psychosocial Stressors;  
 Increase Tx Participation and Compliance;  
 Improving coping and problem solving skills;  
 Health System Integration/Collaboration of Care

**Interventions**

What:	Who:	Frequency:	Start Date Target Date:	Completed:	Completed :
I.				<input type="checkbox"/> No <input type="checkbox"/> Yes	
II.				<input type="checkbox"/> No <input type="checkbox"/> Yes	
III.				<input type="checkbox"/> No <input type="checkbox"/> Yes	
IV.				<input type="checkbox"/> No <input type="checkbox"/> Yes	

**2. Problem:**

**Date Added:**

**Target Date:    Goal:**

**Goal Type:    Goal Met:    Achieved I**  
 Short Term     No  
 Long Term     No

**Goal Category:**     Resource Development;  
 General Health Maintenance;  
 Formation of a Healthy Lifestyle;  
 Managing Psychiatric Symptoms;  
 Addressing Substance Abuse Issues;

Crisis Mgmt/Risk of Harm Reduction;  
 Resolving Current Psychosocial Stressors;  
 Increase Tx Participation and Compliance;  
 Improving coping and problem solving skills;  
 Health System Integration/ Collaboration of Care

**Interventions**

What:	Who:	Frequency:	Start Date Target Date:	Completed:	Completed
I.				<input type="checkbox"/> No <input type="checkbox"/> Yes	
II.				<input type="checkbox"/> No <input type="checkbox"/> Yes	
III.				<input type="checkbox"/> No <input type="checkbox"/> Yes	
IV.				<input type="checkbox"/> No <input type="checkbox"/> Yes	

**3. Problem:**

**Date Added:**

**Target Date:**    **Goal:**    **Goal Type:**    **Goal Met:**    **Achieved I**  
 Short Term     No  
 Long Term     No

**Goal Category:**  Resource Development;     Crisis Mgmt/Risk of Harm Reduction;  
 General Health Maintenance;     Resolving Current Psychosocial Stressors;  
 Formation of a Healthy Lifestyle;     Increase Tx Participation and Compliance;  
 Managing Psychiatric Symptoms;     Improving coping and problem solving skills;  
 Addressing Substance Abuse Issues;     Health System Integration/Collaboration of Care

**Interventions**

<b>What:</b>	<b>Who:</b>	<b>Frequency:</b>	<b>Target Date:</b>	<b>Completed:</b>	<b>Completed</b>
I.				<input type="checkbox"/> No	
				<input type="checkbox"/> Yes	
II.				<input type="checkbox"/> No	
				<input type="checkbox"/> Yes	
III.				<input type="checkbox"/> No	
				<input type="checkbox"/> Yes	
IV.				<input type="checkbox"/> No	
				<input type="checkbox"/> Yes	

**4. Problem:**

**Date Added:**

**Target Date:**    **Goal:**    **Goal Type:**    **Goal Met:**    **Achieved I**  
 Short Term     No  
 Long Term     No

**Goal Category:**  Resource Development;     Crisis Mgmt/Risk of Harm Reduction;  
 General Health Maintenance;     Resolving Current Psychosocial Stressors;  
 Formation of a Healthy Lifestyle;     Increase Tx Participation and Compliance;  
 Managing Psychiatric Symptoms;     Improving coping and problem solving skills;  
 Addressing Substance Abuse Issues;     Health System Integration/Collaboration of Care

**Interventions**

<b>What:</b>	<b>Who:</b>	<b>Frequency:</b>	<b>Target Date:</b>	<b>Completed:</b>	<b>Completed</b>
I.				<input type="checkbox"/> No	
				<input type="checkbox"/> Yes	
II.				<input type="checkbox"/> No	
				<input type="checkbox"/> Yes	
III.				<input type="checkbox"/> No	
				<input type="checkbox"/> Yes	
IV.				<input type="checkbox"/> No	
				<input type="checkbox"/> Yes	

**For additional problems, please use page 1, changing the problem number**

I accept the responsibility for the quality of care of only those services in this plan, which I am directly providing.

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Care Coordinator Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Case Manager Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Psychiatrist:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Care Coordination Continuing Care Assessment

Member Name: \_\_\_\_\_ Member #: \_\_\_\_\_ Acuity: \_\_\_\_\_

Care Coordination Agency: \_\_\_\_\_

**I. Diagnosis: (Update on Profile)**

**II. Current Medications: (Update on Profile)**

**III. Since the last Assessment, has the member:**

**Y            N**

- |           |   |                          |                          |
|-----------|---|--------------------------|--------------------------|
| <b>A.</b> | 1. remained engaged in care coordination process? .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 2. consistently kept appointments with CC, BHP, MD?.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 3. participated in self-help, clubhouse, other PSR? .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 4. participated in school, volunteer activities, or work? .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 5. shown indications of improved rapport?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 6. shown any improvement on insight/judgment? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 7. been stable for more than 6 months? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 8. been medication compliant? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>B.</b> | 1. phoned in a crisis? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 2. used ER? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 3. used a crisis bed? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 4. admitted to a psychiatric unit?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 5. been in an Intensive Outpatient program? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 6. been in a Partial hospital or Day Treatment program?.....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 7. been in a Residential program? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>C.</b> | 1. experienced a major life change (e.g. Divorce, homelessness, death, loss of employment)? . | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 2. shown variations in daily living patterns (e.g. Sleep, eating, self-care)? .....           | <input type="checkbox"/> | <input type="checkbox"/> |
|           | 3. relapsed on alcohol or other drugs? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**IV. Current Assessment of Status:** Check Appropriate Response: 1 = Least; 5 = Greatest

- |                                       |                            |                            |                            |                            |                            |
|---------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Housing Stability .....               | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Management of Symptoms .....          | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Crisis Coping Skills .....            | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Psychosocial Stability.....           | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Treatment Compliance .....            | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Stability of Comorbid Illnesses ..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

Since Last Assessment	0 = no Hx	1 = abstinent	2 = use without impairment	3 = abuse	4 = dependency	5 = dependence with institutionalization
<b>Alcohol</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Substance Abuse</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Vocational/Educational Scale:**    1    2    3    4    5    6    7    8    9    10

**No Employment**

**Employed**

<p>01 – No employment or education program AND no history of employment</p> <p>02 – No current employment or educational program; some history of employment</p> <p>03 – Day program which is not vocationally focused</p> <p>04 – Employment preparation program (e.g. Pre-Voc PSR, Clubhouse work unit)</p> <p>05 – Community-based vocational training program (e.g. Div. Of Voc-Rehab, Network, Work Hawaii)</p>	<p>06 – Community-based educational program (e.g. Tutoring, GED, continuing education)</p> <p>07 – Volunteer Work</p> <p>08 – Supported Employment program (e.g. Holds a job with job coaching from MH personnel)</p> <p>09 – Community-based post secondary education</p> <p>10 – Employed</p>
--	---

**(Assessment)**

**Member's Name:** \_\_\_\_\_

**V. Member's current living situation:**

- |   |                                 |                           |
|---|---------------------------------|---------------------------|
| 01 – Hospital   | 05 – Board or Care Home         | 09 – No current residence |
| 02 – Residential Program  | 06 – Private house or apartment | 10 – Other                |
| 03 – Transitional Living Program (up to 16 hrs on-site supervision) | 07 – Shelter                    | 11 – No information       |
| 04 – Supportive Living program (up to 6 hrs on-site supervision)    | 08 – Jail                       |                           |

**VI. Strengths Inventory**

1. Who helps you when you're in trouble? \_\_\_\_\_
2. How do you like to spend your time? \_\_\_\_\_
3. What can we do to help you? \_\_\_\_\_
4. What talents or skills do you have? \_\_\_\_\_
5. What education and/or training have you had? \_\_\_\_\_
6. Other strengths observed: \_\_\_\_\_

**VII. Interpretive Summary of Assessment Information and Progress Summary**

- Psychiatric Issues/Needs: \_\_\_\_\_
- Medical: \_\_\_\_\_
- Substance Abuse: \_\_\_\_\_
- Interpersonal: \_\_\_\_\_
- Vocational/Educational: \_\_\_\_\_
- Basic Needs (including spiritual and cultural issues): \_\_\_\_\_
- Legal: \_\_\_\_\_
- Leisure: \_\_\_\_\_
- Other: \_\_\_\_\_

**VIII. Summary: Priorities/Preferences**

**Member:**

**Care Coordinator:**

1.	1.
2.	2.
3.	3.
4.	4.

\_\_\_\_\_  
**Member Signature**

\_\_\_\_\_  
**Case Manager Signature**

\_\_\_\_\_  
**Date**

## CARE COORDINATION INITIAL ASSESSMENT

### I. MEMBER INFORMATION

Member Name: \_\_\_\_\_ Member #: 0000 \_\_\_\_\_  
 Date of Enrollment: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Care Coordinator/Agency: \_\_\_\_\_

Program (currently involved with)	Type of Assistance & Contact Person/Phone	Date

What agencies have helped you in the past? \_\_\_\_\_  
 \_\_\_\_\_

### II. FAMILY INFORMATION

Name	Age	Location	Emotional Rel.	Substance Hx.	Psychiatric Hx.
Parents:					
Siblings:					
Spouse/SO:					
Children:					

### III. PSYCHIATRIC TREATMENT HISTORY

Hospital/Program/Therapist	Dates of Tx	Level of Care	Reason for Treatment

### IV. SUBSTANCE ABUSE TREATMENT HISTORY

	# 1	#2	#3	#4
Dates of Tx				
Facility				
Length of Tx				
Level of Tx				
Substance				

### V. STRENGTHS INVENTORY

1. Who helps you when you're in trouble? \_\_\_\_\_
2. How do you like to spend your time? \_\_\_\_\_
3. What are your hobbies? Interests? \_\_\_\_\_
4. What can we do to help you? \_\_\_\_\_
5. What talents or skills do you have? \_\_\_\_\_
6. What education and/or training have you had? \_\_\_\_\_

VI. Check all that apply over the last six months.	COMMENTS	Priority	
		Member	CC
<b>MENTAL STATUS</b> Thinking: <input type="checkbox"/> +SI <input type="checkbox"/> +HI <input type="checkbox"/> Paranoid <input type="checkbox"/> Delusional <input type="checkbox"/> Confusion <input type="checkbox"/> Disoriented <input type="checkbox"/> Poor Memory <input type="checkbox"/> Poor Judgment <input type="checkbox"/> Poor Communication <input type="checkbox"/> AH <input type="checkbox"/> VH Behavior: <input type="checkbox"/> Suicide/Homicide Attempt <input type="checkbox"/> Impulsive <input type="checkbox"/> Self-Injury <input type="checkbox"/> Assaultive <input type="checkbox"/> Isolative <input type="checkbox"/> Agitated <input type="checkbox"/> Bizarre <input type="checkbox"/> Hyperactive Feelings: <input type="checkbox"/> Hopeless <input type="checkbox"/> Depressed <input type="checkbox"/> Irritable <input type="checkbox"/> Tired <input type="checkbox"/> Manic <input type="checkbox"/> Euphoric <input type="checkbox"/> Anxious Is Member Medication Compliant? : <input type="checkbox"/> Y <input type="checkbox"/> N			
<b>MEDICAL</b> Diabetes – Insulin Dependent <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> TB <input type="checkbox"/> Asthma <input type="checkbox"/> Hearing Difficulty <input type="checkbox"/> Vision Problems <input type="checkbox"/> Hepatitis <input type="checkbox"/> Seizure <input type="checkbox"/> STD <input type="checkbox"/> Liver <input type="checkbox"/> Weight <input type="checkbox"/> Thyroid <input type="checkbox"/> Other: _____ Medications:			
<b>SUBSTANCE ABUSE</b> <input type="checkbox"/> Alcohol <input type="checkbox"/> ICE <input type="checkbox"/> Cocaine <input type="checkbox"/> Pot <input type="checkbox"/> Heroin <input type="checkbox"/> Methadone <input type="checkbox"/> Hypnotics <input type="checkbox"/> Benzodiazepines (e.g. valium, clonazepam) <input type="checkbox"/> Pain Meds <input type="checkbox"/> Inhalants (e.g. Glue/Paint) <input type="checkbox"/> Opiates (e.g. vicodin, TC3) <input type="checkbox"/> OTC <input type="checkbox"/> Other:			
<b>INTERPERSONAL/RELATIONSHIPS</b> <input type="checkbox"/> Family/Significant Other/Sibling <input type="checkbox"/> Isolation <input type="checkbox"/> Communication <input type="checkbox"/> Social Skills <input type="checkbox"/> Peer Relations <input type="checkbox"/> Parenting Skills <input type="checkbox"/> Abuse Issues: <input type="checkbox"/> Verbal <input type="checkbox"/> Emotional <input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Other:			
<b>VOCATIONAL/EDUCATIONAL</b> <input type="checkbox"/> Finding/Maintaining Employment or Volunteer Work <input type="checkbox"/> Lack of Job Skills <input type="checkbox"/> Lack of Training <input type="checkbox"/> Lack of Education – last grade completed: _____ <input type="checkbox"/> Other:			
<b>BASIC NEEDS</b> <input type="checkbox"/> Housing <input type="checkbox"/> Food <input type="checkbox"/> Clothing <input type="checkbox"/> Mobility/Transportation <input type="checkbox"/> Spiritual <input type="checkbox"/> Cultural <input type="checkbox"/> Self-Care (e.g., Grooming, Hygiene, Bathing, Shopping, Meal Prep) <input type="checkbox"/> Meaningful Activity <input type="checkbox"/> Financial: Specify <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Other:			
<b>LEGAL</b> <input type="checkbox"/> Arrests <input type="checkbox"/> Pending Cases <input type="checkbox"/> Outstanding Warrants or Fines <input type="checkbox"/> Incarceration <input type="checkbox"/> Probation/Parole <input type="checkbox"/> TRO <input type="checkbox"/> CPS <input type="checkbox"/> APS			

**VII. Current Assessment of Status:** Check Appropriate Response: 1 = Least; 5 = Greatest

Housing Stability.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Management of Symptoms.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Crisis Coping Skills.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Psychosocial Stability.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Treatment Compliance.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Stability of Comorbid Illnesses.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Since Last Assessment	0 = no Hx	1 = abstinent	2 = use without impairment	3 = abuse	4 = dependency	5 = dependence with institutionalization
<b>Alcohol</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Substance Abuse</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Current Vocational/Educational Status**

(Place an X in the appropriate box)

1-Never  2-Not Now  3-Day Prog.  4-Emp. Prep.  5-Voc.Train.  6-Educ.Prog.  7-Volunteer  8-Support Empl.  9-College+  10-Employed

Member Signature

Date

Case Manager Signature

## MEMBER'S CRISIS PLAN

Member's Name: \_\_\_\_\_

When I start having a crisis, the following changes in my symptoms usually occur:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I can do the following things to prevent a crisis when I am not doing well:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

APS can help me when I am not doing well by:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I want my doctor(s) to give me the medications they think will help me when I begin to have a crisis:  YES  NO

If "NO", this is what I want my doctor to do when I start having a crisis:

\_\_\_\_\_

I would like the following people to be notified when I am in a crisis:

\_\_\_\_\_

Please tell the notified people the following about me when I am in a crisis:

\_\_\_\_\_

I know I am getting better when:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I developed this crisis intervention/management plan with the help of: \_\_\_\_\_

I understand that this crisis intervention/management plan stays in effect until I choose to review it. This plan will be reviewed with me every six months, when I do a new care plan with my case manager.

Member's Signature \_\_\_\_\_ Original date \_\_\_\_\_

Dates Reviewed: \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

## DISCHARGE/TRANSFER SUMMARY

Discharge
  Transfer to \_\_\_\_\_
Agency Name \_\_\_\_\_

Member Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_ Admit Date \_\_\_\_\_

PCP \_\_\_\_\_ Discharge/Transfer Date \_\_\_\_\_

**Reason for Discharge/Transfer:** \_\_\_\_\_

**Diagnosis (at time of Discharge/Transfer):**

Axis I: \_\_\_\_\_ Axis IV: \_\_\_\_\_  
 Axis II: \_\_\_\_\_ Axis V: \_\_\_\_\_  
 Axis III: \_\_\_\_\_

**Assessment (at time of Discharge/Transfer):**

Strengths \_\_\_\_\_  
 Needs \_\_\_\_\_  
 Abilities \_\_\_\_\_  
 Preferences \_\_\_\_\_

**Current Behavioral Health Treatment:**

Psychiatrist \_\_\_\_\_ Psychologist \_\_\_\_\_  
 PSR \_\_\_\_\_ Other \_\_\_\_\_

**Case Management Goals:**

	% Achieved
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

**If substance abuse treatment received while in CBCM, treatment history:**

Program	Dates	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____





## MEMBER'S INFORMED CONSENT TO TREATMENT

I am eligible to receive behavioral health care services through Community Care Services (CCS).

I understand that there is no assurance that I will feel better. Because care coordination is a cooperative effort between my care coordination team, my doctors/therapists, and myself I will work with my care coordination team in a cooperative manner to resolve my difficulties.

I understand that confidentiality of records of information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information.

I understand that state and local laws require that my care coordination team report all cases of abuse or neglect of minors or the elderly.

I understand that state and local laws require that my care coordination team report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my care coordination team to disclose confidential information.

I understand that I may be contacted by Community Care Services or APS Healthcare (APS) (i) to ensure continuity and quality of my treatment and/or (ii) to assess the outcome of treatment.

I have read and had explained to me the basic rights of individuals who undergo care coordination/treatment through Community Care Services. I have also received a copy of the *Member Rights and Responsibilities* statement, which includes:

1. the right to be informed of the various steps and activities involved in receiving services;
2. the right to confidentiality under federal and state laws relating to the receipt of services;
3. the right to humane care and protection from harm, abuse, or neglect;
4. the right to make an informed decision, whether to accept or refuse care coordination/treatment; and

I understand that my CCS care coordination team/therapist or other authorized treatment providers may disclose any and all records pertaining to my CCS care coordination/treatment to representatives of Community Care Services or APS and its affiliates within the QUEST program, if such disclosure is necessary for claims processing, case management, coordination of treatment, or utilization review purposes.

I understand that I can revoke my consent to treatment at any time, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

\_\_\_\_\_  
Member's signature

\_\_\_\_\_  
Date



## MEMBERS' RIGHTS AND RESPONSIBILITIES

Please read the following statements and ask your Case Manager about any items you do not understand. Your basic rights and responsibilities as a member of the CCS program are also described in your member handbook.

### Your Rights

- Right to be treated with dignity and respect.
- Right to have treatment and services provided:
  - ✓ without regard to race, ethnicity, religion, gender, sexual orientation, age, handicap, or disability,
  - ✓ That are culturally appropriate
  - ✓ That encourage family participation
  - ✓ that are free from physical, chemical, and mental abuse,
  - ✓ in the least restrictive manner and by qualified, competent staff.
- Right to confidentiality. Your prior consent is required to release information except in an emergency or as required by law.
- Right to be clearly informed about:
  - ✓ Your treatment and condition,
  - ✓ All options regarding treatment and services,
  - ✓ The availability of providers,
  - ✓ Clinical guidelines used in providing or managing your treatment or care,
  - ✓ Your rights and responsibilities as a CCS member,
  - ✓ State and federal laws that relate to your rights and responsibilities,
  - ✓ The complaint, grievance, and appeal procedures,
  - ✓ When audio or video recording devices will be used for activities that will involve you,
  - ✓ Non CCS personnel visiting CCS premises, or CCS affiliates' premises,
  - ✓ Your right to refuse treatment and the consequences for refusing treatment and services,
  - ✓ Information in your clinical record and the right to request copies of your clinical record
- Right to provide input:
  - ✓ In your treatment planning,
  - ✓ On CCS policies and services,
  - ✓ On CCS members' rights and responsibilities.

### Your Responsibilities

- To treat those who provide care and services with dignity and respect.
- To inform providers:
  - ✓ When the treatment or care coordination plan no longer works,
  - ✓ About changes in status such as marital, health insurance, address, telephone, and income,
  - ✓ About changes in medications, including medications given by other providers.



- To actively participate in developing and implementing a care coordination or treatment plan.
- To avoid threats or actions that could harm CCS employees or its affiliates' employees including CCS employees, providers and other members.
- To keep appointments with providers and cancel appointments when unable to keep them.
- To ask providers questions in order to understand your care and their role in that care.
- To follow all reasonable instructions, guidelines, or plans regarding treatment and services as a part of the CCS program.



## Notice of Privacy Practice

APS Healthcare Inc. (APS)  
Community Care Services (CCS) program

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### Understanding Your Health Record/Information

There are strict Federal and State requirements for use and disclosure for some types of Protected Health Information (PHI), for example, mental health, substance abuse, developmental disability, and HIV/AIDS/ARC information. However, there are still limited circumstances in which these types of information may be used or disclosed without your authorization.

Each time you visit your Case Manager, therapist, physician, or other healthcare provider, a record of your visit is made. Typically, information about your problems, examination results, and treatment plan are recorded. We call this your legal health or medical record, and it describes the care you received. This information is used to:

- Plan your care and treatment
- Communicate with other health professionals involved in your care
- Check to see that the bills for service sent by the treatment professionals were actually provided

Sometimes portions of this information *that do not identify you* are used for:

- Medical/mental health research
- Planning and improving treatment and services in general
- Improving the health of people
- A tool for public health officials to assist them with improving the health of the nation

Knowing what is in your record helps you understand and ask questions about how information will be used when you authorize disclosure to others and it ensures that the information is accurate.



## **Your Health Information Rights:**

Although your record is the physical property of CCS or the facility that compiled it, the information belongs to you. You have the right to:

- Ask that certain information not be disclosed for particular reasons. However, CCS will inform you if they are not in agreement;
- Receive confidential communications of your protected health information;
- Inspect and copy your health record;
- Amend your health record;
- Be informed of any disclosures of your health information;
- Request communications of your health information by alternative means or at alternative locations; and
- Withdraw your authorization to use or disclose health information in the future except to the extent that action has already been taken.

## **Our Responsibilities:**

CCS is required to:

- Ensure the privacy of your health information;
- Notify you about our legal duties and privacy practices regarding information we collect and maintain about you;
- Honor the terms of this notice; and
- Accommodate any reasonable requests you may make to communicate health information by alternative means or at alternative locations.

CCS reserves the right to change its practices and to make any new provisions effective for all protected health information we maintain. Should our practices change, we will mail a revised notice (within 60 days) to the address you've given us.

CCS will not use or disclose your health information without your authorization, except in certain situations that are listed in the following section.

## **Examples of Disclosures for Treatment, Payment and Health Operations**

Your health information will only be used when it is necessary for CCS to carry out the functions of our work. If your health information needs to be shared with other agencies or providers, CCS will require those agencies or providers to protect this



health information. And then, only the minimum necessary amount of your health information will be released in order for that entity to carry out the functions of their work. CCS will use and share your health information for:

**Treatment.** For example: Information obtained by your healthcare provider or other members of your treatment team will be recorded in your file/record and will be used to determine the most appropriate care for you. This documentation also assists the Case Manager determine if the goals, in your plan of care, are being met.

**Payment.** For example: A bill may be sent to CCS or to a third party payer. The information on or accompanying the bill may include your identity, as well as your diagnosis, and procedures or services that were provided.

**Regular Health Operations.** For example: Members of the fiscal staff, the risk or quality improvement manager, or members of the quality improvement or utilization management team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to evaluate and improve the quality and effectiveness of the services we provide.

## **Other Uses or Disclosures (Authorization not Necessary)**

**Business Associates:** There are some services provided by our organization through contracts with business associates. Examples include independent auditors who monitor CCS's compliance, the State's Office of the Attorney General, or an accreditation body, such as URAC. Information in your health record may then be used to evaluate and improve the quality, appropriateness and effectiveness of the mental health services we provide.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

**Communication with Family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, relevant health information to that person, depending on that person's involvement in your care or payment related to your care.

**Research:** We may disclose information to researchers when an Institutional Review Board (IRB) that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.



**Public Health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Correctional institution:** If you are an inmate of a correctional institution, we may disclose to the institution or its agents, health information that is necessary to maintain your health, and the health and safety of other individuals.

**Victims of Abuse (including Child Abuse), Neglect or Domestic Violence:** Should CCS suspect or receive a report that you are the victim of abuse or neglect at the hands of a parent, foster parent, family member, guardian or provider, CCS will report the suspected abuse or neglect to the necessary authorities, e.g., CPS (Child Protective Services), APS (Adult Protective Services), Police, etc. Some of the information that we report may contain limited health information about you.

**Specialized Government Functions:** CCS may disclose health information for national security and intelligence and protective services for the President and others as required by law.

**Judicial and Administrative Hearings:** CCS may disclose protected information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

**Other Government Agencies or organizations providing Benefits or Services:** CCS may share information with other government agencies or organizations that are providing benefits or services when the information is necessary in order for you to receive those benefits or services.



## **For More Information or to Report a Problem**

If you have questions or feel like your privacy has been violated, you may file a complaint with us or the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with the Secretary or us.

To file a complaint or receive more information contact APS Customer Service at:

Phone: 952-4400 or 1-888-225-4122

Fax: 952-4450 or 1-800-210-7210

Address:

APS Healthcare Inc.

1600 Kapiolani Blvd., Suite 920

Honolulu, HI 96814

To file a complaint with the Secretary of Health and Human Services, write to:

Office of Civil Rights

Medical Privacy, Complaint Division

U.S. Department of Health and Human Services

200 Independence Avenue, S.W., HHH Bldg., Room 509H

Washington, DC 20201

Phone: 866-627-7748

TTY: 886-788-4989

E-mail: [www.hhs.gov/ocr](http://www.hhs.gov/ocr)

There will be no retaliation for filing a complaint.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more consumers, workers or the public.



## **Privacy Practices Acknowledgement**

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

\_\_\_\_\_

Name

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

If signed by a legal representative, relationship

\_\_\_\_\_

Effective Date: 010109



## ORIENTATION CHECKLIST

Member Name: \_\_\_\_\_ Date: \_\_\_\_\_

Yes	No	<b><u>Completed during orientation:</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	CCS Mission, values, goals, services explained
<input type="checkbox"/>	<input type="checkbox"/>	The Case Management Process explained
<input type="checkbox"/>	<input type="checkbox"/>	Informed Consent explained and signed by member
<input type="checkbox"/>	<input type="checkbox"/>	Members' Rights and Responsibilities explained and given to member
<input type="checkbox"/>	<input type="checkbox"/>	Disclosure of personal health information
<input type="checkbox"/>	<input type="checkbox"/>	Complaint process
<input type="checkbox"/>	<input type="checkbox"/>	Crisis Plan obtained
<input type="checkbox"/>	<input type="checkbox"/>	CCS Member Handbook reviewed and given to member
<input type="checkbox"/>	<input type="checkbox"/>	CCS Profile completed
<input type="checkbox"/>	<input type="checkbox"/>	Appointment made for BHP (if applicable)
<input type="checkbox"/>	<input type="checkbox"/>	Appointment made for Initial Assessment with Case Manager
<input type="checkbox"/>	<input type="checkbox"/>	Authorization to Obtain/Release Information – list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where orientation took place:

\_\_\_\_\_

Language or other special needs identified:

\_\_\_\_\_

Additional Information (include plan to complete orientation, if not completed):

\_\_\_\_\_

**Next Scheduled**

**Contact:**

\_\_\_\_\_ (location and date)

Member Signature

Date

Care Coordinator

Date

Case Manager

Date



## COMMUNITY CARE SERVICES DAILY ACTIVITY LOG

Member Name: \_\_\_\_\_ Member ID: **0000**

Date: \_\_\_\_\_ Care Coordinator: \_\_\_\_\_

Service:	Start Time:	End:	Total Time:	Units:	Place (see codes):
<input type="checkbox"/> H0007-52 Crisis					
<input type="checkbox"/> H0023 Outreach/Contact					
<input type="checkbox"/> H0023-52 Outreach/No Contact					
<input type="checkbox"/> T1017 Monitoring /Svc. Coord					
<input type="checkbox"/> T1017 Monitoring /Svc. Coord					
<input type="checkbox"/> T1017 Monitoring /Svc. Coord					
<input type="checkbox"/> T1017 Monitoring /Svc. Coord					
<input type="checkbox"/> T1017 Monitoring /Svc. Coord					
<input type="checkbox"/> T1017-22 Case Assessment					
<input type="checkbox"/> T1017-51 Case Planning					

If the member's address changed recently, enter the date it changed: \_\_\_\_\_

What is the new address? \_\_\_\_\_

When is the member's next DHS appointment? \_\_\_\_\_

Reason for Encounter: \_\_\_\_\_

<input type="checkbox"/> Managing Psychiatric Symptoms <input type="checkbox"/> Addressing Substance Abuse Issues <input type="checkbox"/> Improving coping and problem solving skills <input type="checkbox"/> Resource Development <input type="checkbox"/> Resolving Current Psychosocial Stressors	<input type="checkbox"/> General Health Maintenance <input type="checkbox"/> Formation of a Healthy Lifestyle <input type="checkbox"/> Crisis Management/ Risk of Harm Reduction <input type="checkbox"/> Health System Integration/ Collaboration of Care <input type="checkbox"/> Increase Treatment Participation and Compliance
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Disenroll Date: \_\_\_\_\_ Re-enroll Date: \_\_\_\_\_ Acuity Level: \_\_\_\_\_

**Additional Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Date Received: \_\_\_\_\_ Approved by: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Place of service codes:

04 – Homeless Shelter	11= Office	12 = Home	14 – Group Home	21 – Inpatient Hospital
22 – Outpatient Hospital	23 – ER	49 – Independent Clinic	51 – Inpatient Psych	52 – Psych Fac. Partial
53 – CMHC	55 – Residential SA	56 – Psych Resid Trt Ctr	57 – Non-Resid SA	71 – Public Health Clinic
72 – Rural Health Clinic	TM – Telemedicine			



## Acuity Level Review/Care Coordination Response

Member Name \_\_\_\_\_ Date of Last Review: \_\_\_\_\_ Acuity at Review: \_\_\_\_\_  
 Care Coordinator \_\_\_\_\_ Agency: \_\_\_\_\_ Date of Review \_\_\_\_\_

### Acuity: Criteria and Rating

(Please indicate by checking the appropriate acuity criteria in each dimension.)

Dimension	Acuity Criteria			
	I. Intensive	II. Intermediate	III. Routine	IV. Maintenance
1. <u>LOF</u>	<input type="checkbox"/> GAF:>20 points below baseline or significantly below baseline	<input type="checkbox"/> GAF: 5 – 20 points below baseline or moderately below baseline	<input type="checkbox"/> GAF: at or near baseline	<input type="checkbox"/> GAF: at or near baseline for >1 year
2. <u>Course</u>	<input type="checkbox"/> Progressive Deterioration Poor or Variable Progress Present to 3 months	<input type="checkbox"/> Consistent Progress Relative to Tx Goals For 3 months	<input type="checkbox"/> Condition Stable >6 months	<input type="checkbox"/> Condition stable >1 year
3. <u>Relapse</u>	<input type="checkbox"/> IP, Crisis or Residential Care Present to 3 months	<input type="checkbox"/> IP, Crisis or Residential Care Within last 3 to 6 months	<input type="checkbox"/> Only Partial, IOP or OP care >6 months	<input type="checkbox"/> No higher levels of treatment for more than 1 year
4. <u>Compliance</u>	<input type="checkbox"/> Poor Participation Requires Support	<input type="checkbox"/> Sporadic or Progressive Participation Requires Limited Support	<input type="checkbox"/> Consistent Participation Infrequent Need for Support	<input type="checkbox"/> Established Pattern of Participation Infrequent Need for Support

Comments: \_\_\_\_\_

Does the Care Coordination response support the Acuity Level? If not, why not. \_\_\_\_\_

Are the Care Coordination Assessments and Plan of Care up to date? If not, why not. \_\_\_\_\_

<p><b>Acuity:</b></p> <p><input type="checkbox"/> <b>I. Intensive</b></p> <p><input type="checkbox"/> <b>II. Intermediate</b></p> <p><input type="checkbox"/> <b>III. Routine</b></p> <p><input type="checkbox"/> <b>IV. &gt;12 months at IIIA</b></p> <p><input type="checkbox"/> <b>U. Unknown</b></p>	<p><b>Care Coordination Response:</b></p> <p><input type="checkbox"/> <b>A. Service requirements met</b></p> <p><input type="checkbox"/> <b>B. Service requirements partially met</b></p> <p><input type="checkbox"/> <b>C. Service requirements unmet</b></p> <p><input type="checkbox"/> <b>E. Service requirements unmet despite efforts</b></p> <p><input type="checkbox"/> <b>P. Pending</b></p>
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Comments: \_\_\_\_\_

Case Manager \_\_\_\_\_ Care Coordinator: \_\_\_\_\_



March 6, 2009

CCS Member Name

Address

City, HI Zip Code

Dear CCS Member Name,

I have been unsuccessful in my attempts to contact you. Please call me at 845-7771 or toll free at 1-800-947-8881 so we can set up a meeting at a location that is convenient for you. If I am not available when you call, please leave a number where you can be reached, and I will get back to you as soon as possible.

I look forward to hearing from you soon.

Very truly yours,

CC Name  
Care Coordinator  
CCS