



Behavioral Health and EAP Programs

PROVIDER MANUAL

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Welcome

Welcome to the HMC HealthWorks (HMC) behavioral health/EAP provider network. We are pleased to have you as a member of our strong team of providers.

This handbook serves as a reference document for our network providers. It details the policies and procedures developed and followed by HMC to assure that appropriate and quality treatment is accessible to our members at all times. Revisions or updates will be added to the manual as information changes. We welcome your comments and suggestions regarding the manual and want to assist you in providing quality care to our members. We look forward to our continued working relationship with you.

Should you not be able to find an answer to your questions here, please feel free to contact the HMC Provider Relations Department at 855-487-8914. We are available 8am-8pm EST Monday – Friday to assist you.

In the rare event that information in this document differs from that provided in the member's benefit plan, the member's benefit plan should be given precedence over the information in this manual.

Introduction to HMC HealthWorks

HMC is a Total Healthcare Management company with over 35 years of experience in behavior change. HMC's **mission** is to help our clients make "*smarter healthcare decisions.*" Our **vision** is to provide the necessary support and tools for assisting individuals in navigating the health care system, obtaining access to the best health services based on their needs, and supporting their health and well-being. We believe these components provide us with the foundation, understanding, and experience to successfully deliver results through a tailored program unique to the Client.

HMC Philosophy

HMC's BH and EAP programs are designed to:

- Enhance our members' treatment and life experience
- Gain trust from our members to raise awareness, enthusiasm and increase engagement
- Motivate participants and improve members' health
- Support treatment approaches that are evidence based, goal directed and consistent with accepted standards of care and URAC Guidelines
- Educate members and providers about available treatment options and the importance of continuity of care among providers
- Adhere to the importance of "mind-body" principle and connection

HMC manages behavioral health and employee assistance programs for a variety of clients nationwide. Benefit plans are set by clients contracted with HMC in compliance with state and federal laws, rules and regulations. HMC arranges for, and manages, the provision of a wide range of behavioral health and EAP services for our members. Behavioral health services may include: Inpatient Psychiatric, Inpatient Detoxification, Inpatient Rehabilitation, Partial Hospitalization, Intensive Outpatient for Mental Health and Substance Abuse, Outpatient Psychotherapy, Medication Management, and Applied Behavioral Analysis (ABA), depending on the particular benefit plan. EAP services may include face to face sessions, legal/financial consultation, formal referrals and work/life benefits.

HMC maintains a national network of practitioners and facilities that are credentialed to provide quality care to the members we serve. HMC contracts with, and credentials, a continuum of behavioral health providers for our members including individual behavioral health practitioners, provider groups, agencies and facilities. We contract with licensed psychiatrists, psychologists, social workers and other master's-prepared clinicians. Our network includes numerous clinical, linguistic, and cultural specialties to serve individual member and geographic needs. We believe that the key to quality care and member satisfaction is through a diverse, well-informed, high-quality network. To accomplish this, we credential clinicians who are independently licensed and well trained in their particular area of expertise.

As a condition of in-network status with HMC, it is expected that all providers abide by the following:

- Provide medically necessary, appropriate services to all covered members
- Provide services in accordance with applicable state and federal laws, and within the scope of their license or accreditation

- Follow the policies and procedures outlined in this Handbook as well as any applicable supplements as included in your executed provider agreement
- Agree to participate in all care management, quality improvement, peer review, and appeal and grievance processes
- Comply with HMC's credentialing and re-credentialing policies and procedures
- Inform HMC provider relations department in writing of any material changes to provider status or information related to name, address, phone number, TIN, fax, or email 30 days prior to effective date
- Have an NPI number that is submitted on every electronic claim

HMC HEALTHWORKS QUICK REFERENCE GUIDE

| Important Information on Departments | |
|--|---|
| <p>Provider Relations Provider complaints, information on provider application, fee schedules, credentialing status, and change of information.</p> | <p>5840 Banneker Rd, Ste. 110 Columbia, MD 21044 Phone: 855-487-8914 Fax: 860-785-4860 Email: providerrelations@hmcebs.com Important forms and information may be found under the Provider Tab at www.hmchealthworks.com</p> |
| <p>Benefit and Eligibility Inquiries</p> | <p>Contact the toll-free number for behavioral health on the back of the member's ID card</p> |
| <p>Claims Inquiries</p> | <p>Contact the toll-free number for behavioral health on the back of the member's ID card</p> |
| <p>Claims Submissions Submit original "red claim" form for claim and encounter submissions. No handwritten claim forms will be accepted.</p> | <p>Paper claims: HMC Health Works P.O. Box 981605 El Paso, Texas 79998-1605</p> <p>Electronic: Preferred EDI Partner: Change Healthcare EDI Payer ID: 75318</p> |
| <p>Claim Disputes</p> | <p>Addresses issues related to improper claim processing or questions related to how a claim was adjudicated. Inquiries may be made by calling the 800 number for behavioral health on the back of the member's ID card.</p> |
| <p>Clinical and Administrative Appeals The Appeals Department handles all clinical and administrative appeals.</p> | <p>HMC HealthWorks 5840 Banneker Rd, Ste. 110 Columbia, MD 21044 Attention: Appeals Fax: 443-583-4830 Phone: 301-238-5429</p> |

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| <p>Complaints/Grievances Members or member’s provider (if they have member written consent) may file a grievance.</p> | <p>HMC HealthWorks 5840 Banneker Rd, Ste. 110 Columbia, MD 21044 Attention: Complaints Fax: 443-583-4830 Phone: 301-238-5429</p> |
| <p>Reporting Fraud and Abuse</p> | <p>To report suspected fraud please contact Provider relations: Phone: 855-487-8914 Fax: 860-785-4860 Email: providerrelations@hmcebs.com</p> |
| <p>Pre-authorization</p> | <p>Pre-authorization is required for some or all levels of care, depending on the benefit plan. To obtain preauthorization contact the toll-free number for BH Benefits on the back of the member’s ID card.</p> |

Credentialing and Recredentialing

All individual practitioners, agencies, and facilities must be credentialed in order to be considered to be participating in the HMC network. HMC's credentialing and recredentialing processes comply with NCQA accreditation standards as well as with all applicable state and/or federal laws, rules and regulations. All decisions to approve or deny credentialing and recredentialing applications are made by the HMC Behavioral Health (BH) credentialing committee, however HMC has retained the services of VerifPoint, a nationally recognized healthcare practitioner Credentials Verification Organization (CVO), to provide ongoing credentialing and license verification services for the HMC BH provider network. VerifPoint ensures that all HMC participating providers meet comprehensive quality assurance standards established by URAC, NCQA, AAAHC, CMS and others.

Providers and Facilities are credentialed to provide specified services and/or levels of care. Should additional services/LOC be added later they may be subject to additional credentialing and will be subject to OON status until approved.

Initial Contracting and Credentialing

The process for becoming a participating provider with HMC begins with submission of a completed application and group along with a copy of your license, a completed W-9 form, and a sample claim form. Applications may be emailed to: providerrelations@hmcebs.com, faxed to: 860-785-4860, or mailed to: HMC at 5840 Banneker Rd., Ste. 110, Columbia, MD 21044. Once those documents are received by HMC, providers will be contacted by VerifPoint requesting specific documents and background information.

These documents will include the following:

- A Statement regarding physical and mental health status
- Lack of impairment due to substance abuse
- History of felony convictions and/or loss of professional license
- History of loss, limitation, or disciplinary action related to hospital privileges
- Listing of sanctions imposed by government entities and managed care organizations
- A Curriculum Vitae showing at least 5 years of work experience as health care professional with any gaps over 6 months explained in writing
- Evidence of current malpractice insurance coverage
- Verification of education, professional training, board certification status, current and historical licensure information, work history, and evidence of current DEA certificate (if applicable)
- Signed attestation regarding the accuracy and completeness and veracity of the information provided in application and other documents

Regulations deem that all provider credentialing documents must be received and verified within a limited period of time. Therefore, we ask that documents be completed accurately and completely and submitted within 30 days of request. If requested information is not provided in a timely manner, time limits may be exceeded. Such delays may result in having to provide the requested information again or even being denied entry to the HMC network.

All information requested is required (including social security number and date of birth) and will be protected by VerifPoint and HMC and used only for credentialing purposes.

Once all primary source verifications have been completed, the provider's file is forwarded to the HMC credentialing committee for review. Applicants are then informed in writing of acceptance or rejection from the HMC network.

Participating providers have the right to make the following requests related to the credentialing and/or recredentialing process. They may:

- Submit a written request to review information obtained in support of credentialing or recredentialing application where not prohibited by state/federal laws or regulations
- Submit a written request for correction of erroneous information collected during the cred or recredentialing process
- Request information about the status of the credentialing or recredentialing application either verbally, or in writing

All requests should be sent to the HMC provider relations department:

5840 Banneker Road, Ste. 110

Columbia, MD 21044

Phone: 855-487-8914

Fax: 860-785-4860

Email: providerrelations@hmcebs.com

Re-Credentialing

All participating providers must be re-credentialed at least every 3 years (or more frequently when required by specific State laws or regulations). The process for recredentialing begins approximately 4 months prior to the end of the current credentialing cycle. At that time VerifPoint will send out notification that re-credentialing documents are needed. If re-credentialing materials are not provided by the deadline stated providers may result in termination of participating status at the end of their current credentialing period and they may be required to go through the initial credentialing process again.

Standards for Credentialing and Recredentialing

At a minimum, providers must meet the following standards in the initial or re-credentialing process.

Individual Practitioners:

- Hold a valid, current and unrestricted license from state(s) listed on provider's application to practice as an independent provider (the license must not be subject to suspension, probation, supervision or any other monitoring requirements)
- Graduation from an accredited professional school applicable to the applicant's degree, discipline and licensure
- For physicians, completion of residency training in psychiatry

- Provider of ABA treatment must be a board-certified behavior analyst (BCBA), or be supervised by one
- Ongoing specialized training as required for licensure
- Malpractice/professional liability insurance in amounts specified in the HMC provider agreement

Facilities/Agencies

- Hold current valid licensure, without contingencies or provisions, in accordance with applicable State and federal laws, to provide services specified in HMC contract with given facility
- Appropriate current accreditation acceptable to HMC (e.g., CARF, Joint Commission)
- Malpractice insurance coverage in amounts specified in the HMC provider agreement
- Good standing with all relevant state and federal authorities and programs
- No criminal charges filed related to quality of care provided by facility/organization

Required Updates and Ongoing Monitoring

HMC providers are required to report all material changes to information gathered in the credentialing/re-credentialing processes to HMC Provider Relations department in writing within 10 calendar days of the provider becoming aware of the change.

Material changes that must be reported include, but are not limited to, the following:

- Loss of license
- State sanctions, restrictions, and/or limitations in scope of practice
- Loss or limitation of hospital privileges
- Loss of malpractice insurance
- Professional liability claims settlements

Ongoing monitoring of credentials information and any actions taken against a credentialed provider is also performed regularly. This monitoring includes requesting disciplinary listings from state licensing boards. Changes noted above as well as failure to report such material changes may result in immediate termination from the HMC network.

Indicators of quality of service and quality of care are also monitored regularly. These include monitoring of service and quality of care complaints received about the provider as well as other quality performance indicators. Upon learning of a quality of service or quality of care complaint (e.g., complaints related to access to services, billing practices, potential fraud, waste or abuse, other actions by provider's office staff), HMC will attempt to gather information about the alleged incident(s) and depending on the severity of the complaint and evidence available, may attempt to work with the provider to improve service or take more severe actions. Providers are encouraged to cooperate and provide all requested information related to claims audits, records audits, and any other monitoring activities by HMC. All actions will be documented in the provider's file, and when deemed to require additional intervention, may be reported to the credentialing committee. Further actions may include consultation, written warning(s), ongoing monitoring, and/or suspension or termination from the network. Providers who decline to respond to requests for information regarding a complaint or to work with HMC to address the issues in question may also face sanctions up to and including termination from the network.

Determinations to terminate a provider from the network may be reported to the NPDB and the State licensing agency in accordance with applicable federal and state laws and guidelines.

Site Visits

As part of the credentialing process, in response to quality of care or member satisfaction concerns, or as required by a client or by NCQA standards, HMC may conduct a site visit of individual practitioner, group practices, and facilities. These visits will be scheduled in advance. The HMC site visitor will utilize a structured site visit tool to evaluate a variety of areas.

Individual Practitioners/Groups

Items assessed during site visits to individual practitioners and groups may include, but not be limited to, the following:

- Organization, completeness, consistency and quality of medical records
- Security of PHI, including both written and verbal communication
- Accessibility and appearance of the office and related amenities (e.g., rest room, parking)
- Safety concerns
- Adherence to HMC provider standards

If deficiencies are identified during the review, the practitioner will be informed and a corrective action plan will be put into place with specific timeframes for making changes.

Facilities and Agencies

HMC attempts to contract with facilities and agencies that are accredited by one of the following organizations:

- The Joint Commission
- CARF International

HMC may conduct an onsite quality assessment of any facilities/agencies that meet all other credentialing standards but are not accredited by one of the above organizations. Site visits may also be completed on any facility for which HMC receives member complaints. Areas that will be reviewed include, but are not limited to:

- Policies and procedures for credentialing and/or privileging providers
- Policies and procedures related to quality management
- Policies and procedures around clinical operations and best practices
- Organization, completeness, consistency and quality of medical records
- Policies and procedures related to safety

Appealing Credentialing Committee Determinations

HMC will notify providers in writing of any determinations to impose sanctions, up to and including termination from the network. Such determinations may be appealed in writing within 30 days of notification. The written appeal must include an explanation of why the provider believes the determination was incorrect along with documentation supporting that explanation. Further information on how to appeal such a determination will be included in the written notification.

Provider Termination and Non-Renewal

Pursuant to the *without cause* subsection of the *term and termination* section of the provider agreement, if a provider chooses to resign from the network at any time provider must notify HMC in writing of their request to terminate 90 days prior to termination date. HMC will respond to the request in writing documenting the effective date of termination. During the 90 days, the provider is still considered to be participating with HMC and must accept HMC rates without balance billing the member as well as following all other HMC requirements.

Contracted Provider shall continue to provide Covered Services in accordance with the terms of this Agreement to Members who are receiving active treatment on the date of termination until those services are completed, or until medically appropriate arrangements have been made to transfer the responsibility for care of the Member to another Participating Provider, or until such patient is no longer a Member. The termination of this Agreement shall not affect any rights to compensation for Covered Services rendered prior to termination.

Practice Guidelines

Member Rights and Responsibilities

HMC's Member Rights and Responsibilities Statement is available on-line at <https://www.hmchealthworks.com/behavioralhealth> and may be requested through the provider relations department. Please make this statement available to members on initial visit or upon request.

Privacy, Confidentiality and Security of PHI

Providers must follow all applicable federal and state laws, rules and regulations related to privacy, confidentiality and security of protected health information. This includes but is not limited to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). It is the provider's responsibility to monitor for changes in laws and to implement changes to practices as needed to maintain full compliance at all times.

Standards for Providers

HMC members may access behavioral health services by self-referring to a network provider, by calling HMC, or by referral through another provider; however a referral is never required for behavioral health services. Authorization for outpatient treatment may or may not be required, depending on the member's benefit plan. Authorization is required for all higher levels of care.

Contracted providers are expected to be available to HMC members and to follow certain required standards. The following standards will apply to all providers serving HMC members:

- New referrals from HMC must be accepted on the same basis as that used for non-HMC referrals
- New referrals may be declined only when the patient is requiring treatment outside of provider's expertise/training or licensure, or when provider is not accepting any new patients due to full caseload.*
- Covered services must be rendered to HMC members in the same manner as services are rendered to non-HMC members.
- Coverage plans must be made when a provider is unable to continue treating members in active treatment for a given time period or permanently.

**When a provider is unable to accept any new patients, or will not be practicing for a period of time for whatever reason, provider must submit notification to HMC provider relations department in writing by email, fax or letter. Notification must include a coverage plan for members already in active treatment. When provider is able to take new patients and/or resume treatment of ongoing patients, HMC must also be notified.*

In addition to the above standards, it is the responsibility of participating providers to do the following:

- Verify members' eligibility and benefits prior to providing non-emergent services. This can be done by calling HMC HealthWorks during regular business hours (8am-8pm EST M-F) for outpatient treatment, and 24/7 for higher levels of care, at the number on the back of the member's insurance card.

- Obtain preauthorization for treatment prior to rendering services, when required under the member’s benefit plan. HMC is available to precertify treatment 24/7 for higher levels of care, including inpatient psychiatric, inpatient detoxification, inpatient rehabilitation, residential MH and SA, PHP MH and SA. HMC is available during normal business hours (8am-8pm EST M-F) to authorize EAP and other outpatient treatment.
- Advise members prior to rendering services of their financial responsibilities for co-payments, co-insurance or for any services that are not covered under their benefit plan. *For most contracts HMC does not quote benefits please contact us so we can direct you to the appropriate fund administrator for that information.*
- Coordinate with HMC to find in-network resources and to verify benefit coverage when making referrals for additional or alternative treatment.
- Obtain authorization to release information, and coordinate care with other providers treating the member.
- Submit complete and accurate claims on behalf of the member. If member has other benefit coverage, that must be documented and claims must be submitted to primary coverage initially.
- Coordinate with HMC in developing ongoing treatment plan when member’s benefits terminate.
- Submit copies of treatment records upon request by HMC without charge at written request of HMC.

Access Standards

Participating providers are expected to provide access to appointments that meet the standards established by HMC. These standards are dependent on the type of situation leading to the member requiring to be seen. Descriptions of various access needs and standards are described below.

| Level of Access Need | HMC Access Standard |
|---|--|
| Life Threatening Emergent -- A situation in which clear and present, imminent danger exists for the member, others, or the environment. | Member must be seen in person immediately or referred to emergency services. |
| Non-life threatening Emergent – A situation in which the member is in serious distress and is likely to decompensate if rapid intervention does not occur. | Member must be offered to be seen within 6 hours of request or referred to appropriate emergency services. |
| Urgent – No imminent risk but high likelihood of decompensation if not seen within 48 hours. | Member must be offered to be seen within 48 hours of request. |
| Routine | Member must be offered to be seen within 10 business days of request. |

Emergency Coverage

Participating providers must either maintain 24-hour coverage or must maintain a method for referring members in need to a resource for emergency assistance during non-business hours.

Authorization Requirements

It is the provider’s responsibility to ensure that authorization is obtained in a timely manner when required under a member’s plan, and provider may not bill a member for services denied for failure to obtain authorization. Authorization requirements vary by benefit plan. All plans require authorization

for EAP sessions, psychological testing, ECT and all higher levels of care.

Self-Referral

Members may refer themselves to any level of medically necessary treatment. No external referrals are required. Members participating in HMC administered EAP may continue to see the same provider under an HMC administered behavioral health benefit as long as all authorization requirements are met.

Provider Reimbursement

Provider Reimbursement – EAP

When an authorization is entered for an EAP session, an EAP billing form is forwarded to the provider. Upon completion of authorized EAP sessions, the provider must complete and submit the billing form to HMC by fax or mail within 30 days of completion of service.

Fax: 443-545-5270
Mail: Attn: EAP Claims
5840 Banneker Rd., Ste. 110
Columbia, MD 21044

Incomplete forms may be rejected.

Provider Reimbursement – Behavioral Health Claims

HMC's claim processing procedures and standards follow the requirements of client plans, CMS and applicable state laws, rules and regulations. Unless otherwise specified in the provider agreement, providers are encouraged to submit claims within 90 day of the date of service. Claims received 365 days after date of service will be denied for lack of timely filing. Professional claims must be filed on a CMS-1500 version 02/12 claim form and facility claims must be filed on a UB04 (CMS-1450) claim form with all data elements completed. Claims that are not complete, accurate and legible may be rejected.

A Provider should not submit claims under his/her name for any services that were not directly provided by him/her (e.g., services provided by an assistant, intern or other provider).

HMC does not reimburse providers for any fees charged when a member "no shows" for a scheduled behavioral health appointment.

HMC may request treatment records for review. All information submitted on the claims must be reflected in the treatment records including time span of session.

Authorization of services is not a guarantee of payment. Services are authorized based on benefits and eligibility information available at the time of the request. Claims are verified to ensure that preauthorized services and claims information is consistent, that the member was eligible for services at the time services were rendered, that all billed services are covered by the member's benefit plan, and that all benefit requirements have been met, such as copays, deductibles, coinsurances and any applicable limits. In the event that a member is found to be ineligible for services on a date submitted, the claim will not be reimbursed, regardless of prior authorization status. In the event that HMC determines a provider or facility has been paid for services provided to an ineligible member, HMC reserves the right to recover payments made.

Completing CMS-1500 Claim form

- Coverage type (field 1)
- Insured's plan ID number (field 1a) - This must match the ID on the insured's identification card
- Patient's name (field 2)
- Patient's date of birth and gender (field 3) – using 8 digit format for date of birth
- Insured's name (field 4)
- Patient's address (street or P.O. Box, city, zip) (field 5)
- Patient's relationship to insured (field 6)
- Insured's address (street or P.O. Box, City, Zip Code) (field 7)
- Whether patient's condition is related to employment, auto accident, or other accident (field 10)
- Insured's policy number (field 11) (optional)
- Insured's birth date and gender (field 11a)
- Insurance company or program name (field 11c)
- Disclosure of any other health benefit plans (field 11d)
- Patient's or authorized person's signature or notation that the signature is on file with the physician or provider (field 12)
- Insured's or authorized person's signature or notation that the signature is on file with the physician or provider (field 13)
- Date of current illness, injury, or pregnancy (field 14) (N/A)
- First date of previous, same or similar illness (field 15) (N/A)
- Name of Referring Provider or Other Source (field 17) (N/A)
- Referring Provider NPI Number (field 17b) (N/A)
- Hospitalization dates related to current services (field 18); - Required if claim includes charges for services rendered during an inpatient admission.
- Diagnosis codes or nature of illness or injury (current ICD-9 codes are required) (field 21)
- Prior authorization number (field 23) – If applicable
- Date(s) of service (field 24A) - Grouping is allowed only for services on consecutive days.
- Place of service codes (field 24B) - Must use HIPAA compliant codes. See POS codes listed below.
- EMG (field 24C) (N/A)
- Procedure/modifier code (current CPT or HCPCS codes are required) (field 24D)
- Diagnosis code (ICD-9) by specific service (field 24E). Enter diagnosis code reference number from item 21 to relate date of service and procedure codes to primary diagnosis. Do NOT enter the actual diagnosis code here.
- Charge for each listed service (field 24F)
- Number of days or units (field 24G)
- Rendering provider NPI (field 24J) - Enter the NPI number in the unshaded part of the field.
- Physician's or provider's federal taxpayer ID number (field 25)
- Total charge (field 28)
- Signature of physician or provider that rendered service, including indication of professional license (e.g., MD, LCSW, etc.) (field 31). For a group practice, this name will be different than the one in field 33.
- Name and address of facility where services rendered (if other than home or office) (field 32)
- The service facility Type 1 NPI (if different from main or billing NPI) (field 32a)
- Physician's or provider's billing name and address (field 33)

- Main or billing Type 1 NPI number (field 33a)

Completing UB04 Claim form

- Facility name, address, phone and country code (field 1) – Complete service address
- Pay-to Name and Address (field 2) – Required if different from field 1
- Patient Control number (field 3a) – Patient number assigned by the provider
- Medical Record Number (field 3b) – Assigned by provider
- Type of Bill (field 4) – Enter appropriate 4 character bill type code as specified in the National Uniform Billing Committee UB-04 Data Specifications Manual
- Federal Tax Number (field 5)- Enter TIN or EIN
- Statement Covers Period (field 6) – Enter start and end dates of service
- Patient Identifier (field 8a) – Not Required
- Patient Name (field 8b)
- Patient Address (field 9a)—Patient’s street address
- (field 9b) – Patient’s city
- (field 9c) – Patient’s state code
- (field 9d) – Patient’s zip code
- (field 9e) – Patient’s Country code
- Patient date of birth (field 10) – use 8 digit format
- Sex (field 11)
- Admission Date (field 12)
- Admission Hour (field 13) – Not Required
- Priority of Visit (field 14) – Not Required
- Source of referral (field 15)- Not Required
- Discharge hour (field 16) – Not Required
- Discharge Status (field 17) – Not Required
- Condition codes (fields 18-28) – Not Required
- Accident State (field 29) – Not Required
- (field 30) – N/A
- Occurrence codes and dates (fields 31-34) – Not Required
- (field 37) – N/A
- Responsible Party Name and Address (field 38)
- Value codes and amounts (fields 39-41) – N/A
- Revenue code (field 42) –Use appropriate HIPAA compliant numeric code
- Description (field 43)—Narrative description or standard abbreviation for each revenue code
- HCPCS/Rate/HIPPS code (field 44) – When billing for professional services use separate CMS form
- Service date (field 45)—For outpatient billing
- Service units (field 46)
- Total Charges (field 47)
- Non-covered charges (field 48) – may not be applicable
- (field 49) – N/A
- Payer Name (fields 50a-c) – If multiple payers list in priority sequence
- Health Plan Identification Number (field 51a-c)

- Release of Information Certification Indicator (field 52a-c) – Enter code indicating if signed statement from patient or legal representative to release information is on file
- Assignment of Benefits certification indicator (field 53a-c)— N/A for participating providers
- Prior Payments (field 54)
- Estimated Amount Due (field 55a-c) –N/A
- NPI (field 56)
- Other provider identifier (field 57)-- N/A
- Insured's Name (field 58) – Enter last name, first name and middle initial of insurer
- Patient's relationship to insurer (field 59) – enter applicable relationship code
- Insured's unique ID (field 60) – Must match ID on member's ID card
- Group name (field 61a-c) – Plan or group name for primary, secondary and tertiary payer if applicable
- Insurance Group Number (field 62a-c)
- Treatment Authorization Codes (field 63a-c)
- Document control number (field 64)—N/A
- Employer Name (field 65) –Fund providing coverage to Insured
- Diagnosis (field 66)
- Principal diagnosis code/other diagnosis codes (field 67a-q)
- (field 68) –N/A
- Admit Diagnosis (field 69)
- (fields 70-75) – Not Required
- Attending Provider Name and Identifiers (field 76)
- (field 77) – N/A
- Other Provider Data (fields 78-79)
- Remarks (field 80)—Not Required
- Code (fields 81a-d)—N/A

See <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf> for additional information on coding.

Valid Place of Service (POS) Codes

- 01-Pharmacy (not covered by HMC)
- 02-Unassigned
- 03-School
- 04- Homeless Shelter
- 05-Indian Health Service Free-Standing Facility
- 06-Indian Health Service Provider-Based Facility
- 07-Tribal 638 Free-Standing Facility
- 08-Tribal 638 Provider Based-Facility
- 09-Prison/Correctional Facility
- 10-Unassigned
- 11-Office Visit
- 12-Home
- 13-Assisted Living
- 14-Group Home

- 15-Mobile Unit
- 16-Temporary lodging
- 17-18-N/A
- 19-Unassigned
- 20-Urgent Care Facility
- 21- Inpatient Hospital
- 22-Outpatient Hospital
- 23-Emergency Room
- 24- N/A
- 25- N/A
- 26- Military Treatment Facility
- 27-30-Unassigned
- 31-Skilled Nursing Facility
- 32-Nursing Facility
- 33-Custodial Care Facility
- 34-Hospice
- 35-40- Unassigned
- 41-Ambulance - Land
- 42-Ambulance - Air or Water
- 43-48-Unassigned
- 50-Federally Qualified Health Center
- 51-Inpatient Psychiatric Facility
- 52-Psychiatric Facility Partial Hospitalization
- 53-Community Mental Health Center
- 54-Intermediate Care Facility
- 55-Residential Substance Abuse Treatment Facility
- 56-Psychiatric Residential Treatment Center
- 57-Non-residential Substance abuse treatment facility
- 58-59-Unassigned
- 60-N/A
- 61-Comprehensive Inpatient Rehab Facility
- 62-Comprehensive Outpatient Rehab Facility
- 63-64-Unassigned
- 65-N/A
- 66-70-Unassigned
- 71-State or Local Public Health Clinic
- 72-Rural Health Clinic
- 73-80-Unassigned
- 81-Independent Laboratory
- 82-98-Unassigned
- 99-Other POS not identified above

Electronic Data Interchange (EDI) Submission

HMC encourages all providers to submit claims electronically. HMC accepts both facility and professional HIPAA compliant electronic claims through most clearinghouses including the Change Healthcare or MedAdvant clearinghouses. Electronic claims sent to Office Ally **will not** be received by HMC electronically though Office Ally may forward the claims by mail to HMC.

The HMC EDI Payer ID is **75318**.

All claims submitted electronically must be submitted in a HIPAA 5010 compliant format and must include the following:

- Full name of provider rendering service
- Tax Identification Number (TIN) of provider rendering service
- National Provider Identifier (NPI)
- Member's name, ID number (which must match the ID on the insured identification card), date of birth and gender
- Diagnosis on date of service
- Procedure code
- Place of service
- Type of bill (for facility claims)

Paper claims

Paper claims should be mailed to the following address:

HMC Health Works

P.O. Box 981605

El Paso, Texas 79998-1605

When submitting paper claims, the following guidelines should be following:

- Use original red claim forms
- Use black ink
- Keep data within defined boxes on the form
- Separate forms must be used for each rendering provider when member receives services from multiple providers in a practice
- Separate forms must be used for each member seen by a provider
- Use the following format for dates (MMDDYYYY)

Coordination of Benefits (COB)

Providers should obtain information from members concerning all of their group health insurance coverages, and that information should be provided to HMC on submitted claims. When members are covered under multiple plans, coverage is coordinated between payers. Coordination of benefits guidelines are used by the Funds to determine claims payment in those cases.

If a member has other insurance that is primary, the claim must first be submitted to the primary insurance and an Explanation of Benefits (EOB) from the primary insurance, including the primary payer's determination, must be attached to the claim or the claim will be denied.

As also noted in the provider contract, when HMC or responsible payer is not primary under COB rules, only those amounts shall be paid which, when added to the amounts received by Contracted Provider from other sources, pursuant to the applicable Coordination of Benefit rules, equal one hundred percent (100%) of the reimbursement amount specified in HMC's rate schedule.

Claims Disputes

HMC will make every attempt to resolve claims disputes in conjunction with provider. Please contact claims customer service at the number on the back of the member's insurance card for assistance with claims disputes within 90 days of the original claims determination. You may also request assistance in writing to:

HMC HealthWorks

5840 Banneker Road, Ste. 110

Columbia, MD 21044

Participating providers may not pursue legal action regarding a claim until all administrative processes offered have been exhausted.

Member Non-Responsibility

Participating providers may not, in any circumstances, seek payment from any member for medically necessary covered services beyond applicable co-payments, co-insurance or deductibles. The provider may only pursue additional payment from the member for non-covered services. Neither the Member, HMC, or Responsible Payer shall be liable for payment for any Contracted Provider Services which are determined not to be Medically Necessary; unless member has assumed financial responsibility in writing and requests participating provider services after being informed by provider, prior to the rendition of such services that the Services have been determined to be not Medically Necessary. In those cases, member shall be solely liable for payment. These stipulations apply even after the termination of the provider agreement.

Utilization Review and Authorization Processes

Provider and facility participation in utilization review and care management is integral to ensuring timely authorization of medically necessary services. HMC's Utilization Review and Management program is designed to assist providers and facilities in providing high quality, appropriate treatment to members. The program provides management of care from the point of admission through discharge, and throughout the continuum of care. Participating providers and facilities are required to comply with all applicable pre-authorization and concurrent review processes and procedures to ensure appropriate and effective utilization of member benefits. The treatment approach of all providers is expected to be evidence-based, goal-directed and consistent with accepted standards of care.

Care management is a collaborative process that involves assessment, planning, implementing, coordinating, monitoring and evaluating services to meet an individual member's needs. Care managers base clinical reviews on the established medical necessity criteria adopted by HMC (discussed below) and are trained to match the needs of members to appropriate services, levels of care, lengths of stay and available community supports. This ensures careful consideration of the intensity and severity of clinical data presented, with the ultimate goal of approving quality treatment in the least restrictive, safest setting. Those cases that appear to be outside of best practice guidelines or appear to have extraordinary treatment needs are referred for specialized review, which may include Physician Advisor review, clinical case rounds or more frequent care manager reviews.

HMC Standards of Care

HMC adheres to URAC Health Utilization Management Accreditation, Version 7.2 standards in all of our utilization and care management policies and procedures. To the extent that an HMC client requires standards of care that may exceed URAC standards, HMC will follow the more stringent standard.

Medical Necessity Criteria

HMC adheres to McKesson InterQual™ Behavioral Health Medical Necessity Criteria for all clinical Psychiatric authorization determinations, and the American Society for Addiction Medicine (ASAM) care guidelines for all Substance Abuse authorization determinations. These criteria can be accessed at www.mckesson.com and www.asam.org.

Medical Necessity Determination and Certification

Clinical reviews are conducted by HMC's Care Management staff who are qualified, experienced licensed behavioral health professionals. Care Management staff review and authorize proposed treatment that meets medical necessity criteria. A Care Manager can never deny a request for authorization due to a lack of medical necessity. If the care manager believes that a case may not meet medical necessity guidelines, she/he will refer the request for a Peer Clinical Review. Denials of certification or authorization must be determined by a Peer Reviewer who is a licensed M.D. or a licensed healthcare professional in the same licensing category as the treating provider. The term "**certification**" refers to a determination by HMC that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Services That Require Authorization

Member benefit plans and utilization review requirements vary. If you are uncertain if the service you are planning to provide requires precertification, you can obtain this information by calling HMC's Call Center. As a general rule, members presenting for services other than routine outpatient therapy or medication management will require authorization, though routine outpatient services may also require authorization for some contracts. When calling to request authorization, be prepared to provide HMC with a thorough assessment of the member and rationale for the requested level of care. Services that most likely will require preauthorization include:

- Inpatient
- Residential
- Partial Hospitalization
- Intensive Outpatient
- Inpatient and Outpatient ECT and TMS
- Psychological and Neuropsychological Testing

Initial Clinical Review

Prospective Review

Prospective review is defined as utilization management conducted prior to a patient's admission, stay, or other service or course of treatment (including outpatient services and procedures). It is also sometimes called "precertification review" or "prior authorization."

The information that HMC requires for a precertification authorization is obtained through a thorough clinical assessment of the member. Be prepared to provide HMC the following information (please note that the list below is not intended to be exhaustive):

- Demographics
- Reason for admission and precipitating event(s)
- Symptoms and Mental Status Exam
- Suicidal/Homicidal risk, including:
 - Ideation
 - Plan
 - Intent
- Evidence of psychosis
- Substance use history
- Type and amount
- Withdrawal symptoms
- Vital signs
- Date of initial and last use for each substance
- Periods of abstinence or sobriety
- Clinical history, including medical, behavioral health, alcohol and other drug treatment episodes
- Current medications, including types, dosages, duration and response
- Individualized treatment plan or plan of care
- Anticipated discharge date and discharge plan to include discharge indicators
- Current outpatient behavioral health providers and PCP for the purpose of care coordination

Concurrent Review

Concurrent review is defined as utilization management conducted during a patient's hospital stay or course of treatment (including outpatient procedures and services). It is sometimes called "continued stay review." HMC Care Managers schedule concurrent reviews based on the individualized needs of the member during the course of treatment. It is the responsibility of the facility to contact HMC to request concurrent review on the scheduled date. Be prepared to provide HMC the following information (please note that the list below is not intended to be exhaustive):

- Patient's current status
- Efficacy of treatment to date
- Planning for post discharge needs including arrangement for post-acute treatment follow-up and support.

The frequency of concurrent reviews is based on the severity or complexity of the patient's condition and/or on necessary treatment and discharge planning activity.

Discharge and Aftercare Planning

Discharge planning begins on admission of each patient to any level of care with the purpose of facilitating a smooth transition of members from a more intensive level of care to a less intensive or restrictive setting. As a member transitions from inpatient or other higher levels of care, the Care Manager will review and discuss with the provider the discharge plan for the member. Discharge planning will be the responsibility of the provider, and care managers may be utilized as a resource for referrals and other questions in the discharge planning process. If a request for continued stay authorization results in a Physician Advisor review, discharge planning may also be discussed with the treating provider and treatment team to negotiate the appropriate level of care for the member. For all Inpatient admissions, it is HMC's expectation that follow-up care will be scheduled with an in-network provider within 7 days of discharge.

The objectives of discharge planning are to:

- Facilitate smooth transition of members from a more intensive level of care to a less intensive level of care
- Provide continuity of care through planning for the member's next stage of care
- Make optimum use of resources and allow staff to focus on active treatment
- Help staff recognize and plan for the continuing needs of the member
- Sustain the gains made by the member during treatment by providing, securing and/or utilizing community services as necessary
- Minimize or prevent a recurrence of the member's illness
- Establish procedures to ensure that the discharged member has access to continuing health and/or rehabilitative services as well as other supportive services as may be required to enhance or sustain his/her capacity to function in the community

Discharge summaries for higher levels of care must be provided to the HMC Care Manager, and must include the following:

- Discharge Diagnosis
- Mental status at time of discharge

- Aftercare appointments (scheduled within 7 days of discharge for all Inpatient admissions)
 - If aftercare includes a step-down to a lower level of care (e.g., Inpatient to Partial Hospitalization), the discharge summary must include clinical information in support of the step-down level of care
- Discharge address and phone number

Retrospective Review

Retrospective review is defined as utilization review conducted after services (including outpatient procedures and services) have been provided to the patient. Most often a retrospective review is conducted based on the submission of the patient's record. The outcome of the review takes into consideration the terms of the member's benefit including any requirements to preauthorize care. In some circumstances, a medical necessity review will be conducted in the event treatment was provided in good faith and administrative review processes were not followed due to the inability to obtain the member's information.

Physician Advisor Review

In the event a case being reviewed for medical necessity by a care manager does not appear to meet the established criteria for the requested level of care or condition, the care manager will attempt to negotiate with the facility/treating provider contact for transition to a more appropriate level of care based on the member's needs and presentation. If the care manager and treating provider or facility cannot come to an agreement, or in the event that quality of care issues are identified, the case will be referred to a Physician Advisor for a physician advisor review. Physician advisors are available to discuss review determinations with attending physicians or other ordering providers in the prospective and concurrent review cases. The care manager notifies the treating provider that the request for authorization is being sent for a Physician Advisor Review. The care manager also notifies the treating physician of his/her right to speak to the Physician Advisor. This notification, including how and when the Physician Advisor may be contacted, may be done verbally, via fax, e-mail or voicemail.

The HMC Physician Advisor will make 3 attempts to contact the treating provider for a Peer-to-Peer conversation. This conversation can occur by telephone, in person, or electronically. In the event that the Physician Advisor is unable to reach the treating provider or designee for the Peer-to-Peer conversation, the Physician Advisor will make a decision based on the available clinical information. The care manager will advise the provider of the determination verbally, and if the determination results in a denial of authorization, written notification will be provided within the timeframe appropriate to the type of request. When a determination is made to issue a non-certification and no peer-to-peer conversation has occurred, HMC will provide, within one business day of a request by the attending physician or ordering provider, the opportunity to discuss the non-certification decision with the Physician Advisor who made the initial determination to deny, or with a different Physician Advisor if the original PA cannot be available within one business day. If the peer-to-peer conversation does not result in a certification, HMC will inform the provider and the consumer of the right to initiate an appeal and the procedure to do so.

Time Frames for Utilization Review

HMC adheres to URAC's Health Utilization Management Accreditation, Version 7.2, "UM Review Time Frame and Notice of Certification Decisions." As per these standards, the time frames are inclusive of the entire UM process, from the receipt of the request for a UM determination to the issuance of the decision, including the sending of the written notification (but not necessarily receipt of the decision by the patient or provider, as the mail can take several days). It is HMC's policy to conduct reviews and make determinations within the following time frames:

Initial Clinical Reviews

| Type of Request | Urgent or Non-Urgent | Decision/Notification Timeframe (starting from time of request) | URGENT Inpatient Residential Partial Hospitalization Intensive Outpatient NON-URGENT Outpatient Psychological Testing Outpatient ECT |
|-----------------|----------------------|---|--|
| Prospective | Urgent | 72 Hours | |
| | Non-Urgent | 15 Calendar Days | |
| Concurrent | Urgent | 24 or 72 Hours* | |
| | Non-Urgent | 72 Hours | |
| Retrospective | Non-Urgent | 30 Calendar Days | |

*Depending on when request is made. 24 hours if request is made at least 24 hours before end of prior authorization, 72 hours if request is NOT made at least 24 hours before end of prior authorization.

Clinical Appeals

| Type of Appeal | Timeframe for Decision (from time of request) | Timeframe for Verbal Notification (from time of request) | Determination Letter Timeframe |
|-----------------------|---|--|--|
| Standard Pre-Service | 15 days | N/A | 15 days from request |
| Standard Post-Service | 30 days | N/A | 30 days from request |
| Expedited | 72 hours | 72 hours | 3 calendar days from verbal notification |

Prospective Review Timeframes

For cases involving urgent care, HMC issues a decision as soon as possible based on the clinical situation, but at a maximum, no later than 72 hours after the receipt of request for a utilization management determination. For cases involving non-urgent care, HMC issues a decision within 15 calendar days of the receipt of the request for a utilization management determination. For non-urgent cases, this period may be extended one time for up to 15 additional calendar days based on the determination that an extension is necessary due to matters beyond the control of HMC; the member is notified prior to the expiration of the initial 15 calendar day period of the circumstances requiring the extension; and the date when HMC will make a decision is provided. If a member fails to submit necessary information, the notice of extension must specifically describe the required information, and the member is given 45 calendar days from receipt of notice to respond to the request for more information.

Concurrent Review Timeframes

HMC conducts requests for concurrent review of a course of treatment and issues the determination within:

- 24 hours of the request for a utilization management determination, if it is a case involving urgent care and the request for extension was received at least 24 hours before the expiration of the currently certified period or treatments; or
- 72 hours of the request for a utilization management determination, if it is a case involving urgent care and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments.

Retrospective Review Timeframes

For retrospective review, HMC issues a decision within 30 calendar days of the receipt of request for a utilization management determination. This period may be extended one time for up to 15 additional calendar days based on the determination that an extension is necessary due to matters beyond the control of HMC; the member is notified prior to the expiration of the initial 15 calendar day period of the circumstances requiring the extension; and the date when HMC will make a decision is provided. If a member fails to submit necessary information, the notice of extension must specifically describe the required information, and the member is given 45 calendar days from receipt of notice to respond to the request for more information.

Notification of Certification and Non-Certification Decisions

Notification of Certification Decisions (Medical Necessity Determination)

For certifications, HMC notifies treating providers both verbally and in writing of all review determinations. The notification includes a tracking number and the number of days or units of service being authorized. Notification for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

Notification of Non-Certification Decisions and Rationale (Medical Necessity Determination)

For non-certifications, HMC issues written notification of the non-certification decision to the attending physician or other ordering provider or facility rendering service that includes:

- The principal reason for the determination not to certify
- A statement that the clinical rationale used in making the non-certification decision will be provided , in writing, upon request
- Instructions for:
 - Initiating an appeal of the non-certification
 - Requesting a clinical rationale in writing for the non-certification.

Appeals of Adverse Determinations (Denials)

An appeal is defined as a written or verbal request by a provider or member to contest an adverse determination.

An appeal of an adverse determination may be submitted to the HMC Appeals Department by calling the number listed on the ID card.

Appeals may also be submitted by fax to 443-583-4830 or in writing to:
HMC HealthWorks Appeals Department
5840 Banneker Rd., Suite 110
Columbia, MD 21044

The member, member's authorized representative, or the provider, if the member has assigned appeal rights to the provider, may appeal initial denial decisions. If a participating provider requests the appeal, that provider is required to inform the member of any adverse determinations and appeal rights communicated to the provider during the initial determination and appeal processes.

The member's benefit plan determines the appeal rights available and may involve one or more levels of appeal.

Types of appeals include administrative or clinical, depending on the nature of the initial determination. Appeals are further categorized as expedited or standard. The category is determined by the member's care circumstances, the member's benefit plan, and state and federal laws and regulations.

Written notification of the appeal decision is sent to the member and the attending physician or other ordering provider or facility rendering service.

Clinical Appeals

Clinical appeals are those requested due to an adverse medical necessity decision. Clinical appeals are conducted by peer reviewers who, for each appeal case they take, attest to having:

- A scope of licensure or certification that typically manages the behavioral health condition, procedure, treatment or issue under review
- Current relevant experience and/or knowledge to render a determination for the case under review

In addition, the clinical appeal reviewer is neither the reviewer who made the initial determination to deny, nor the subordinate of the initial determination reviewer.

When the clinical appeal decision is to uphold in whole or in part the decision made during the initial determination, the written notification of that decision will include the following information:

- The principal reason for the decision
- A statement that the clinical rationale used in making the decision will be provided, in writing, upon request
- Information about additional levels of appeal, if any

Levels of Clinical Appeals

Level I Appeals

A Level I appeal may be filed up to one hundred and eighty (180) calendar days from the date of the adverse determination notification. This request may be made verbally or in writing (including by mail or by fax). The member, member's authorized representative and/or the provider may submit written comments, documents, records, and other information they believe to be pertinent to the appeal. All information submitted will be taken into account during the appeal review even if it was not submitted or considered in the initial consideration of the case.

Expedited

An expedited appeal is available for cases involving urgent care. Only Level I appeals can be processed as an expedited appeal. The decision and notification for an expedited appeal occur within seventy-two (72) hours of the appeal request and includes a verbal notification to the requesting party as well as written notification to the member and provider.

Standard Appeals

The decision and notification for a Level I standard appeal occur within 30 calendar days of the appeal request.

Level I Appeal Review Process

The case is assigned to a Peer Reviewer (PR). The PR reviews all information available regarding the appeal and attempts to conduct a telephonic review with the provider or clinical representative of a facility or program provider as appropriate. After considering all pertinent information and applying relevant medical necessity criteria, a decision is made by the PR to uphold or overturn the initial denial in part or in whole.

If the decision results in authorization, the provider is notified verbally (for urgent or expedited requests) and/or in writing of the number of days or units of service approved and an authorization letter is sent to the member and the provider.

Level II Appeals

A Level II Appeal, if available under the member's benefit plan, may be filed within 60 calendar days from the date of the Level I appeal decision notification. This request may be made verbally or in writing (including by mail or by fax).

Level II Appeal Review Process

The same process is followed as described for Level I appeals. The decision and notification for a Level II standard appeal occur within 30 calendar days of receipt of the appeal request.

Notification of Appeals Decisions

For clinical appeal determinations, HMC issues written notification of the adverse appeal decision to the patient and attending physician or other ordering provider or facility rendering services that includes:

- The principal reasons for the determination to uphold the non-certification
- A statement that the clinical rationale used in making the appeal decision will be provided, in writing, upon request
- Information about additional appeal mechanisms available, if any

Administrative Appeals

Reviews of administrative appeals are conducted by the Vice President of Clinical Operations. This reviewer is neither the individual who made the initial administrative denial decision nor the subordinate of that individual.

If a decision is made to overturn the original administrative denial in whole or in part, a medical necessity review is conducted following UM protocols. Written notifications are sent for both the administrative decision and the medical necessity decision.

Additional Levels of Appeal

If provided by the member's benefit plan, additional appeals may be available through other review entities and/or processes including external review. Information regarding additional levels of appeal are included in decision notifications and HMC will cooperate with the requirements of additional levels of appeal.