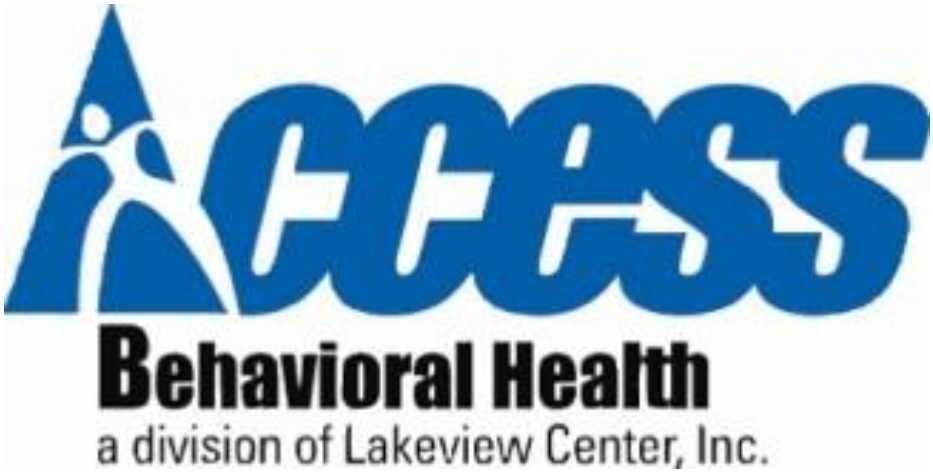

PROVIDER HANDBOOK
2023

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I. INTRODUCTION

Mission

"Helping people throughout life's journey by connecting them to hope and recovery"

Access Behavioral Health (ABH) is an operating division of Lakeview Center, which is a 501 (c) (3) not-for-profit organization, incorporated Chapter 617, F.S. As not-for-profit organizations, neither Lakeview Center does not have shareholders who benefit financially from the performance of the organization. Rather, the organization is 'owned' by the community and any financial gains are retained by the organization and reinvested into furthering the mission of helping people overcome life's challenges.

Company History

Lakeview Center, Inc., (Lakeview Center) the corporate entity of which Access Behavioral Health is a division, was initially established in 1954 as the Escambia County Child Guidance Clinic, the result of the vision and effort of many community leaders and the Pensacola Junior Women's Club. In 1959, the Clinic's charter was amended to include services for adults, and the center was renamed the Escambia County Guidance Clinic. In 1963, with the passing of the federal Mental Retardation Facility/Community Mental Health Center Construction Act, the Clinic became one of the first comprehensive community mental health centers (CMHCs) in southeastern United States, and was renamed the Community Mental Health Center of Escambia County, Inc.

In the 1970's and 1980's the Center expanded its service offerings to include crisis stabilization, residential, day treatment, emergency services, outpatient, case management, and prevention services and began offering a full range of substance abuse services, as well as vocational services. In 1982, the center was renamed as Lakeview Center, Inc., a change made in recognition of the wide array of services that Lakeview was providing. In 1996, Lakeview Center and Baptist Health Care Corporation (also a 501(c) (3) organization that operates numerous healthcare facilities in northwest Florida) entered into an affiliation agreement.

During the 1990s, Lakeview Center operated numerous at-risk managed care behavioral health contracts for commercial health insurers. As a result, Lakeview Center was able to significantly expand its managed care administrative services including utilization management services, provider credentialing, network management, claims adjudication, and quality management and improvement services. This experience set the foundation for future growth in the managed behavioral healthcare arena, culminating in being awarded a Prepaid Limited Health Service Organization license (PLHSO) in February 2001 by the State of Florida Department of Insurance.

Access Behavioral Health (ABH), a separate division of Lakeview Center, was established in February 2001 to manage the Region 1 PMHP contract. Lakeview Center organized ABH to manage risk-bearing contracts and in August 2001, was awarded a contract with AHCA to operate the PMHP in Region 1. ABH's organizational, governance, and administrative structure ensures that there is no conflict of interest between Lakeview Center, which serves as one of the many contracted provider agencies, and ABH, which manages the contract.

ABH has managed the contract with integrity and efficiency since it began operations on November 1, 2001 and this has been recognized by AHCA by having the contract renewed in October 2004 and in October 2007 as well as yearly renewals.

In 2014, Access Behavioral Health contracted with Statewide Medicaid Managed Care (SMMC) health plans in Region 1 to serve as the Managed Behavioral Health Organization for Florida Medicaid members enrolled in the plans.
In 2018 AHCA reprocured the Statewide Medicaid Managed Care contracts for all Regions in Florida. ABH contracts with Medicaid MMA health plans in Regions 1 and 2 and began operations in February 2019. ABH now manages the mental health and substance abuse services for Medicaid members in 18 counties in northwest Florida.

In late 2021, Lakeview Center disaffiliated with Baptist Health Care to enable continued focus on Lakeview's non-healthcare (human services) business lines.

In 2022, Lakeview Center rebranded the parent organization LifeView Group. Lakeview Center still remains an operating division within the newly branded parent company, and Access Behavioral Health remains an operating division of Lakeview Center.

Accreditations

Access Behavioral Health has maintained full accreditation status under the Health Utilization Management (HUM) module with URAC from 2005 – 2017.

In 2017, ABH attained full accreditation status as a Managed Behavioral Healthcare Organization (MBHO) with the National Committee for Quality Assurance (NCQA). ABH has been awarded full reaccreditation status as a Managed Behavioral Healthcare Organization (MBHO) in January 2020 and again in February 2023.

II. ACCESS BEHAVIORAL HEALTH CONTACT INFORMATION

Access Behavioral Health may be contacted through our toll-free phone number, (866) 477-6725, or through our general email address: abhinfo@lifeviewgroup.org. Contact information for Access Behavioral Health staff is available on our website, www.abhfl.org.

III. ACCESS STANDARDS

Emergency mental health services are defined as those services that are required to meet the needs of an individual who is experiencing an acute crisis, resulting from mental illness, which is at the level of severity that would meet the requirements for involuntary hospitalization pursuant to Chapter 394.463, F.S., and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization. Members with emergencies have access to behavioral healthcare immediately and/or 24 hours per day 7 days per week.

Urgent appointments:

- Life threatening emergency: Seen immediately
- Non-life threatening emergency: Seen within 6 hours of the request
- Within 48 hours of the request (if no prior authorization is required); seen within 96 hours (if prior authorization is required)

Non-Urgent Appointments:

- Within fourteen days of the request for initial outpatient behavioral health treatment
- Within 7 (seven) days post discharge from an inpatient behavioral health admission for follow up behavioral health treatment
- Within 60 days of the request for a prescriber.

IV. ABH COMMUNICATIONS

Toll-free information Line

Access Behavioral Health operates a toll-free information line for members and providers through the ABH Call Center. This information line is available 24 hours per day, 7 days per week and is staffed by experienced, qualified member services representatives and backed up by the ABH Care Management team. Representatives assist members with finding a network provider and scheduling appointments, and assist providers with eligibility and benefit inquiries.

Fax

ABH operates a fax line for sending and receiving communication: (850) 353-6041

Email

ABH receives communication via email using the address: abhinfo@lifeviewgroup.org. This email address is a group email delivered to several ABH staff.

Non-English Speaking Members

A telephonic translation service is available for non-English speaking members through Language Line Solutions, a telecommunications company equipped to interpret over 175 different languages. Language Line Solutions interpreters are medically certified.

Hearing Impaired

ABH offers interpreter services for the deaf, hard of hearing, or speech-impaired members when needed at no charge to the member. Telephone services for the hearing impaired are provided through the Florida Relay Center and include both TTY ASCII and TTY Baudot phone numbers.

In addition, our Community Behavioral Health Providers operate TTY lines in their emergency services departments, 24 hours/day, and seven days per week. These centers also have staff “language banks” where staff may turn for help when a member who does not speak English presents for services.

V. NETWORK MANAGEMENT

Provider Network

The diversity and breadth of our network ensures that members have the flexibility to choose a provider that meets their behavioral health, social, and cultural needs. Our focus on evidence based practice, recovery and resiliency approach, and member rights ensures that members actively participate in the treatment process and contribute to the treatment plan and their short and long term treatment goals. Over the past two decades, we have expanded and further refined this network to provide members with a variety of needed services, ranging from basic inpatient and outpatient services, including infant mental health services, to psycho-educational groups and aftercare services. We have invested resources to provide optimal care while also giving members broader discretion in how treatment decisions are made. The treatment process requires that members be involved in making treatment decisions and ABH provides training on this important concept to providers and reviews for this type of inclusion as part of our quality management activities. Our wide range of services coupled with our focus on member empowerment and recovery and resiliency has allowed us to transform the system of care and provider network in Regions 1 and 2 from one focused on alleviating and reducing symptoms to one that focuses on increasing a member's ability to overcome life's challenges by being an active participant in their treatment and self-management process.

Provider Quality Enhancement Program – The Medicaid Community Behavioral Health Home

ABH contracts with the large community behavioral health systems in the region on a capitated basis. Each of these behavioral health systems, called Regional Care Centers (RCCs) serves as a Medicaid Community Behavioral Health Home. Under the capitated financial system, ABH and a participating Community Behavioral Health Home enters into a contract to provide the full range of Medicaid benefits to members in the RCC's capitated geographic area. Community Behavioral Health Homes receive a per-member-per-month payment for all of the required Medicaid services and they bear the financial risk for their patients for the specified services. The capitation rate reflects the behavioral health services required by Florida Medicaid and provides incentive for a fully integrated, outcomes based delivery of Medicaid services. This approach incentivizes investments in care coordination, quality improvement efforts, and efficiency across the full continuum of care, including coordination of care with hospitals, and multi-specialty provider groups. The value-based model establishes a reimbursement system designed to manage the needs of Medicaid members who have persistent complex behavioral health conditions. ABH requires by contract that the Medicaid Community Behavioral Health Home be accountable for the full range of behavioral health services based on clinical outcome oriented services, rather than simply on utilization of services.

Overall, this capitation model payment methodology offers the following:

- Alignment of incentives;
- Flexibility for providing behavioral health services;
- Improved quality of and access to behavioral health care services for members; and
- Controls costs

With value-based contracts, ABH demonstrates that it has the capacity to serve the expected enrollment in its service Regions in accordance with the State's standards for access to care and quality performance outcomes. ABH maintains a network of providers, with Community Behavioral Health Homes as the cornerstones, that is sufficient in number, specialty mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

Availability and Accessibility Standards

Access Behavioral Health conducts network analyses on an ongoing basis. Availability standards are analyzed throughout the year utilizing a variety of means to include monitoring of member satisfaction surveys and complaints.

In addition, a network analysis is conducted prior making any new credentialing recommendations, to determine if there is a need in the network. Geospatial availability is also calculated periodically to assure that members have access to care within the required timeframes. Additions to the network may include new specialties, location, language(s) spoken, and cultural/ethnic background. Geospatial access standards are reviewed to assure that members are able to access services in the required typical travel times.

ABH Network

The ABH network is reviewed on an ongoing basis to assure the network meets the health plans' requirements of the MMA programs and meets and provides members a choice of qualified behavioral health care providers.

Provider Training

The ABH Quality Department conducts training with providers and practitioners bi-annually. As a Behavioral Health network provider, organizational providers, individual providers, and individual members of provider groups must regularly participate in trainings offered by ABH. The Provider Handbook is made accessible to all newly credentialed providers via the ABH website.

Annual Provider Training may include, but is not limited to, the following topics:

- ABH Operational Updates
- Quality Management and Improvement

- Medicaid Documentation and Medical Records Requirements
- HEDIS, Clinical Improvement Activities, and other Contract Performance Measures
- Member Experience and Satisfaction
- Authorizations and Claims Payment
- Critical Incident Reporting
- Member and Provider Complaints
- Eligibility
- Benefit Plan Limitations
- Timely Access to Services
- Coordination of Care of BH and BH Services
- Coordination of Care of BH and Medical Services
- Cultural Competence
- Health, Safety, and Welfare Education
- Fraud, Waste and Abuse/Corporate Compliance

VI. CREDENTIALING AND RECREDENTIALNG

The ABH credentialing process ensures that providers of behavioral health services meet minimum standards of practice and are capable of meeting the quality of care required by Access Behavioral Health. The credentialing process ensures adequate member choice, adequate capacity within the ABH network, timely access to services, and prevents discrimination in the ABH provider Network. To participate as a Behavioral Health network provider, organizational providers, individual providers, and individual members of provider groups must meet established criteria as set forth by ABH and outlined in the policies and procedures, and successfully complete the credentialing review process. ABH requires that all applicants meet all state standards and requirements regarding background screenings. ABH will not credential any individual or organization that is excluded from participation in Federal health care programs.

Practitioners must post their liability insurance in a prominent location that is visible to members. Providers must post the AHCA Consumer Help Line number (888-419-3456) in a prominent location in the waiting areas.

Medical Records Standards

All providers and practitioners are required to understand and adhere to the medical documentation standards set forth by the most current version of the Agency for Healthcare Administration (AHCA)'s Community Behavioral Health Services Coverage and Limitations Handbook the Provider General Handbook (July 2012), and any other relevant AHCA handbook that governs service delivery and medical necessity. Providers are also required to participate in medical record audits to ensure documentation follows Medicaid guidelines, that documentation matches services billed, and to monitor for fraud, waste, and/or abuse.

Provider and Practitioner Rights

If a provider or practitioner chooses to appeal a credentialing decision the following steps are to be taken:

- All appeal requests must be in writing within 30 days of the adverse decision;
- The request should include a detailed explanation of the reasons for reconsideration and provide new, supporting documentation;
- The ABH Director of Quality Management and Improvement will review the appeal and make a recommendation to the Quality Management Committee's appropriate subcommittee (i.e. Quality, Credentialing, etc.)

If the ensuing decision is again adverse, the individual may request in writing, a review of the decision by the Lakeview Center CFO. The Lakeview Center CFO will review the documentation and render a final decision which shall be binding. The Director of Quality Management and Improvement will send written notification, containing specific reasons for the outcome, of the appeal decision within 30 days. If the provider or practitioner chooses to utilize the appeals process, that individual or organization may be represented by an attorney, or another person of their choosing.

VII. QUALITY MANAGEMENT

The Quality Improvement Program at Access Behavioral Health provides a formal mechanism whereby ABH can systematically and objectively monitor, evaluate, improve, and impact the quality, efficiency, safety, and effectiveness of care to our members. Through this process ABH is able to identify and focus on opportunities for improving the quality of clinical service delivery by our network of providers. The Quality Improvement program approach enables ABH to focus on opportunities for improving clinical care to our members, service quality, member safety, and customer satisfaction. The Quality Improvement plan helps ensure accountability of staff and network providers for the quality of care and services provided to ABH members.

Access Behavioral Health maintains a network of contracted behavioral healthcare providers. The Quality Improvement Department governs the quality assessment and improvement activities of network providers and spans the system to any function that impacts the quality of service delivered to our members. The ABH QI Department accomplishes this governance via internal and external monitoring of care management, utilization management, the development and maintenance of a provider network, member safety, and monitoring of clinical services to ensure that all members receive the highest quality care and service.

Program Structure

The Quality Improvement Program provides a means whereby all functions of ABH, both clinical and non-clinical, can be tracked, trended, and reviewed by the oversight body, opportunities for improvement identified, and interventions to address those opportunities applied.

The Quality Improvement program is designed to monitor, evaluate, and continually improve the care and services to all ABH consumers and encompasses services delivered in both outpatient and inpatient settings. ABH integrates quality improvement into all functional areas. Participation in the QI program is required of all contracted network providers. All staff, network providers, and members are asked to participate in the quality management process through satisfaction surveys, committee meetings, and corrective action plans which are implemented as part of the overall quality plan whenever barriers and opportunities for improvement are identified.

The primary goals of the Quality Management program are to ensure safe, quality, timely, and effective behavioral health services to our Members. Improvements in these areas are measured using Health Plan Effectiveness Data Information Set (HEDIS) information, internal quality studies, and other health outcomes data and utilized to improve Member Experience and System Effectiveness.

The major responsibilities of the four components of the ABH QI Program are:

1. **Quality Management and Improvement (QMI)**
   - Provider and practitioner monitoring/medical records audits
   - Member Safety
   - Member Satisfaction
   - Member and Provider Complaints Resolution
   - HEDIS and Performance Measures
   - Monthly, Quarterly, and Annual Quality Reports, and annual Committee Approval
   - Credentialing and Re-Credentialing
   - Quality of Care and Incident Reporting,
   - Fraud, Waste, and Abuse monitoring,
   - Self-Management Tools,
   - Screening Programs,
   - Access to services, and
   - Facilitation of Quality Management Committee Meetings Quarterly.

2. **Utilization Management (UM)**

   - UM Authorizations and utilization review
   - Short-term Case management for inpatient and SIPP services
   - Care Coordination
   - Provider Satisfaction with the UM process
   - Call Center Communication and
   - Daily, Monthly, Quarterly, and Annual UM Reports

3. **Network Management**

   - Manage network provider negotiations and contracting
   - Provider network analysis that meets health plan requirements

- Provider network performance management in conjunction with ABH Quality Management Department and health plan and
- Ensure Culturally, Ethnically, Racially, and Linguistically Competent Network

4. Data Analysis and Reporting

- HEDIS and Performance Measure Analysis
- GAP Reports for Underperforming Providers
- Population Assessments
- Intervention Analysis and Re-Measurement

Oversight of QI Activities by the Quality Management Committee

The Quality Management Committee (QMC) is the governing body of the ABH QI Program and is responsible for oversight of the Quality Improvement program, along with its subcommittees. The QMC is responsible for ensuring the quality improvement processes outlined in the QI Program Description are implemented measured, re-measured, reviewed on a regular basis, and updated as needed. The QMC also serves as an advisory group and communication forum for all ABH Quality Improvement components.

The QMC is the decision making body ultimately responsible for implementation, coordination, and integration of all QI activities for ABH. The QMC reviews and approves all ABH Policies and Procedures, Program Descriptions, Work Plans, and the Annual Evaluation. The QMC is also the designated anti-fraud unit for Access Behavioral Health's Anti-Fraud Plan.

The Quality Management Committee meets quarterly and Ad hoc meetings may be called when necessary. The Director of Quality Management and Improvement is responsible for conducting the meeting.

The QMC is comprised of ABH Directors and Managers who work together to achieve program goals and objectives. The QMC's focus is on key quality outcome areas designed to improve overall system effectiveness of service delivery to ABH members. Although each component and subcommittee operates to achieve specific objectives and processes that are operationalized through the ABH QI Program, all components operate as a whole to create the ABH Quality Program.

Quality Management Committee Members include:

- Medical Director (designated Behavioral Health Care Practitioner)

- Director of Access Behavioral Health
- Director of Quality Management & Improvement
- Accreditation and Quality Improvement Manager
- Director of Care Management
- Director of Network Management and Contracting

The authority to implement the ABH Quality Improvement Program plan is held by the QMC. The ABH Medical Director is the designated behavioral health staff member and senior member staff designated to oversee all components of the QI plan. The QMC is assigned oversight responsibilities to all ABH quality improvement efforts.

Quarterly reports, pertinent reports, data analysis, and recommendations or actions are presented to the QMC for consideration. This process allows ABH to routinely monitor the activities and effectiveness of the Quality Improvement program. This monitoring includes, but is not limited to:

- Reviewing data and reports to identify trends that may require corrective action
- Ensuring practitioner participation in the QI process
- Analyzing and evaluating the results of QI activities
- Monitoring the implementation and effectiveness of corrective actions
- Identifying needed actions
- Determining the need for follow up and/or ad hoc committees
- Reporting conclusions and actions as appropriate to meet the goals of ABH QI.

Subcommittees of QMC:

- Quality Improvement-Utilization Management (QI-UM)
- Credentialing
- Member Rights, Responsibilities, and Safety
- Quality

QMC Roles

The QMC consists of the following voting members:

The Director of Access Behavioral Health is responsible for the overall operations of Access Behavioral Health. The Director of Access Behavioral Health ensures that the ABH network has the capacity and capability of meeting the behavioral healthcare needs of members.

The ABH Medical Director is the designated Behavioral Health Care Practitioner who provides supervision and oversight to the Quality Improvement program, the Quality Management Committee, and all subcommittees. The Medical Director reports to the Director of Access Behavioral Health. The Medical Director oversees the utilization review functions for the Care Management Department and the ABH Utilization Management Plan. The Medical Director provides support and consultation to ABH and provider staff

The Director of Quality Management and Improvement is the senior level quality staff person responsible for and with the authority to manage Quality policies and procedures (including Credentialing and Rights and Responsibilities). This role reports directly to the ABH Director. The Director of Quality Management and Improvement coordinates the Quality Management Committee, compliance and quality monitoring activities, and other activities related to quality management of the ABH network. This position is also responsible for leading the QMC meetings.

Accreditation and Quality Improvement Manager reports to the Director of Quality Management and Improvement. The Accreditation and Quality Improvement Manager is responsible for designing, building and strategizing quality programs that meet NCQA, CMS, and Health Plan requirements and that improve performance and population health outcomes for ABH members. This position is also responsible for oversight of quality interventions for HEDIS and other performance measures.

The Director of Network Management and Contracting reports to the Director of Access Behavioral Health. The Director of Network Management and Contracting is responsible for provider negotiations, contracting and network management, ensuring that the provider network meets the needs of the Medicaid members for access to services, and meets contractual requirements for provider and practitioner to member ratios. The Director of Network Management and Contracting is responsible for updating contract terms that meet CMS, Florida Medicaid, and NCQA requirements.

The Director of Care Management is responsible for the functions and operations of the Care Management Department. This position reports to the ABH Director. The Director of Care Management oversees the utilization review, utilization management, care coordination, and authorization processes for ABH. The Director of Care Management works closely with the Medical Director in coordination of care and outreach to primary care physicians, to medical providers, and to other behavioral health care providers.

Minutes are recorded at each meeting using a standardized format which includes topic, discussion, recommendations, follow up, and applicable graphs or associated reports. Follow up items become topics for the next meeting. The minutes are reviewed and approved at the beginning of the subsequent meeting with any changes or corrections noted. All members of the QMC annually sign a confidentiality attestation.

Continuity and Coordination of Care

Continuity of Care is a key element contributing to a successful treatment outcome. Intra- and inter-agency communication of relevant clinical information is vital as ABH members move through a continuum of care or services to minimize disruption to the member and to the treatment plan. All communication is within federal and state laws, rules and regulations, contract requirements, and ABH Policy and Procedures.

Cultural Competence

ABH expects services to be provided within a framework of cultural competence. Cultural Competence is a set of congruent practice skills, behaviors, attitudes, and policies that comes together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. Cultural Competence is about adapting mental health care to meet the needs of members from diverse cultures. One key aim is to improve their access to care. Others are to build trust and to promote their engagement and retention in care.

Above all, cultural competence aims to improve the quality of care and to help members recover quicker and better. Its broader societal purpose is to reduce or eliminate mental health disparities affecting disenfranchised groups.

The following steps are offered to Providers as a means of becoming Culturally Competent:

- Understand the racial, ethnic, and cultural demographics of the population served
- Become most familiar with one or two of the groups most commonly encountered
- Create a cultural competence advisory committee consisting of members, family and community organizations
- Translate your forms and brochures
- Offer to match a member with a practitioner of a similar background
- Have access to trained mental health interpreters
- Ask each client about their cultural background and identity
- Incorporate cultural awareness into the assessment and treatment of each member
- Tap into natural networks of support, such as the extended family and community groups representing the culture of a member
- Reach out to religious and spiritual organizations to encourage referrals or as another network of support

- Offer training to staff in culturally responsive communication or interviewing skills.
- Understand that some behaviors considered in one culture to be signs of psychopathology are acceptable in a different culture
- Be aware that a member from another culture may hold different beliefs about causes and treatment of illness

To request a full copy of the ABH Cultural Competence Plan at no cost, please contact the Quality Improvement Director at abhqualitydepartment@lifeviewgroup.org.

Member Safety

The Access Behavioral Health Quality Management Committee retains the following subcommittees: Quality and Member Rights, Responsibilities and Safety to ensure safe clinical practices across the system of care. Data reviewed and analyzed by this these subcommittees includes:

- Member complaints regarding potential safety concerns;
- Critical Incidents
- Quality of Care
- Environment of Care;
- HIPAA Compliance;
- Confidentiality of members;
- Review of clinical records, and
- Review of site monitoring findings.

All quality of care and/or member safety concerns are reported to the Quality Management Department. The investigation is initiated within one business day from when the concern is received. Suspension or restriction of clinical privileges may occur when a potential quality of care or member safety incident has a direct and imminent impact on the health or well-being of any Access Behavioral Health member.

Member Complaints, Grievances, and Appeals

Access Behavioral Health works at the direction of the Member's Health Plan for resolution of any complaint, grievance, or appeal. Members may contact Access Behavioral Health for assistance in reaching their Health Plan to file a complaint, grievance, or appeal by calling 850.469.3870.

Members have the right to request continuation of benefits while utilizing the grievance and appeal system in accordance with 42 CFR 438.414.

Members may also contact the AHCA Consumer Help Line at 888-419-3456 to file a complaint or grievance.

The address and toll-free telephone number for Medicaid Fair Hearings are:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O Box 60127
Ft. Myers, FL 33906
(877) 254-1055 (toll-free)
239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

ABH Privacy and Security of Information

The purpose of the Privacy and Security Program is to ensure the confidentiality, integrity and availability of the information we collect and use for health care and business purposes. The program extends to all information regardless of location or storage medium and it applies to both paper and electronic based information.

- Confidential information is protected by federal and state law and must receive the highest degree of protection. For our purposes, we've grouped this information into two categories:
- Confidential Personal Information – Any information that can be considered personal in nature, such as diagnosis and treatment information, individual names, social security numbers, insurance numbers, credit card numbers, drivers' license numbers, dates of birth, automobile tags and registration information.
- Sensitive Business Data – Any information that we collect and use for business purposes such as budgeting and financial data, staffing schedules and turnover statistics.

Guiding Principles of Information Security and Privacy

- We will become familiar and comply with policies and procedures relating to information security and privacy.
- We will safeguard confidential information regarding our customers and coworkers from misuse, theft or unauthorized access.
- We will share confidential information as necessary to provide prompt and effective treatment to our customers.
- When sharing confidential information for purposes other than treatment we will adhere strictly to the minimum necessary standard and only disclose the minimum information necessary to accomplish the task.

- We will use reasonable steps to ensure unauthorized persons do not overhear or see confidential information.
- We will not place any confidential information in public areas where the information can be easily seen by unauthorized persons.
- We will become familiar with the Notice of Privacy Practices and adhere to the consumer privacy rights it contains.
- We will use approved procedures for obtaining our own confidential information or that belonging to our dependents.
- We will not access any confidential information, including our own unless we are doing so as part of our official duties.
- We will not discuss any confidential information pertaining to our coworkers or others that we obtain in our official capacity unless doing so is ethical and necessary to complete our duties.
- We will promptly report any theft or loss of confidential information to our supervisor.

Principles Specific to Information in Electronic Form

- We will access computer systems that contain confidential information by using our own unique identification (user ID).
- We will not share our user IDs and passwords and will take reasonable steps to protect them from unauthorized disclosure.
- We will not allow vendors or contractors to access any ABH computer unless approved by Information Services.
- We will not load any unauthorized computer programs onto any ABH computer.
- We will not disable or try to defeat any security device or procedure utilized by ABH.
- We will not connect any unauthorized device to an ABH computer.
- We will only use approved methods for storing confidential information electronically.
- We will properly dispose of media such as floppy disks, DVDs, or CDs that contain confidential information.
- We will not allow unauthorized persons such as family members to use any ABH computer.

Principles Specific to Information in Paper Form

- We will properly dispose of confidential information by placing it in approved containers or by shredding.
- We will store confidential information in a way that prevents unauthorized access. When it is necessary to store confidential information, we will follow ABH record retention policies and we will ensure the information is properly destroyed when the retention period has expired.
- We will strictly adhere to company policy regarding the faxing of confidential information, including the verification of fax numbers and the use of approved fax cover sheets.

When You Believe There May Be a Problem

If you believe you have information about health care providers, practitioners, entities, or other persons engaging in improper types of activities or arrangements, it is your responsibility to report these concerns. Persons reporting information in good faith will not receive any kind of reprisal or retribution. This provision, however, cannot be used to absolve or clear any personal confessions of wrongdoing.

- Discuss concern with your immediate supervisor. The management structure (starting with your immediate supervisor) and existing policies and procedures should be used as the first approach.

- Contact the Human Resource Manager or the Corporate Compliance Officer at your facility.
  If you receive an unacceptable response or if you are unsuccessful using the initial reporting mechanism, the Human Resource Manager or Corporate Compliance Officer will arrange for you to meet with the area department head. If your concern is related to your treatment as an employee, you should meet directly with the Human Resources Manager or Corporate Compliance Officer. Should the settlement continue to be unsatisfactory, the Human Resources Manager or Corporate Compliance Officer will, in agreement with the employee, present the grievance to the Administrator.

- Contact the ABH Quality Department. The ABH Director of Quality Management and Improvement will be available to discuss any concerns with you and can be reached at (850) 469-3924.

- Your identity will be protected to the limit of the law. Concerns brought to the attention of the ABH Quality Department will be promptly and thoroughly evaluated and investigated for prompt resolution. Due to the nature of the concerns, detailed feedback may be difficult or impossible to provide due to confidentiality.

The Director of Quality Management and Improvement serves as the Corporate Compliance Officer for ABH. Also, each organizational provider is required to have a Compliance Liaison who can be contacted if you believe there is a problem that needs to be addressed.

Members' Rights and Responsibilities

All ABH members must receive a copy of their rights and responsibilities upon initial enrollment into services and then when requested thereafter. ABH Member Rights and Responsibilities are also located on the ABH website (www.abhfl.org). Rights and Responsibilities provided to members must include and be materially similar to the following:

1. The right to free exercise of rights, receive information about the organization, its providers and practitioners, its services, and the members' rights and responsibilities.
2. The right to be treated with respect and recognition of dignity and right to privacy.
3. The right to participate in decisions about their care, including the right to refuse treatment.

4. The right to a candid discussion of appropriate or medically necessary treatment options and alternatives for their condition, presented in a manner appropriate to the members' condition and ability to understand, regardless of cost or benefit coverage.

5. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

6. The right to request and receive a copy of his or her medical records.

7. The right to voice complaints or appeals about their provider, practitioner, or organization, and/or the care provided.

8. The right to make recommendations regarding the organization's member rights and responsibilities policy

Members Have the Following Responsibilities:

1. To supply information (to the extent possible) that their chosen organization and providers and practitioners need in order to provide care.

2. To follow plans and instructions for care they have agreed upon with their Healthcare practitioners and providers.

3. To understand their health problems and participate in the development of mutually agreed-upon treatment goals, to the degree possible.

Identifying and Reporting Abuse, Neglect and Exploitation of Members

Professionally mandatory reporters are required to contact the Florida Abuse Hotline when they know or have reasonable cause to suspect that a child or a vulnerable adult has been abused, abandoned, neglected, or exploited, including suspected victims of human trafficking. The Abuse Hotline Counselor will determine if the information provided meets legal requirements to accept a report for investigation.

There are four ways to make a report:

1. By Telephone 1-800-96ABUSE 800-962-2873
2. By Fax 800-914-0004
3. Florida Relay 711
4. By TTY 800-955-8771
5. Web Reporting https://reportabuse.dcf.state.fl.us

Fraud, Waste and Abuse Prevention

Access Behavioral Health works with the Health Plans to prevent, detect, and correct fraud, waste, and abuse activities. The ABH Compliance Program is intended to establish methods for consistent adherence to

applicable laws, regulations, and requirements governing Corporate Compliance as well as for preventing, detecting, and investigating fraud, abuse, and overpayment. ABH has established a centralized mechanism via the Corporate Compliance Program, the Anti-Fraud Unit, and the Quality Management Committee (and subcommittees), to track compliance and achieve the goal of preventing fraud and abuse. These mechanisms have created a corporate culture of strict adherence to federal, state, and local laws. The ABH Fraud, Waste and Abuse Plan is structured to demonstrate our commitment to the highest standards of ethical conduct, to prevent and deter criminal activity, and to encourage employees to report potential problems that will allow for appropriate internal inquiry and corrective action.

The purpose of the ABH compliance plan is to create and maintain a corporate culture that:

- Promotes integrity and ethical behavior;
- Establishes formal standards that comply with increased governmental regulation; and
- Demonstrates the commitment of Lakeview Center, Inc. d/b/a Access Behavioral Health to act in compliance with all legal and ethical responsibilities.

The ABH Compliance Plan ensures that the organization as a whole has ethics, culture, and values which are consistent with the highest standards of business conduct and provides uniform guidance for fraud, abuse, and overpayment activities.

This plan is a broad and comprehensive strategy to ensure that:

- The risk for fraud, abuse, or overpayment is eliminated and/or reduced;
- All employees of ABH, their contracted network providers and their employees conduct themselves in accordance with the high standards of business and professional conduct established by ABH;
- Encounter data accurately reflects the documented services provided; compliance with all general regulatory matters;
- Reporting of potential violations of applicable laws, rules and regulations is encouraged; and
- Network providers take responsibility for the actions of their employees.

Providers may request a copy of the ABH Corporate Compliance Plan and Anti-Fraud, Abuse, and Overpayment Plan for more information by contacting the ABH Quality Management and Improvement Director.

VIII. TELEMEDICINE/TELEHEALTH

Telemedicine is the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment.

Services must be delivered from a facility that is enrolled in Medicaid as a community behavioral health services provider for Medicaid to reimburse for services delivered through telemedicine. Services that can be provided through telemedicine are listed in the Medicaid Handbook for Community Behavioral Health Services Procedure Codes and Fee Schedule, found in the appendices.

The following interactions do not constitute reimbursable telemedicine services:

- E-mail messages
- Facsimile transmission

Providers utilizing telemedicine must implement technical written policies and procedures for telemedicine systems that comply with the Health Insurance Portability and Accountability Act privacy regulations as well as applicable state and federal laws that pertain to patient privacy. Policies and procedures must also address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312, where applicable.

Services provided via Telemedicine and Telehealth must adhere to the Agency for Health Care Administration's (AHCA) *Community Behavioral Health Services Coverage and Limitations Handbook* guidelines and requirements and must only be rendered by a practitioner who meets the AHCA qualifications for that service. Appropriate services codes with the GT modifier must be used for billing.

Documentation for Telemedicine and/or Telehealth should follow standard documentation protocols and should include justification as to why the service is being provided via Telemedicine and/or Telehealth instead of in person. Telemedicine and/or Telehealth services must be provided to members in a secure office location. The member must consent in writing to service delivery via Telemedicine and/or Telehealth. The computer used to provide Telemedicine and Telehealth must not be able to access any client records or information. If the member is using an in-facility computer, staff must assist the member with computer operation to ensure proper operation and assist the member, if needed, to address any computer or other problems, or if the member has questions.

Access Behavioral Health reimburses for telehealth services at the same rate as equivalent services offered face-to-face.

UTILIZATION MANAGEMENT

Scope and Goals

The clinical philosophy at Access Behavioral Health (ABH) is to provide a care management system that offers easy and immediate access to the most appropriate, quality mental health, services for members, and a utilization management system that supports providers in delivering clinically necessary and effective care with minimal administrative barriers. The Utilization Management Plan encompasses management of care from the point of entry into care through discharge from care. ABH believes in macro-management of care as much as possible through the use of objective, standardized, widely distributed clinical protocols and outlier management programs. Intensive utilization management is reserved for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk. The Care Management team bases its reviews on clear and concise criteria developed specifically to guide level of care, treatment and length of stay determinations. Care Management staffs are trained to match the needs of patients to appropriate services, levels of care, and community supports. This requires a careful consideration of the intensity and severity of clinical data presented with the goal of quality treatment in the least restrictive environment. The clinical integrity of the Utilization Management Program ensures that members who present for care are appropriately monitored. Those cases that appear to be outside of best practice guidelines are referred for specialized reviews. These may include peer clinical review, peer-to-peer conversation, or more frequent care manager review.

Access Behavioral Health has designed a system of care that is not only based on principles of quality care, but also one that is flexible in meeting the needs of diverse populations, communities and customers.

Access Behavioral Health:

- Provides easy and early access to appropriate treatment;
- Works collaboratively with providers in delivering quality care according to accepted best-practice standards;
- Addresses the special needs of children in the mental health system;
- Identifies common illnesses or trends of illness;
- Targets high risk cases for intensive care management; and
- Emphasizes prevention, education and outreach.

Principles

ABH Clinical Management staff adheres to the following principles:

- All persons shall be treated with respect and dignity;
- The person directs the recovery process; therefore, the individual's input is essential throughout the process;
- Individuals are able to recover more quickly when their hope is encouraged, enhanced, and/or maintained; life roles with respect to work and meaningful activities are defined; spirituality is considered; culture is understood; educational needs as well as those of their family/significant others are identified; and socialization needs are identified;
- Individual differences are considered and valued across the life span;
- Recovery from mental illness is most effective when a holistic approach is considered;
- To the maximum extent possible, members shall be offered a choice of direct service providers;
- Services to members shall be tailored to the individual and provided in the least restrictive and most natural setting environment as possible, preferably in the member's own community;
- For children, services and treatments must be family centered, geared to give families real and meaningful choices about treatment options and providers; care must focus on increasing the child's ability to successfully cope with life's challenges and on building resilience, not just on managing symptoms;
- Services to members are built on the strengths of the member and the member's family and foster independence;
- Utilization review shall follow established best-practice guidelines and industry standards;
- Grievance procedures shall be developed for the member or provider to resolve issues according to established timeframes;
- The confidentiality and privacy of the member shall be protected at all times.
- Information shall be collected, analyzed, and disseminated to foster system accountability and quality improvement;
- Patient rights and other member information shall be communicated in a manner understood by the abh member; and
- Access behavioral health does not discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and does not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

Staff Qualifications

Access Behavioral Health places high value on the selection, training, and performance evaluation of clinical staff performing utilization management services. All staff involved in utilization management activities possesses terminal degrees and licensure in their field. The ABH Medical Director and Physician Advisors are experienced, senior level clinicians, many of whom remain active in private practice. They are board certified in their specialty areas, and are required to maintain a current knowledge of behavioral health research findings and nationally recognized practice guidelines.

Care Management staff are multidisciplinary and are able to manage care in all general psychiatric, psychiatric subspecialty, and substance abuse areas. ABH requires that all Care Management staff be fully licensed mental health professionals with a minimum of three years' prior clinical experience in a mental health/substance abuse setting providing direct patient care. First-level review staff are licensed nurses with experience in psychiatric nursing (RN). These reviewers complete all types of reviews, including precertification, concurrent review, discharge planning, and care coordination. The status of current licensure is maintained within the Lakeview Center, Inc. Human Resources Department for all actively employed clinical staff.

ABH ensures that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The ABH Quality Management Committee is responsible for the development of clinical policy and standards for the Utilization Management department, the standardization of operational systems, and the assurance of clinical integrity throughout all lines of business.

UM Staff Responsibilities

The overall clinical responsibility within ABH rests with the Medical Director. The Medical Director reports to the ABH Director of Access Behavioral Health. The Medical Director provides medical and clinical leadership for the day-to-day clinical operations, oversees the UM Program implementation and ensures the application of policies and procedures and participates in training of clinical staff. The Medical Director participates in the continuous quality improvement program, which includes the ongoing development and monitoring of key indicators, outcome studies, provider quality profiling, and best practices. The Medical Director routinely reviews utilization and quality improvement reports to help identify quality practices that can be shared with other providers, and to identify aberrant practices and participate in corrective actions. The Medical Director helps design, monitor and control utilization targets. The Medical Director assists in the development and implementation of necessary corrective action plans related to utilization. In addition, the Medical Director

oversees the certification process and appeals decisions and serves as a Physician Advisor in the peer review/appeals process.

Physician Advisors are independently contracted employees and perform their reviews as designees of the Medical Director, but are not subordinate to the ABH Medical Director.

The Director of Care Management collaborates with the Medical Director to identify and resolve clinical issues related to referral, care management, and peer review processes. The Director of Care Management manages the day-to-day operations of the Care Management Department and provides direct clinical and administrative supervision to the Care Management staff. Additionally, the Director of Care Management monitors departmental productivity and utilization statistics. This position works closely with the ABH Director of Quality Management and Improvement to ensure that care management and referral processes are performed at or above established performance benchmarks. The Director of Care Management reports to the ABH Director of Managed Care.

ABH Clinical Care Coordinators provide clinical assessment and referral services as well as concurrent inpatient, alternative levels of care, and outpatient reviews. The primary function of the Clinical Care Coordinator is to ensure that members receive quality services in the most appropriate level of care. Clinical Care Coordinators inform clinical management of problem cases and resolve these issues in consultation with the Director of Care Management and the Medical Director. Clinical Care Coordinators receive clinical supervision from the Medical Director and the Director of Care Management and report directly to the ABH Director of Care Management.

Conflicts of Interest

No person may participate in the review and evaluation of any case or clinical activities in which he or she has been professionally involved or where judgment may be compromised. Utilization Management decision-making is based solely on the clinical appropriateness of the care and services needed. Access Behavioral Health does not offer incentives to individuals engaged in utilization review for issuing denials of coverage or service, or for rendering decisions that result in underutilization. Psychiatrists and other mental health professionals who carry out care management or peer review activity must be free from conflict of interest when reviewing the work of providers. Among other things, this means that clinical staff, including peer reviewers, must not review the work of any health care facility or entity where they have active staff privileges and treat patients or from which they derive any income.

Access to UM Services

A member or provider has access to a toll-free number for referral to a network provider for assessment, 24 hours per day, 7 days per week, and 365 days per year through the ABH Call Center. ABH Care Management staffs are available for consultation for urgent as well as non-urgent circumstances 24 hours per day, 7 days per week, 365 days per year via the ABH Call Center. After normal business hours, 8am to 5pm CST, non-urgent messages may be left on the confidential voice mail of the Care Management staff or may be submitted electronically to ABH CCM staff at abhreferral@lifeviewgroup.org. Response to telephonic and electronic general administrative communications to ABH Care Management staff will occur immediately in most cases, but in no less than one business day.

Clinical Criteria

The clinical criteria used by ABH to make admission, level of care and continuing treatment decisions reflects ABH's philosophy and clinical values. These criteria are assessed and revised at least annually by the ABH Quality Management Committee. Prior to a criterion set being approved for use it is reviewed to ensure adherence to clinical best practices guidelines and overall core criteria standards. Clinical criteria are reviewed and approved by the ABH Quality Management Committee.

Sources for various criteria include:

- Florida Medicaid Coverage and limitations Handbooks for Behavioral Health:
    - Community Behavioral Health
    - Specialized Therapeutic Services
    - Targeted Case Management
    - Statewide Inpatient Psychiatric Services
- Florida Medicaid Statewide Inpatient Psychiatric Program Coverage Policy (Dec 2015)
- American Society of Addiction Medicine (ASAM) criteria
- Florida Medicaid Drug Therapy Management Program for Behavioral Health
- Diagnosis-based treatment guidelines for adults
    - American Psychiatric Association
- Diagnosis-based treatment guidelines for Children and adolescents
    - American Academy of Child and Adolescent Psychiatry

Clinical criteria are routinely disseminated to ABH providers via provider forums, the ABH website, and at individual or group training sessions. The criteria are accompanied by the following statement, "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

To determine the appropriate level of care, Care Management staff evaluates the clinical information relative to the levels of care clinical criteria.

A hard copy of UM decision-making criteria may be requested by contacting Access Behavioral Health.

Medical Necessity

It is the policy of ABH to authorize payment only for services that are medically necessary and provided for the identification and/or treatment of a member's illness. ABH considers medically necessary treatment as that which is:

- Necessary to protect life, to prevent significant relapse of a mental illness or significant disability, or to alleviate severe pain;
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs;
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
- Furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.

Authorization and Notification for Behavioral Health Services

Access Behavioral Health manages authorization requests for the following services:

- Inpatient behavioral health services in a psychiatric bed (both in- and out-of-network; notification is requested by the first business day after the admission)
- Statewide Inpatient Psychiatric Programs (SIPP)
- Psychological and psychiatric testing (both in- and out-of-network)
- Electroconvulsive therapy (ECT) treatments (Note: ECT treatments rendered while a member is in an inpatient setting are included as part of the DRG payment to the facility.)

In-network non-emergent outpatient services

- All non-emergent outpatient services rendered within the regions where ABH operates are to be provided by in-network providers.
- No prior authorization is required for in-network providers.

Out-of-network non-emergent outpatient services

- No prior authorization is required for out-of-network providers outside the regions where ABH operates who participate in the Florida Medicaid program and provide transition benefit services to ABH members.
- A single case agreement may be requested for out-of-network non-emergent outpatient services by contacting Mike Potters at (850) 469- 3742.

Submitting Authorization Requests for Inpatient Psychiatric Hospitalization

Authorization requests can be made by Access Behavioral Health or by faxing clinical information directly to ABH at (850) 353-6041, or by secure email to abhreferral@lifeviewgroup.org. All information and documentation noted below should be included in the authorization request.

Information needed when requesting preauthorization

To obtain authorization through ABH, supporting clinical documentation, containing the following information, needs to be faxed to ABH or be available when calling ABH:

- Member name, date of birth, Medicaid identification number
- Member diagnosis
- Clinical information relevant to the admission, such as:
    - Significant clinical history, including mental status exam and history of present illness, Baker Act status, significant comorbidities, current medications and adherence
    - Current relevant laboratory reports
    - Treatment plan, including inpatient days requested and expected discharge placement and outpatient follow-up

Please note: Screening intake and physician history and physical forms are usually sufficient.

Additional information

Following Access Behavioral Health's review of the submitted information, the health care provider will be given an authorization number, the number of approved days, and the date of the next review. If the request is incomplete or does not meet evidence-based criteria for the level of care requested, the health care provider will be asked for additional information.

Continued stay reviews are not required for hospitals paid by DRG (Diagnosis Related Groups).

If Access Behavioral Health requests medical records as a result of an authorization request, prompt return of the information will facilitate the timely processing of the authorization request.

Questions

Questions about this program may be directed to Access Behavioral Health from 8 a.m. to 5 p.m. CST, Monday through Friday.

Peer Clinical Review

Physician Advisors provide clinical case review of those cases that do not meet medical necessity or that present quality of care issues. For after hour's coverage, a clinical supervisor, and Medical Director are on call to deal with any emergencies. ABH's Medical Director' who is responsible for the clinical decisions' is a board certified psychiatrist and provides case consultation in general adult psychiatry at all levels of care. Physician Advisors utilize Access Behavioral Health's clinical criteria for determining medical necessity decisions. Specialists are available for adult and child/adolescent to assist in the determination of clinical appropriateness.

Resources available through the Utilization Management Program and utilized by ABH Care Management staff include the following:

- Informal discussions with the Medical Director or the Access Behavioral Health Physician Advisors on a daily basis.
- Weekly case rounds for case review and monthly in-service training.
- Review of "outlier" cases on every level of care.

Determination of No Medical Necessity

If the Care Management staff questions the medical necessity and/or appropriateness of the treatment as outlined in Access Behavioral Health's clinical criteria, or if there are quality of care concerns, the case is referred to the ABH Medical Director or a Physician Advisor (PA). The ABH Medical Director or Physician Advisor reviews the available information, and may offer to speak directly with the attending or primary provider to discuss the case. Through this communication, the ABH Medical Director or Physician Advisor may obtain clinical data that was not available to the care management staff at the time of the review. This collegial clinical discussion allows the ABH Medical Director or Physician Advisor the opportunity to explore alternative treatment plans with the provider and to gain insight into the attending providers anticipated goals, interventions and time frames. The ABH Medical Director or Physician Advisor may request more information from the provider to support specific treatment protocols and ask about treatment alternatives. Determinations of no medical necessity are rendered only by the ABH Medical Director or a Physician Advisor and only if the ABH Medical Director or Physician Advisor and the attending provider are unable to reach an agreement. It is always possible for the treating provider to provide additional written or verbal information prior to the peer review decision. This additional information may alter the medical necessity determination.

Disagreement may be a result of anyone or a combination of the following:

- the current level of care;
- the frequency of a specific treatment modality;
- the duration of care; and/or
- the treatment modality being utilized

ABH is not delegated sending notices of adverse determination. When a determination of no medical necessity is made in a case, the treating provider (and hospital, if applicable) is notified telephonically of the decision. Written notification of a determination of no medical necessity is provided to the member and the member's treating practitioner by the member's MMA plan. The notification letter specifies the level of care for which a determination of no medical necessity has been made, the reason(s) why the determination has occurred and instructions on how to initiate an appeal. Access Behavioral Health Care Management staff always work with providers in finding alternatives when a given level or type of care is not determined to be medically necessary, and this is documented in the case review notes.

Peer-to-Peer Conversation

Based on criteria for medical necessity, Care Management staff concludes that the proposed treatment of a member does not appear to meet the clinical criteria. The Care Management staff reviews these concerns with the facility UR staff or treating provider on the same business day. If the Care Management staff and the treating provider are not able to resolve these concerns, the process for referral of the case for peer-to-peer review is initiated, if not already completed as described above.

The peer review process follows core policies and procedures which are established by the Access Behavioral Health QI/UM Committee. The procedure is as follows:

An appointment is scheduled for the Physician Advisor and the treating provider by an ABH Care Management Department staff member. If the treating provider cannot be reached, a message is left, indicating that the call pertains to a question of medical necessity determination, and unless a call is received within (24) hours, a non-certification decision is issued unless special circumstances are identified that prevent the treating physician from returning the call. After reviewing the information with the treating provider, the Physician Advisor determines whether the treatment services the provider intends to render (or has already rendered) are medically necessary. If so, the case is referred back to the ABH Care Management staff for continued review. If not, the provider is informed of the determination of no medical necessity and of the appeal process. Peer review decisions are usually rendered immediately, but in all cases within 24 hours of the review. Note: It is always possible for the treating provider to provide additional written or verbal information prior to the peer

review decision. This additional information may alter the medical necessity determination. However, once Access Behavioral Health has sent a no medical necessity determination letter according to contractual standards, the case is governed by the protocols established for an appeal. The determination remains valid until and/or unless it is overturned by an appeal.

Appeal Process

Access Behavioral Health is not delegated member or provider Grievances, Complaints and Appeals. Provider Complaints and all aspects of the grievance and appeal process are handled by the member's MMA Health Plan. In the event an appeal or complaint is received by Access Behavioral health, it will be forwarded immediately to the member's MMA plan.

Practitioner Satisfaction with Access Behavioral Health UM Processes

Satisfaction surveys are sent, on an annual basis, to those providers who regularly use the ABH Care Management services. Data are aggregated, trended and used to identify improvement opportunities including areas in which our administrative and clinical practices need revision. Results are presented to the Quality Management Committee and are shared with providers.

IX. CLAIMS

Member Eligibility

Member eligibility within a designated health plan is determined by the Agency for Health Care Administration (AHCA). Access Behavioral Health's contracted health plans bear the responsibility of providing daily member eligibility files to ABH. ABH is required to attest to the health plans that eligibility files are uploaded exactly as they are received. ABH is not permitted to determine or change member eligibility.

Members may request assistance with eligibility questions by contacting Choice Counseling at 877-711-3662.

Reporting Member Demographic Information changes to Florida Medicaid

The Department of Children and Families (DCF) needs to know when a member's name, address, county, or telephone number change.

The member may:

- Call DCF toll-free at 1-866-762-2237 (TTY 1-800-955-8771) Monday through Friday from 8 a.m. to 5:30 p.m.
- Go online and make the changes in their Automated Community Connection to Economic Self Sufficiency (ACCESS) account.
- Contact the Social Security Administration (SSA) to report changes. Call SSA toll-free at 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday from 7 a.m. to 7 p.m.
- Contact their local Social Security office or go online and make changes in their Social Security account.

Claims Processing

Access Behavioral Health is committed to processing all claims accurately and in a timely manner by following all rules and regulations set forth by federal and state requirements.

Claims Submission

Per provider contracts, all claims must be submitted to Access Behavioral Health within ninety (90) days from the date of service. Non-contracted providers have 6 months or 180 days from the date of service in which to submit claims. Claims are not denied for late file unless received beyond 1 year (365 days) of the date of service.

Paper Claims

Outpatient services must be billed on a CMS-1500. Inpatient services are billed on a UB-04.

All fee-for-service claims must be submitted on paper claims to:
Access Behavioral Health
ATTN: Claims

Access Behavioral Health

A division of Lakeview Center, Inc.

1221 W. Lakeview Avenue
Pensacola, FL 32501

Electronic Claims

Providers should contact Access Behavioral Health for questions regarding filing claims electronically. Electronic claims must be submitted with a single type procedure code per claim. Secondary claims may not be submitted electronically. Secondary claims must be submitted via paper claim with the completed explanation of benefits/remittance advice from the primary payer attached

Clean Claims

A clean claim form means a standard, original and legible claims form UB04, CMS 1500, 837 or successor forms which has been accurately completed by inserting all the correct information required to answer each data element needed to immediately process claims within the time period stated for services rendered and to promptly approve or deny payment.

Covered Diagnosis Codes

ABH covers both mental health and substance abuse diagnosis codes with the following exceptions:

ABH does not authorize community behavioral health services for the treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation. Services are not considered to be medically reasonable when the recipient has an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that have produced a cognitive deficit severe enough to prohibit benefit to the recipient.

ICD-10 Reimbursable behavioral health diagnosis codes: F01.50 – F53.1; F55.0 – F63.9; F68.10 – F69; F80.82, F88 – F99; Z03.89

Authorization Numbers

Authorization numbers are not required to be on the claim for claims payment.

Claims Payment

Electronic claims are processed within 15 days. Paper claims (fee-for service claims) are processed within 20 days.

Claims Remittance

Claims payments to providers is accompanied by an itemized accounting of the individual claims included in the payment including but not limited to, the member's name, the date of service, the procedure code, service units, the amount of reimbursement and the identification of the managed care plan.

Medicaid Benefit Limits

The ABH claims payment system does not allow payment beyond the limitations set forth in the Florida Medicaid Provider handbooks. Medicaid recipients may not be billed for services rendered that are denied by ABH for plan benefit limits.

Member Responsibility

Florida Medicaid does not require any co-payments or cost sharing for covered services to plan members. Members may not be billed for services rendered by out of network providers unless the member agrees in writing prior to the delivery of the services. Members may not be billed for missed appointments.

Disaster Planning

In the event of a disruption in the ability of service providers to contact ABH for authorizations due to an emergency, providers are instructed to provide medically necessary services. ABH will conduct retrospective reviews on these cases and authorize appropriate claims. ABH will pay claims and not hold members responsible for any medically necessary services that incurred during a time of disaster regardless of whether or not prior authorization was obtained. Consumer health and safety is of utmost concern and is not to be jeopardized by an inability of providers to communicate with ABH.

Claims Questions

Providers are encouraged to contact Access Behavioral Health with any questions regarding claims payment. Telephone: (850) 469-3631; email: abhbilling@lifeviewgroup.org

Corrected Claims

For handling and addressing corrections concerning claims issues, a provider has 35 days after receipt of notification to resubmit a claim to:

Access Behavioral Health
Attention: Claims Corrections
1221 W. Lakeview Avenue
Pensacola, FL 32501

Provider Complaints

Provider complaints (including overpayment disputes) must be issued in writing to:

Access Behavioral Health
1221 West Lakeview Avenue
Pensacola, FL 32501

Provider Claims Related Complaints

Providers are allowed ninety (90) calendar days from the date of final determination of the primary payer to file a written complaint for claims issues. Within three (3) business days of receipt of a claim complaint, the provider is notified (verbally or in writing) that the complaint has been received and the expected date of resolution. Within thirty(30) calendar days of receipt of a claim complaint, the provider is given written notice of the status of the complaint, and again every thirty (30) calendar days thereafter until the complaint is resolved. Complaints related to claims are resolved within sixty (60) calendar days of receipt and written notice of the disposition and the basis of the resolution is sent to the provider within three (3) business days of resolution.

Provider Non-Claim Related Complaints

Providers may file a complaint regarding any aspect of their experience as a provider of service to ABH members. Providers have forty-five (45) days to file a written complaint for issues that are not related to claims.

The member's Health Plan will

- Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;
- Document why a complaint is unresolved after thirty (30) calendar days of receipt and provide written notice of the status to the provider every thirty (30) calendar days thereafter; and
- Resolve all complaints within ninety (90) calendar days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

Provider Change Notifications

Prompt notification of Access Behavioral Health in the event of any demographic change such as provider name or address by calling the ABH claims department at (850) 469-3631 or emailing abhinfo@lifeviewgroup.org will facilitate timely claims payment.

X. PROVIDER CONTRACTS

It is the responsibility of each contracted provider to familiarize themselves with the requirements in his/her signed contract with Access Behavioral Health. Contract questions will be addressed promptly by contacting the ABH Director of Network Management directly listed in the staff directory.

XI. Appendix 1: Humana Healthy Horizons

Access Behavioral Health is contracted with Humana Healthy Horizons in Florida's Regions 1 and 2.

SMMC Plan Contact:
Email: LTCProviderrelations@humana.com
Phone: 561-860-8660

MMA Provider contact:
Email: FLMedicaidProviderRelations@humana.com
Phone: 305-626-5006

Address:
Humana Healthy Horizons
PO Box 14546
Lexington, KY 40512-4546

XII. Appendix 2: Sunshine Health

Access Behavioral Health is contracted with Sunshine Health in Florida Region 1.

Address:
Sunshine Health
P.O. Box 459087
Fort Lauderdale, FL 33345-9087
Provider Services: 1-844-477-8313