PROVIDER MANUAL
2022

Table of Contents

Welcome to the Network

Mission

*"*To create a world class organization that sets the standard of excellence in the compassionate treatment of behavioral health and addiction disorders.*"*

Welcome to NBH's network of providers. This manual is an extension of the provider agreement and includes requirements for doing business with NBH Provider Network.

Forms referenced in this manual or in the provider agreement are available for download or printing through the Providers' section of the website.

NBH arranges for the provision of and access to a broad scope of behavioral health services for members through its provider networks, consisting of appropriately licensed and/or certified practitioners, facilities, providers, and programs offering varying levels of service.

Direct questions, comments and suggestions regarding this manual should be directed to:

Nevada Behavioral Health Systems (NBH)
(702)857-8800
info@nvbhs.com.

Additional information about the locations, email addresses, and toll-free numbers of NBH's offices are conveniently located on our website, www.nvbhs.com

NBH Membership

NBH provides mental health and substance use disorder services for members with or at risk for serious emotional disturbance, severe mental illness, intellectual/developmental disabilities, and substance use disorders. Our programs are designed to give individuals, within the identified populations, greater choice, and involvement in their treatment. Our guiding principles are: (1) providing choice, (2) Person- Center Planning principals, and (3) maximizing the use of and developing new community-based services.

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, 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.

- Life threatening emergency: Seen immediately
- Non-life-threatening emergency: Seen within 6 hours of the request
- Urgent Appointments: Seen within 48 hours of the request (if no prior authorization is required); seen within 96 hours (if prior authorization is required)
- Routine Appointments: Seen within ten (10) calendar days of the request

- Follow up after hospitalization is required within 7 (seven) business days
- Follow-up Appointment: Seen no more than 30 days after initial assessment with a non-prescriber; no more than 90 days with a prescriber.

NBH Communications

Toll-free information Line

NBH operates a toll-free information line for members and providers **844.978.8100** through the NBH Appointment Desk. This information line is available 24 hours per day, 7 days per week and is staffed by experienced, qualified member services representatives. Representatives assist members with finding a network provider and scheduling appointments. Providers can call and ask questions related to network inclusion, contract and billing issues, request a mobile assessment at an emergency department or an IMD and request site consult or capacity evaluations.

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.

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. 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 case management, to psycho- educational groups and aftercare services. 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 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.

Availability and Accessibility Standards

Nevada 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. Access availability is also calculated periodically to assure that members have access to care within the required timeframes. Additions to the network may include new providers, location, language(s) spoken, and cultural/ethnic background. Access standards are reviewed to assure that members are able to access services in the required typical travel times.

Provider Training

The NBH Quality Department conducts training with providers and practitioners annually. The Handbook is made accessible

to all newly credentialed providers via the NBH website.

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

- NBH 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
- Critical Incident Reporting
- Member and Provider Complaints
- Timely Access to Services
- Coordination of Care of Behavioral Health and Medical Services
- Cultural Competence
- Fraud, Waste and Abuse/Corporate Compliance

Credentialing and Recredentialing

The NBH 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 Nevada Behavioral Health. The credentialing process ensures adequate member choice, adequate capacity within the NBH network, timely access to services, and prevents discrimination in the NBH 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 NBH and outlined in the policies and procedures, and successfully complete the credentialing review process. NBH requires that all applicants meet all state standards and requirements regarding background screenings. NBH will not credential any individual or organization that is excluded from participation in Federal health care programs.

A few of your rights in the credentialing and recredentialing process to be aware of:

1. You have the right to review information obtained about your credentialing application from outside sources from primary source verification.
2. You have the right to correct erroneous information.
    - You have 30 days to submit written corrections to the Credentialing Department at: 3321 N Buffalo Dr, Suite #225, Las Vegas, NV 89129
3. You have the right to receive the status of your credentialing/recredentialing application, upon request.

Credentialing

Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation using of the following method:

- After completing the online universal credentialing process offered by the Council for Affordable Quality Healthcare (CAQH), give NBH access to your credentialing information and ensure a current attestation. Call the CAQH Help Desk at 888-599-1771 for answers to your questions related to the CAQH application or website at www.caqh.org.

This includes without limitation attestation as to:

- Any limits on the provider's ability to perform essential functions of their position or operational status
- With respect to individual practitioner providers, the absence of any current illegal substance or drug use
- Any loss of required state licensure and/or certification
- Absence of felony convictions
- With respect to individual practitioner providers, any loss or limitation of privileges or disciplinary action
- The correctness and completeness of the application

Failure of a provider to submit a complete and signed credentialing application, and all required supporting documentation timely and as provided for in the credentialing application and/or requests from NBH, may result in rejection of request for participation status with NBH.

Recredentialing

Recredentialing for providers is required every three years, or such shorter period of time where required by a specific state law or regulation. The process for recredentialing begins approximately three months prior to the end of the initial credentialing cycle or the preceding recredentialing cycle, as applicable, and can be accomplished using one of the following methods:

- After completing the online universal credentialing process offered by the Council for Affordable Quality Healthcare (CAQH), give NBH access to your credentialing information and ensure a current attestation. Call the CAQH Help Desk at 888-599-1771 for answers to your questions related to the CAQH application or website at www.caqh.org.
- NBH will email or fax a recredentialing application to the provider upon receipt of their current attestation.

Required documentation includes without limitation attestation as to

- Any limits on the provider's ability to perform essential functions of their position or operational status
- With respect to individual practitioner providers, the absence of any current illegal substance or drug use
- The correctness and completeness of the application (including without limitation identification of any changes in or updates to information submitted during initial credentialing)

Failure of a provider to submit a complete and signed recredentialing application, including all required supporting documentation timely and as provided for in the recredentialing application and/or requests from NBH, may result in termination of participation status with NBH and such providers may be required to go through the initial credentialing process.

Updates

Providers are required to report material changes to information included in credentialing and/or recredentialing applications submitted to NBH. Except as noted below, all such changes must be reported in writing within the time period provided for in the provider agreement, but not to exceed 10 calendar days of the provider becoming aware of the information.
Failure to comply may result in immediate termination of network participation status. The following is a list (not exhaustive) of examples of the types of material changes for which the above report is required:

- Any action against licenses, certifications, registrations, and/or accreditation status*
- Any legal or government action initiated that could materially affect the rendering of services to members
- Any legal action commenced by or on behalf of a member
- Any initiation of bankruptcy or insolvency proceedings, whether voluntary or involuntary

- Any other occurrence that could materially affect the rendering of services to members
- Discovery that a claim, suit or criminal or administrative proceeding is being brought against the provider relating to the provider's delivery of care (i.e., a malpractice suit), compliance with community standards and/or to applicable laws, including but not limited to any action by licensing or accreditation entities and/or exclusions from a government-sponsored health benefit program (e.g., Medicare/Medicaid)

* *The suspension, revocation, expiration and/or voluntary surrender of professional license/certification, DEA certificate, CDS certificate, and/or board certification must be reported within five calendar days of the effective date of the action. (Contact NBH to coordinate the transition of members to the care of other providers where licensure/certification no longer meets NBH's credentialing/recredentialing standards and/or requirements pursuant to state and/or federal laws regarding the provision of services.)*

Note: If a provider moves to or expands their practice and/or operations into another state, a copy of the provider's license/certification and malpractice/professional liability coverage is s required in order to complete primary source verification and credential the provider to treat NBH's members in another state.

Expiration, non-renewal and/or decrease in required malpractice or professional liability coverage must be reported 30 days prior to such change in coverage.

Any changes in demographic information or changes in practice patterns, such as change of services and/or billing address, name change, coverage arrangements, tax identification number, hours of operation, and/or changes in ownership, must be provided to NBH in advance of such changes.

NBH must receive 60 days' advance notice of any new programs or services offered by a facility provider in order to allow for completion of the credentialing process prior to provision of services to members.

Changes in ownership and/or management of providers may require negotiation and execution of consent to assignment and assumption agreements as related to provider agreements and the parties to provider agreements.

Appeals of Credentialing Committee/Peer Review Committee Decisions

The NBH credentialing committee will give Providers written notice of the committee's decision regarding credentialing or recredentialing applications submitted, any sanctions imposed or recommended, the reason for the decision, and of the provider's/provider's right to appeal adverse decisions along with an explanation of the applicable appeals procedure(s). Unless otherwise identified in such written notice, Providers have 30 calendar days from the date of the committee's notice of an adverse decision to file a written request for an appeal.

Provider appeals of adverse credentialing/recredentialing decisions by the credentialing committee may be appealed to the Peer Review Committee (PRC) at attention: Peer Review Committee, 3321 N. Buffalo Dr., Las Vegas, NV 89129.

The PRC:

- Functions as a peer review body under NCQA standards
- Is made up of representatives from major clinical disciplines and includes providers
- Makes the final decision regarding:
    - Approval/denial/pending status for credentialing/recredentialing applications
    - Determinations regarding possible provider sanctions identified above

Requests for appeals of adverse credentialing/recredentialing decisions of the PRC should include an explanation of the reasons the provider believes the credentialing committee reached a decision to be in error and include supporting documentation. The PRC will review the explanation provided, the information previously reviewed by the credentialing committee, and any additional information determined to be relevant. The PRC may request additional information from the provider in order to make a determination or decision. The PRC will support, modify, or overturn the decision of the credentialing committee. Written

notification of the PRC's decision, an explanation of the decision, and any appeal and/or fair hearing rights available for adverse decisions, will be sent to the provider within 14 business days after the PRC's record is complete.

Professional Review Activities/Fair Hearing Process

Individual Providers, where required by applicable law, may request a second level of appeal/a fair hearing when the PRC denies credentialing or recredentialing, issues a sanction, or recommends termination of participation status of the provider from the provider network, where such denial, sanction, or recommendation is based on quality of care issues and/or issues related to professional competence or professional conduct.

Included in written notification of an adverse decision based on quality of care issues and/or issues related to professional competency or professional conduct, will be an explanation of the decision, whether or not fair hearing rights are available to the provider, and an explanation of fair hearing procedures if applicable.

Requests for a fair hearing must be submitted to NBH within 30 calendar days of the date of notification of adverse decision to the provider. While NBH will make reasonable efforts to coordinate the date and time of fair hearings requested with the involved provider, should NBH and the involved provider be unable to come to agreement on the date and time of the requested fair hearing NBH will identify the date, time and location for the fair hearing, which date shall be within the 90-calendar day period following request for the fair hearing or within the timeframe required by applicable State regulations.

NBH will identify peer reviewers who will participate as the fair hearing panel. Every effort will be made to include a representative of the discipline of the provider requesting the fair hearing on the panel. Members will be asked to represent that they do not have an economic interest adverse to the provider. One member of the fair hearing panel will be selected to act as the hearing officer and will preside over the fair hearing.

The provider will receive the written recommendation from the panel within 15 business days after the fair hearing. The fair hearing process as set forth above is subject to applicable state and/or federal laws and/or regulations.

Quality Management/Quality Improvement

NBH's comprehensive Quality Improvement Program (QIP) includes Quality Improvement (QI) policies and procedures applicable to all staff to provide for consistency and excellence in the delivery of services, includes a program description, an annual work plan that includes goals and objectives and specific QI related activities for the upcoming year and evaluation of the effectiveness of those activities. Providers are responsible for adhering to the QIP and are encouraged to provide comments to NBH regarding ongoing QIP activities through direct telephone communications and/or via the Provider website.

Quality Improvement Committee

The NBH Quality Improvement Committee (QIC) has ultimate accountability for the oversight and effectiveness of the QIP.

The QIC reviews and approves the QI Program Description, QI Program Evaluation, and integrated QI/UM Work plan at least annually and at the time of any revision. The QIC receives a quarterly summary of all QI activities included in the work plan.

Scope of the Quality Improvement Program

The NBH Quality Improvement Program (QIP) monitors and evaluates quality across the entire range of services provided by the network. The QIP is intended to ensure that structure and processes are in place to lead to desired outcomes for members, clients, and providers/participating practitioners.

The scope of the QIP includes:

- Clinical services and Utilization Management Programs
- Supporting improvement of continuity and coordination of care
- Complex Case Management

- Quality Improvement Activities (QIAs)
- Member Experience Survey
- Clinical Treatment Record Evaluation
- Service Availability and Access to Care
- Practitioner and Provider Quality Performance
- Member Rights and Responsibilities
- Health Literacy and Cultural Competency assurance
- Promotion of the use of member self-management tools
- Screening Programs
- Complaints and Grievances

Several of the above activities and processes are described in greater detail in other sections of this manual.

Role of Providers

Participating practitioners/providers are informed about the QIP via the NBH Provider Manual, website information, direct mailings, email provider alerts, and training opportunities. This provides network practitioners/providers with the opportunity to be involved and provide input into the QI and UM Programs. Additional opportunities to be involved include representation on the Credentialing and other relevant Sub-Committees. Involvement includes, but is not limited to:

- Providing input into the NBH medical necessity criteria
- Providing peer review and feedback on proposed practice guidelines, clinical quality monitors and indicators
- Reviewing QIAs and making recommendations to improve quality of clinical care and services
- Reviewing, evaluating, and making recommendations for the credentialing and recredentialing of participating practitioners and organizational providers
- Reviewing, evaluating, and making recommendations regarding sanctions that result from participating practitioner and organizational provider performance issues

As part of the QIP, NBH incorporates principles designed to encourage the provision of care and treatment in a culturally competent and sensitive manner. These principles include:

- Emphasis on the importance of culture and diversity
- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Consideration of sex and gender identity
- Adaptation of services to meet the specific cultural and linguistic needs of members.

Providers are reminded to take the cultural background and needs of members into account when developing treatment plans and/or providing other services

Clinical Practice Guidelines

The National Committee for Quality Assurance (NCQA) requires that NBH regularly inform practitioners about the availability of clinical practice guidelines (CPGs). NBH considers clinical practice guidelines to be an important component of health care. NBH adopts

nationally recognized clinical practice guidelines and encourages our network of providers to utilize these guidelines to improve the health of our Members.

NBH has adopted clinical practice guidelines (CPGs) based on nationally recognized resources, including but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), MCG (formerly known as Milliman Care Guidelines), and the Centers for Medicare and Medicaid Services (CMS). For management of substance use services, NBH uses ASAM criteria.

Diagnosis-Based CPGs are available on the website. Included are those that have been developed or updated within the past two years and represent the best clinical information we have at this time. In addition, if the original source of the guideline publishes an update or makes a change, NBH will initiate additional review of the guideline prior to the two-year review cycle. Updates/changes are then presented to NBH's Quality Improvement Committee for final approval.

How the guidelines help in clinical decision making

- When used in clinical decision making, adherence to these recognized guidelines helps to ensure that care authorized for acute and chronic behavioral health conditions meets national standards for excellence.

- Our adopted guidelines are intended to support, not replace, sound clinical judgment. We welcome your feedback and will consider all suggestions and recommendations in our next review.

Providers can also access the up-to-date listing of the behavioral health guidelines online. To access the guidelines, go to https://nvbhs.com/clinical-practice-guidelines/

Behavioral Health and Substance Abuse Screening Programs

NBH is committed to excellence in behavioral health service delivery. NBH strives not only to meet but also to surpass standards set forth by the National Council for Quality Assurance (NCQA) for Managed Behavioral Health Organizations (MBHO). NCQA is an accrediting organization intended to assist behavioral health organizations in achieving the highest level of performance possible, reducing member risk for untoward health outcomes, and creating an environment of continuous improvement.

To best serve our members with the provision of appropriate behavioral health and substance use services, and to continue to exceed quality standards, NBH is dedicated to advancing wellness and taking action to reduce negative effects of mental illness and substance use disorders through the promotion of early screening and assessment. Towards this effort and dedication, NBH has implemented two screening programs, one for coexisting mental health and substance use disorders using the PHQ-9 and CAGE/CAGE-AID, and a second screening program, for screening for metabolic syndrome. These two screening measures are based on scientific evidence, best practice, and industry standards. NBH will review scientific evidence and update these programs every two years, or more often, where appropriate if new evidence becomes available in between scheduled reviews. The selection of screening measures, identification of population screened, recommended frequency of the screenings, and overall program design has been a collaborative effort between NBH, and providers and practitioners within NBH's Provider Network.

Providers can also access the up-to-date listing of the behavioral health guidelines online. To access the guidelines, go to https://nvbhs.com/provider-resources/

The screening programs will continue to be distributed to new providers and practitioners as part of the credentialing process through the distribution of the Provider Manual.

Treatment Record Standards and Guidelines

Member treatment records should be maintained in compliance with all applicable medical standards, privacy laws, rules and regulations, as well as NBH's policies and procedures and in a manner that is current, comprehensive, detailed, organized and legible to promote effective patient care and quality review. Providers are encouraged to use only secure electronic medical record technology when available. NBH's policies and procedures incorporate standards of accrediting organizations to which NBH is or may be subject (e.g., NCQA), as well as the requirements of applicable state and federal laws, rules, and regulations.

References to 'treatment records' mean the method of documentation, whether written or electronic, of care and treatment of the member, including, without limitation, medical records, charts, medication records, physician/practitioner notes, test and procedure reports and results, the treatment plan, and any other documentation of care and/or treatment of the member.

Progress notes should include what psychotherapy techniques were used, and how they benefited the member in reaching his/her treatment goals.

Member treatment records are based on the record keeping standards set out below:

- Each page (electronic or paper) contains the member's name or identification number.
- Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- All entries in the treatment record are dated and include the responsible clinician's name, professional degree, and relevant identification number, if applicable. The length of the visit/session is recorded, including visit/session start and stop times.
- Reviews may include comparing specific entries to billing claims as part of the record review.
- The record when paper based is legible to someone other than the writer.
- Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status and the results of a mental status exam, are documented.
- Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented, and revised in compliance with written protocols.
- Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data, and relevant family information.
- For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events (when available), along with a developmental history (physical, psychological, social, intellectual and academic).
- For members 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.
- A DSM (or the most current version of the DSM) diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.
- Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.
- Treatment plans are updated as needed to reflect changes/progress of the member.

- Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers, and health care institutions are documented as appropriate.
- Informed consent for medication and the member's understanding of the treatment plan are documented.
- Additional consents are included when applicable (e.g., alcohol and drug information releases).
- Progress notes describe the member's strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives.
- Documented interventions include continuity and coordination of care activities, as appropriate.
- Dates of follow-up appointments or, as applicable, discharge plans are noted.

In addition to other requests for member treatment records included in this manual and/or the provider agreement, member treatment records are subject to targeted and/or unplanned reviews by the NBH Quality Improvement Committee or its designee, as well as audits required by state, local, and federal regulatory agencies and accreditation entities to which NBH is or may be subject to.

Improvement Member/Patient Safety

NBH has a defined procedure for the identification, reporting, investigation, resolution, and monitoring of quality of care and service issues. Quality of care and service issues and trends are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. These types of issues may be identified from a variety of sources, including without limitation member and provider complaints, internal reviews, clients, government agencies and others. The PRC, in which the medical director participates, oversees the investigation and resolution of these issues through to completion.

Quality Improvement Activities

One of the primary goals of NBH's Quality Improvement Program (QIP) is to continuously improve care and services. Through data collection, measurement and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities. Data collected for quality improvement activities are frequently related to key industry measures of quality that tend to focus on high-volume diagnoses or services and high-risk or special populations. Data collected is valid, reliable, and comparable over time. NBH takes the following steps to ensure a systematic approach to the development and implementation of quality improvement activities:

- Monitoring of clinical quality indicators
- Review and analysis of the data from indicators
- Identification of opportunities for improvement
- Prioritization of opportunities to improve processes or outcomes of behavioral health care delivery based on ability to impact performance, and resource availability
- Identification of the affected population within the total membership
- Identification of the measures to be used to assess performance
- Establishment of performance goals or desired level of improvement over current performance
- Collection of valid data for each measure and calculation of the baseline level of performance
- Thoughtful identification of interventions that are powerful enough to impact performance
- Analysis of results to determine where performance is acceptable and, if not, the identification of current barriers to improving performance

Healthcare Effectiveness Data and Information Set (HEDIS®)

There are a number of ways to monitor the treatment of individuals with mental health and/or substance use conditions receive. Many of you who provide treatment to these individuals measure your performance based on quality indicators such as those to meet CMS reporting program requirements; specific state or insurance commission requirements; managed care contracts; and/or internal metrics. In most cases there are specific benchmarks that demonstrate the quality that you strive to meet or exceed.

NBH utilizes a number of tools to monitor population-based performance in quality across regions, states, lines of business and diagnostic categories. One such tool is the Healthcare Effectiveness Data and Information Set (HEDIS) behavioral health best practice measures as published by the National Committee for Quality Assurance (NCQA) as one of our tools. Like the quality measures utilized by CMS, and Joint Commission, these measures have specific, standardized rules for calculation and reporting.

We work with the provider network to ensure behavioral health measure performance reflects best practice. Our providers are the key to guiding their patient to keep an appointment after leaving an inpatient psychiatric facility; taking their antidepressant medication or antipsychotic medication as ordered; ensuring a child has follow up visits after being prescribed an ADHD medication; and ensuring an individual with schizophrenia or bipolar disorder has annual screening for diabetes and coronary heart disease.

**HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Below is a brief description of the HEDIS measures that apply to the behavioral health field requirements associated with each:

1. Follow-up after Hospitalization for Mental Illness (FUH)

Best practice for a member aged six or older to transition from acute mental health treatment to the community is an appointment with a licensed mental health practitioner (outpatient or intermediate treatment) within seven and/or 30 calendar days of discharge.

For this measure, NCQA requires organizations to substantiate by documentation from the member's health record all nonstandard supplemental data that is collected to capture missing service data not received through claims, encounter data, laboratory result files, and pharmacy data feeds. NBH requires proof-of-service documentation from the member's health record that indicates the service was received. All proof-of-service documents must include all the data elements required by the measure.
Data elements included as part of the patient's legal medical record are:

- Member identifying information (name and DOB or member ID)
- Date of service
- DSM diagnosis code
- Procedure code/Type of service rendered
- Provider site/facility
- Name and licensure of mental health practitioner rendering the service
- Signature of rendering practitioner, attesting to the accuracy of the information

The critical pieces of this measure for Providers are:

- **Inpatient facilities** need to:
    - Use accurate diagnoses when submitting claims for inpatient treatment. If the diagnosis on admission is a mental health diagnosis but subsequent evaluation during the stay confirms that the primary diagnosis is substance use, please use the substance use diagnosis on the claim submitted at discharge.
    - Ensure that discharge planners educate patients about the importance of aftercare for successful transition back to their communities.
    - Ensure that follow-up visits are within seven calendar days of discharge. **Note:** It is important to notify the providers that the appointment is post hospital discharge and that an appointment is needed in seven

calendar days.

- Ensure that the appointment was made with input from the patient. If the member has a pre-existing provider and is agreeable to going back to that provider schedule the appointment with that provider. If not, the location of the outpatient provider or PHP (Partial Hospitalization Program), IOP (Intensive Outpatient Program) or other alternative level of care, must be approved by the member and be realistic and feasible for the member to keep that appointment.

- **Outpatient Providers** need to make every attempt to schedule appointments within seven calendar days for members being discharged from inpatient care. Providers are encouraged to contact those members who are "no show" and reschedule another appointment.

2. **Initiation and Engagement of Alcohol and other Drug Use Treatment**

This measure aims to define best practice for initial and early treatment for substance use disorders by calculating two rates using the same population of members who receive a new diagnosis of Alcohol and Other Drug (AOD) use from any provider (ED, Dentist, PCP, etc.):

- **Initiation of AOD Use Treatment**: The percentage of adults diagnosed with AOD Use who initiate treatment through either an inpatient AOD admission or an outpatient service for AOD from a substance use provider AND an additional AOD service within 14 calendar days.
- **Engagement of AOD Treatment**: An intermediate step between initially accessing care and completing a full course of treatment. This measure is designed to assess the degree to which the members engage in treatment with two additional AOD services within 30 calendar days after initiation phase ends. The services that count as additional AOD services include IOP, Partial Hospital, or outpatient treatment billed with CPT-4 or revenue codes associated with substance use treatment.

3. **Antidepressant Medication Management (AMM)**

The components of this measure describe best practice in the pharmacological treatment of newly diagnosed depression treated with an antidepressant by any provider by measuring the length of time the member remains on medication. There are two treatment phases:

- **Acute Phase**: The initial period of time the member must stay on medication for the majority of symptoms to elicit a response is 12 weeks
- **Continuation Phase**: The period of time the member must remain on medication in order to maintain the response is for at least six months.

4. **Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication**

The components of this measure describe best practice in the pharmacological management of children 6-12 years newly diagnosed with ADHD and prescribed an ADHD medication by measuring the length of time between initial prescription and a follow up psychopharmacology visit and the continuation and maintenance phases of treatment.

- **Initiation Phase**: For children, 6-12 years of age, newly prescribed ADHD medication best practice requires a follow up visit with a prescriber within 30 days of receiving the medication.

For ongoing treatment with an ADHD medication, best practice requires:

- C**ontinuation and Maintenance (C&M) Phase**: At least two additional follow-up visits with a prescriber in the preceding nine months; and the child remains on the medication for at least seven months.

5. **Diabetes Screening for People with Bipolar Disorder or Schizophrenia Who Are Using Antipsychotic Medications (SSD)**

For members with Schizophrenia or Bipolar diagnosis who were being treated with an antipsychotic medication, this measure monitors

for potential Type 2 Diabetes with an HbA1C test.

6. **Diabetes Monitoring for People with Diabetes and Schizophrenia Who are Using Antipsychotic Medications (SMD)**

For members who have Type 2 Diabetes, a Schizophrenic or Bipolar diagnosis and are being treated with an antipsychotic this measure's best practice is an annual or more frequent LDL-C test and an HbA1c test (SMD).

7. **Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)**

For members with Schizophrenia or Bipolar diagnosis who are being treated with an antipsychotic medication this measure monitors for potential cardiac disease with a LDL-C test.

8. **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)**

This measure is described as the percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

9. **Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)**

For child and adolescent members (1-17) prescribed antipsychotic medication on an ongoing basis, best practice requires testing at least annually during the measurement year to measure glucose levels (Blood Glucose or HbA1C) and cholesterol levels to monitor for development of metabolic syndrome.

10. **Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)**

This measure identifies children and adolescents who are on two or more concurrent antipsychotic medications.

The best practice here is that multiple concurrent use of antipsychotic medications is not best practice nor approved by the FDA. While there are specific situations where a child or adolescent requires concurrent medications, the risk/benefit of the treatment regime must be carefully considered and monitoring in place to prevent adverse outcome(s).

11. **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)**

For children and adolescents with a new prescription for an antipsychotic, best practice requires that the child receive psychosocial care as part of first line treatment.

First line treatment is associated with improved outcomes and adherence.

12. **Follow-up After Emergency Department Visit for Mental Illness (FUM)**

The percentage of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:

- Follow-up visit to occur within seven days of ED discharge.
- If the seven-day visit goal is missed, the next goal is a visit within 30 days of ED discharge.

13. **Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA)**

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD. Two rates are reported:

- Follow-up visit to occur within seven days of ED discharge.

- If the seven-day visit goal is missed, the next goal is a visit within 30 days of ED discharge.

Experience/Satisfaction Surveys

satisfaction survey data is analyzed annually to identify areas for improvement as a key component of the QI.

Member experience and/or satisfaction surveys measure opinions about clinical care, providers, and NBH administrative services and processes. Members are asked to complete satisfaction surveys at various points in the continuum of care and/or as part of ongoing quality improvement activities. The results of these member surveys are summarized on an annual basis. Where appropriate, corrective actions are implemented in the relevant department

Site Visits for Quality Reviews

NBH conducts site visits at provider facilities and/or offices. A site visit may be conducted as part of monitoring an investigation stemming from a member complaint or other quality issue.

NBH will contact the provider to arrange a mutually convenient time for the site visit. The site visit process is intended to be consultative and educational. Following the site visit, the provider will receive a written report detailing the findings of the site visit. If necessary, the report will include an action plan that will provide guidance in areas that the provider needs to strengthen in order to be in compliance with service standards.

Complaints and Grievances

One method of identifying opportunities for improvement in processes at NBH is to collect and analyze the content of member complaints. Additional member and provider/practitioner complaints are forwarded to NBH directly from the health plan. The NBH complaints and grievance process has been developed to provide a structure for timely responses to track and trend complaint and grievance data by providing categories into which complaints and grievances may be sorted. Complaint and grievance data is compiled and reported to the QIC at least quarterly.

Fraud, Waste and Abuse Prevention

Nevada Behavioral Health works with the Health Plans to prevent, detect, and correct fraud, waste, and abuse activities. The NBH 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. NBH has established a Fraud, Waste and Abuse Plan that 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 NBH 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 Nevada Behavioral Health to act in compliance with all legal and ethical responsibilities.

The NBH 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 NBH, their contracted network providers and their employees conduct themselves in accordance with the high standards of business and professional conduct established by NBH;
- 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 NBH Corporate Compliance Plan and Anti-Fraud, Waste, and Abuse Plan for more information by contacting the NBH Quality Management and Improvement Director.

Utilization Management

The NBH utilization management program encompasses management of care from the point of entry through discharge using objective, standardized, and widely distributed clinical protocols and enhanced outpatient care management interventions. This manual discusses basic UM requirements as NBH is not currently delegated UM functions. Utilization is handled by the members Health Plan. In the event a UM decision is received by NBH, it will be forward via fax within twenty-four (24) hours of receipt to the members health plan.

NBH maintains a utilization management committee (UMC) which is charged with ensuring that standards and criteria set by regulatory and any accrediting agencies are followed and NBH's capacity to accept delegation. The UMC and the Quality improvement committee share relevant data between committees and work collaboratively to address issues.

Objective scientifically based medical necessity criteria and clinical practice guidelines, in the context of provider or member supplied clinical information, guide the utilization management processes.

UM Staff Responsibilities

The overall clinical responsibility within NBH rests with the Medical Director. 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.

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. Nevada 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 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.

Clinical Criteria

Should NBH be delegated the clinical criteria used by NBH to make admission, level of care and continuing treatment decisions will reflect NBH's philosophy and clinical values. These criteria are assessed and revised at least annually by the NBH Quality Improvement 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 NBH Quality Improvement Committee.

Sources for various criteria include:

- Nevada Medicaid Coverage and limitations Handbooks for Behavioral Health:
    - Community Behavioral Health
    - Specialized Therapeutic Services

    - Targeted Case Management
    - Statewide Inpatient Psychiatric Services
- American Society of Addiction Medicine (ASAM) criteria
- 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 to be disseminated to NBH providers via provider forums, and on the NBH website. A hard copy of UM decision-making criteria may be requested by contacting Nevada Behavioral Health.

Determination of No Medical Necessity

NBH is not delegated to send 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 Health 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. Nevada Behavioral Health 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.

Appeal Process

Nevada 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 Health Plan. In the event an appeal or complaint is received by Nevada Behavioral Health, it will be forwarded immediately to the member's Health plan.

Practitioner Satisfaction with Nevada Behavioral Health UM Processes

Satisfaction surveys are sent, on an annual basis, to those providers who regularly use the NBH 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.

Care Coordination

Continuity and Coordination of Care

NBH monitors continuity and coordination of care throughout its continuum of behavioral health services. Processes are established seeking to avoid disruption of care for the member when there is a change in their treating provider. Such changes may include, but are not limited to:

- A member requires a change in level of care, necessitating a new provider
- A change in health plans or benefit plans
- Termination of a provider

Coordination with Primary Care/Treating Providers

As part of care coordination activities, providers should identify all Providers involved in the behavioral health care and treatment of a member. All coordination, including PCP coordination, should be documented accordingly in the member treatment record. NBH consent forms are available through the website.

Continuation following Provider Agreement Termination

Non-renewal and termination of the provider agreement is the process by which the provider agreement is not renewed at the end of the identified period of time and accordingly ends by its own terms, or the provider agreement is terminated as provided for in the terms of the provider agreement.

All notices of non-renewal and/or termination of the provider agreement should be in writing and in accordance with the applicable terms of the provider agreement.

If a provider chooses to resign from the network and voluntarily surrender participation status, the provider must send NBH written notice of such request and/or notice of termination of the provider agreement. NBH will send the provider written acknowledgement of receipt of the provider's written request/notice and confirmation of the effective date of disenrollment/termination.

On or before the effective date of non-renewal or any termination of the provider agreement, providers must provide NBH with a list of members for whom the provider has rendered services in the six-month period prior to the effective date of non-renewal or any termination of the provider agreement.

Providers must provide thirty (30) day notice of termination to members affected by their termination from the network, as well as make appropriate referrals for continuation of services.

Member Rights and Responsibilities

NBH's Member Rights and Responsibilities Statement is available for download from the website. Providers are encouraged to post the statement in their offices or waiting rooms or distribute the statement to members at their initial visit.

Confidentiality, Privacy and Security of Identification Health Information

Providers are:

- Expected to comply with applicable federal and state privacy, confidentiality, and security laws, rules, and/or regulations, including without limitation the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Responsible for meeting their obligations under these laws, rules, and regulations, by implementing such activities as monitoring changes in the laws, implementing appropriate mitigation and corrective actions, and timely distribution of notices to patients(members), government agencies and the media when applicable.

In the event that NBH receives a complaint or becomes aware of a potential violation or breach of an obligation to secure or protect member information, NBH will notify the provider utilizing the general complaint process, and request that the provider respond to the allegation and implement corrective action when appropriate. Providers must respond to such requests and implement corrective action as indicated in communications from NBH. Providers should make every effort to keep protected health information (PHI) secure.

Questions

Questions about this program may be directed to Nevada Behavioral Health from 8 a.m. to 5 p.m. PST/PDT, Monday through Friday at (702)857-8800.