Carisk® BEHAVIORAL HEALTH

Provider Manual

Miami, FL | Fort Lauderdale, FL | Wall, NJ | Florham Park, NJ
www.CariskPartners.com

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I. INTRODUCTION TO CARISK BEHAVIORAL HEALTH

Welcome to Carisk Behavioral Health, a clinical and behavioral health care company. Thank you for joining our Provider Network and for sharing our commitment to ensuring that Patients have access to high quality, compassionate clinical and behavioral healthcare.

This Provider Manual has been developed to help inform and guide your relationship with us. It describes Carisk's mission, values and philosophy, expectations, services, and policies and procedures based on State and Federal regulations, standards established by accrediting agencies, the healthcare industry and Carisk's Plan clients. When Carisk updates and amends the Provider Manual in response to regulatory changes and/or organizational policy revisions, notifications and a summary of the changes will be provided.

Please contact Carisk if you have questions or need additional information. All of Carisk email addresses are secure and compliant with the Health Insurance Portability and Accountability Act () in conjunction with email encryption services.

Main Phone Number:

Local (Miami-Dade):	305-514-5300
Toll Free:	855-541-5300
TTY:	305-514-5399

Health Plan Members should reference the contact information on their Plan ID Card.

Email:

Care Coordination and Advocacy:	advocacy@cariskpartners.com
Providers Relations:	providers@cariskpartners.com
Credentialing:	credentialing@cariskpartners.com
Claims:	claims@cariskpartners.com

Carisk's business hours are Monday through Friday 8:30 a.m. to 5:00 p.m. EST. A licensed Carisk Manager is available 24 hours a day, 7 days a week (24/7) for urgent and emergency situations and other care-related questions.

A. ABOUT CARISK BEHAVIORAL HEALTH

Mission and Vision

To provide a more responsive and compassionate clinical and behavioral health care and recovery experience.

Carisk Behavioral Health ("Carisk") is committed to clinical excellence and integrated mental/clinical and behavioral complex health care by providing Patients with access to the highest quality care and service at affordable and competitive rates. Carisk's management team has a rich history in the national clinical and behavioral healthcare industry. Carisk was founded in 2011, and in 2014 merged with the University of Miami Behavioral Health, a program that served a broad range of behavioral health populations for more than 20 years.

Founded as a Managed Clinical and Behavioral Healthcare Organization (MBHO) in the State of Florida, Carisk utilizes a foundation of clinical and behavioral health expertise blended with strong managed healthcare experience to coordinate and manage complex cases, generally

taking all the risk associated with the medical costs of the case. Carisk utilizes a robust set of medical outcome and cost data to project an individual's recovery from illness and/or injuries, allowing Carisk to accurately determine bundled medical costs, develop a comprehensive, cost effective treatment plan and project the best potential recovery and return to productive life and work. Carisk's Medical Team is comprised of skilled clinical and behavioral health professionals and Physicians in multi-disciplinary areas including: Traumatic Brain Injury, Spinal Cord Injury, Head Injury, General Trauma, Thoracic Medicine, Burn Specialist, Psychiatry, Psychology, Neurosurgery, Orthopedic Surgery, occupational medicine and other medical disciplines.

Complex cases tend to be low frequency but high acuity. Whether the client is a Group Health Insurer, Self-Insured Plan, Casualty Insurer or other risk bearer, dedicated resources to address complex cases in this segment rarely exist. The Payer world has trusted the medical marketplace and treating physicians to move Patients through the system. This approach is incomplete because Patient psychosocial issues also greatly influence outcomes.

Carisk strives to be the gold standard in the delivery of high quality clinical and behavioral health care benefits while assisting health plans, employers, and governmental agencies in making sound management decisions about these benefits.

Focus on the Whole Patient

The recovery from complex conditions should be managed with extreme focus. Systems of care matter. Putting the Patient at the center, with a true understanding of psychosocial AND clinical needs is paramount. In almost all cases, Patients and their families will be required to adjust to a "new normal." Psychosocial support is an approach to injured parties of catastrophic events that fosters resilience in individuals and family support systems. It aims to ease resumption of normal life, facilitate affected people's participation in their convalescence, and prevent psychological consequences of potentially traumatic situations. This adjustment requires recovery strategies that efficiently address the clinical needs of the Patient while focusing on anxiety, depression and addiction avoidance. Carisk is uniquely positioned to manage the "whole" Patient. Its expertise dealing with complex clinical and behavioral conditions coupled with the management team's deep experience in managed care leverages a "best in class" approach to recovery.

Plan the Work, Work the Plan

The initial Post-Acute recovery phase begins with a plan that the Patient and their family has committed to. A Patient's probability of achieving the highest outcome is driven by the "3Rs" (**R**ight care, **R**ight setting, **R**ight time). Care plans rarely exist for complex cases because the marketplace has never focused on them. Creating a Care Plan in the first few weeks following an incident focuses the Patient, the family and the Psychosocial and Clinical Care teams on the journey ahead. It allows Carisk to coordinate care efficiently, and monitor and adjust to any deviations. In many cases, the Field Care Team accompanies Patients to appointments and supports the Patient and their family throughout recovery.

Additionally important is the strategy of approaching the Network Relationship from the Patient perspective, not the Insurer Type. Carisk is a Complex Care Coordination and Management Payer, buying the case and the risk. The origin of the claim does not drive the treatment plan; rather, psychosocial and clinical needs do. Carisk's approach in evaluating each case in real time, quantifying the Patient's needs, projecting the financial requirements and targeting the "New Normal" using clinical and behavioral tools translates into substantial value. Jurisdictional issues are managed but not at the expense of appropriate Patient care.

Carisk is a licensed Third Party Administrator (TPA) and is accredited by the Accreditation Association for Ambulatory Healthcare, Inc. (AAAHC) and the National Committee for Quality Assurance (NCQA).

From its headquarters in Miami, Florida and regional offices in Fort Lauderdale and New Jersey, Carisk works with a comprehensive clinical and behavioral network, comprised of hospitals, psychiatrists, ARNPs, psychologists, licensed social workers, licensed masters-level psychotherapists, and applied clinical and behavioral analysts (ABA), to ensure Patients receive services that match their unique clinical and behavioral health care needs. Their common clinical philosophy is to meet Patient's clinical needs by delivering timely quality care at the appropriate level by integrating psychiatric, psychological and clinical physical healthcare components while emphasizing early intervention. Positive, cost-effective outcomes are maximized through partnerships and an ongoing clinical consultative relationship with experienced network Providers. In fact, Carisk Providers are very satisfied with the utilization management process, and according to a recent survey, over 90 percent of Carisk Patients were well-satisfied with the overall level of care and quality of services they received.

B. CORE VALUES

Compassion	Do to all persons what you would have them do to you. Walk in the shoes of others.
Integrity	Never compromise quality, ethics and morals. Honor commitments.
Creativity	Think outside the box – innovate. Create the future – maximize its endless possibilities.
Gratitude	Be grateful for the opportunity to employ and serve.
Diligence	Work hard. Excel.

C. PHILOSOPHY, EXPECTATIONS AND GOALS

Carisk administers an integrated care delivery system that ensures all clinical and behavioral healthcare services are clinically responsive, safe, timely, cost-effective, and delivered in a compassionate manner, while remaining a socially conscious company that makes a positive difference in the lives of Patients and those with whom we work. Processes and systems are continually reviewed and improved to maximize clinical and behavioral outcomes.

Carisk's founders have been involved in all aspects of the healthcare system. While the organization's principal commitment is to the health and well-being of Patients, it is ultimately guided by a genuine interest in the satisfaction of all who are involved in the care delivery process and aims to exceed the expectations of Patients and Provider partners by ensuring Patients receive most appropriate, available clinical and behavioral healthcare services in the least restrictive environment possible. Exercising flexibility in the utilization of resources and establishing a collegial, cooperative and collaborative relationship with network Providers achieves a good clinical result. Benefits of partnering with Carisk include:

- Support for the growth of Provider partners that minimizes the time Providers spend on non-client centered practices (e.g.: excessive paperwork or waiting for responses).
- Providers Relations Department and staff that is responsive to the needs of Providers and strives to foster respectful and mutually beneficial partnerships.

- Utilization Management (UM) team and clinical staff that views network Providers as colleagues – healthcare professionals whose clinical judgment is valuable, who share a vested interest in the care of Patients, and whose time is honored and respected.
- Care Managers (Licensed), available 24/7, who are trained to facilitate the referral and pre-authorization process, manage requests for service, facilitate referrals and authorizations, assist and help guide level of care transitions, make care and utilization determinations fairly and answer any coordination of care or UM question that may arise.
- Claims Department and personnel dedicated to the timely and accurate processing and payment of claims submitted by Providers for covered authorized services.
- Team that is open to studying and embracing innovative methods for administering effective and responsive clinical and behavioral healthcare to Patients.

Carisk's expectation of network Providers is that they join Carisk s in promoting high-quality, cost-conscious, compassionate Patient care. Earning Patients' trust and empowering them to make informed decisions regarding their treatment and health are basic aspects of quality care that enhance their recovery process, contribute to treatment compliance and improve outcomes. Patients need to know that when it comes to their clinical and behavioral health care, Carisk's network Providers listen attentively, remember their individual stories, respond compassionately, welcome their questions, and invite their active participation in the planning of care.

Carisk believes that collaboration and coordination of care by treating practitioners contributes to the delivery of safe, effective and clinically appropriate treatment. Communicating with the Patient's Primary Care Physician (PCP) is a central to this process. Carisk Providers are expected to explain the importance of this process to Patients so that they provide written consent for these communications early in treatment. Carisk forms related to informed consent are available in its online Provider Portal.

II. EMERGENCY CARE

A. ACCESS AND AVAILABILITY

Patients with emergencies have access to clinical and behavioral healthcare 24/7 by calling toll-free: 1-855-541-5300 or 305-514-5300.

Linguistic Access. Bilingual (English/Spanish) staff members are available to assist Limited English Proficient (LEP) Patients. Carisk accommodates all other non-English speaking Patients through a telephonic translation service. Hearing-impaired patients can call Carisk's TTY line: (305-514-5399).

Approval. Carisk uses and applies the definition of "emergency medical condition" provided by the Balanced Budget Act (BBA, 1997): *"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part."*

Notification. Emergency Service Providers must make an attempt to notify Carisk within twenty-four (24) hours of the Patient presenting or identification of a Member for emergency services. Emergency Service Providers shall notify the health plan as soon as possible prior to

discharge of the Patient from the emergency care area or notify the health plan within twenty-four (24) hours or on the next business day after the Patient's inpatient admission. Carisk will not deny claims payment based solely on lack of notification for inpatient admissions. When a retrospective (post service) review of the emergency care is required, Carisk will consider the presenting symptoms as well as the discharge diagnosis. Payment of services will be granted based on this information and the determination of medical necessity.

B. PROTOCOL FOR CRISIS INTERVENTION

If the Patient has an adequate support system and can be safely treated on an outpatient basis, this level of treatment can be arranged with a Carisk Care Manager. If a Provider determines that the Patient's condition and/or current clinical and/or mental state requires a higher level of care or more intensive treatment, such as a potential inpatient hospitalization, a Carisk Care Manager will assist with coordinating the hospitalization and facilitating a timely, safe transfer if necessary. Patient safety is Carisk's primary concern.

When a Patient has been admitted to an intensive or acute treatment setting, Carisk's policy is to begin discharge planning at the time of admission. Prior to discharge, Patients must have an after-care appointment scheduled with a Network Provider within seven (7) calendar days of discharge. Carisk's licensed Care Managers will follow-up with the Patient or the Patient's authorized representative to remind him/her of the after-care appointment.

Carisk Providers are expected to be either directly accessible to Patients in an emergency situation, or have an on-call Provider acting in their place for admitting purposes or offer a service that provides direction to a Patient seeking emergency services.

III. ACCESS TO CARE STANDARDS

A. ACCESS CONSIDERATIONS.

Four cornerstone principles serve as the foundation for Carisk's care standards. Access is determined by services and care that are:

1. Available:
    - Can handle service referral without placing Patient on a long waiting list
    - Are located relatively close to Patients
    - Have hours of operation that are reasonable and convenient
2. Appropriate:
    - Medically/clinically indicated and practice is evidenced based
    - Licensed/certified Provider, practicing within the scope of their experience and expertise
    - Providers and facility/office personnel are sensitive to and incorporate individual and cultural values
    - Communication with other clinical and behavioral health or medical Providers
3. Affordable and Effective:
    - Offers value, is clinically effective, and is cost-efficient

4. Acceptable:
    - Patient must find the service suitable and agreeable
    - Patient must feel welcomed, respected, well-regarded and cared for
    - Patient outcomes and satisfaction is key

B. ACCESS TIMEFRAME STANDARDS.

Carisk's standardized access to care timeframe standards guide utilization and care management processes, as well as access to services provided by Network Providers.) Utilization Management (UM) and Quality Improvement (QI) processes enable Carisk to continuously monitor, measure, and evaluate service performance to ensure that it meets or exceeds these standards.

Carisk's Access To Care Standards		
Situation	**Description**	**Timeframe**
Emergency	Services that are required to meet the needs of an individual who is experiencing an acute life-threatening crisis	Access to clinical and behavioral health emergency service **immediately referred to emergency services, 24 hours a day, 7 days per week**
Urgent	Situations that require high priority attention and assessment, although the individual is not in immediate danger	Access to urgent care services within 2**4 hours**
Routine "Sick Care"	Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated	Access to routine "sick care" service within **seven (7) business days**

60-Day Transition of Care. In the event of a change in plan, vendor, or subcontractor, the following will apply:

1. Clinical and behavioral Health Services will not be interrupted during the 60-day transition for network and out-of-network (OON) Providers.
2. Carisk Managers will reach out to the Providers of Patients actively in treatment to discuss their current treatment plan and assist with the transition of care.
3. Carisk Managers will assist new Patients in referrals to new Providers as needed.
4. Carisk Managers and Member Service Representatives will educate Patients and provide clarification about the new plan as needed.
5. Non-contracted Providers will be invited to join the network.
6. For those Patients who are currently hospitalized at the time of transition, Carisk will collaborate with the discharge planners to ensure follow-up services are in place with network Providers.
7. Carisk Claim Business Rules for the first 60 days will be followed:

a. No Claim will be denied due to Provider's OON status.

b. No Claim will be denied due to no prior authorization.

c. No Claim will be denied for ongoing course of treatment within 60 days of transition period.

d. No Claim will be denied for prior covered benefit(s).

8. Carisk will honor any written documentation of prior authorization of ongoing covered services for a period of sixty (60) calendar days after the effective date of enrollment, or, until the Patient's clinical and behavioral health Providers review the Patient's treatment plan.
9. Carisk will honor Providers' rates for a minimum of 60 days and may negotiate services rendered afterward.

IV. AUTHORIZATIONS & REFERRALS

A. STAFF AVAILABILITY AND ACCESS.

Representatives from all Carisk departments are available to personally assist Providers:

1. **Routine (Non-Urgent) Contact:** Our business hours are: Monday – Friday from 8:30 a.m. to 5:00 p.m. EST.
2. **After Hours Service Calls/Emergencies:** Calls received through our after-hours service are responded to within **thirty (30) minutes** from receipt of call. For urgent and emergent needs, UM determinations are immediately addressed and appropriate action(s) are taken. Non-urgent calls received after business hours are responded to by a licensed Care Manager no later than **one (1) business day** from receipt of the call, unless otherwise agreed upon (outbound calls).

B. INITIAL AUTHORIZATION AND REFERRAL PROCESS.

When Patients contact Carisk with a request for service, a Carisk Representative assists in arranging needed care, including:

1. Conducting the initial screening to identify the presence of an emergent/urgent/complex need and engaging a Care Manager (licensed Behavioral Health professional) in the process when necessary
2. Confirming Patients' identifying information (e.g.: name, phone, date of birth, and zip code)
3. Verifying eligibility and benefits – informing Patient of any limitations and/or financial obligations, when applicable. (When a Patient's health plan excludes coverage for needed care/service, the Care Coordinator provides information about available care options, community resources, coordinates referrals, and/or may seek the assistance of a Care Manager)
4. Identifying access to care barriers and effectively helping to remove/minimize them
5. Guiding Patients and Providers through the referral and authorization process until successfully linked to the service

C. INITIAL AUTHORIZATIONS AND REFERRALS: OUTPATIENT (ROUTINE) SERVICES.

1. **Patient Request for Initial Outpatient Authorization (As determined by plan benefit grid or the appropriate approved treatment plan):** Patients can access initial outpatient clinical and behavioral healthcare services in various ways. For example, a Patient or a designated Patient representative (e.g.: a family Patient/authorized representative) can contact Carisk directly, or a Patient's Primary Care Physician (PCP), or a representative from the Patient's plan can contact Carisk to request services for the Patient.
2. **Provider Selection:** If a Patient or the Patient's authorized representative contacts Carisk, its Member Services Representatives verify that the Patient is covered and eligible, and guide the Patient through the Provider selection process. This process may also be initiated by a Care Manager, who completes a brief telephonic assessment to assist in making an appropriate referral based on the Patient's responses. If the Patient has been previously treated by one a Carisk practitioner, they are offered the opportunity to return in an effort to enhance continuity. When they need to be referred to a Provider, the selection process will consider such factors as:
    a. The Patient's medical/clinical necessity, level of care, and the type of services that best meets their clinical needs
    b. Any special needs, access requirements, individual preferences – including ethnic, gender, cultural, linguistic (as the Patient's condition permits)
    c. The Provider is eligible for participation in the plan
    d. (For Medicaid only) The Provider has a Florida Medicaid Provider number
    e. The Provider's cultural and linguistic competence
    f. The Provider's geographic proximity to the Patient
    g. The Provider's availability
3. **Patient Choice:** Carisk honors, respects and protects the Patient's right to self-determination, participation in treatment planning decisions, and personal choice. Carisk allows each Patient to choose among network Providers to the extent possible and appropriate. Carisk staff will offer the Patient the names of qualified clinical and behavioral health care Providers and their contact information, making every effort to match the Patient's needs to Providers who are best suited to meet them. The Carisk Representative will assist the Patient with making an appointment with a conveniently located Provider. In some cases, a Carisk Coordinator will accompany the Patient to the appointment.
4. **Provider Requests for Initial Outpatient Authorization:** Carisk's initial authorization policies are consistent with industry standard treatment plans. Some services will require pre-authorization and others will not. Services such as Targeted Case Management, Psychosocial Rehabilitation, and Psychological Testing will require ongoing concurrent reviews for medical necessity determinations related to this level of care. Prior to paying a claim, Carisk will always verify eligibility and benefits and ensure that the Patient was eligible for the billed service on the respective billed date. Carisk will also ensure adherence to the service limitations. Providers can also request authorization online through the Carisk Provider Portal at www.cariskbh.com.

    To submit prior authorization requests for clinical and behavioral health services, please

send the *Outpatient Clinical Review Form or the required supporting clinical documentation for medical review* via secure email to careadvocacy@cariskpartners.com. (type SECUREMAIL anywhere in the subject line of the e-mail to encrypt it).

D. ROLE OF THE CARE MANAGER IN THE INITIAL AUTHORIZATION AND REFERRAL PROCESS.

If the request is determined to present an emergent, urgent or complex need, the Member Services Representative immediately transfers the Patient to a licensed Care Manager who assesses the need, screens for the presence of imminent risk(s), and takes immediate measures to help ensure Patient safety. he Care Manager determines the most appropriate level of care, arranges disposition, and coordinates the provision of the needed service.

E. GENERAL STANDARDS, REQUIREMENTS AND CONSIDERATIONS.

1. Carisk determines Patient eligibility for clinical and behavioral health services through:
    a. Eligibility and benefit coverage at time of service request
    b. Medical necessity/clinical criteria, level of care (LOC) guidelines
2. To ensure fairness and equity, all authorization decisions/utilization review determinations are made by licensed clinical staff consistently applying evidence-based industry standards and published treatment protocols.
3. When appropriate and/or necessary, the requesting Provider is consulted/peer-to-peer review is coordinated.
4. All concurrent reviews are conducted with oversight by the Chief Medical Officer and supervision by the Director of Utilization Management; the Chief Medical Officer is available 24/7 for consultation on utilization decisions.
5. Any compensation to individuals or entities that conduct UM activities/care determination for Carisk is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Patient.
6. Carisk strives to respond to all care determination requests expediently and meet or exceed the national, state and industry standards.

F. CONTINUED AUTHORIZATION: CONCURRENT REVIEWS

1. **Communication and Coordination of Care with Other Health Providers:** The Outpatient Clinical Review Program urges Providers to communicate with the Patient's Primary Care Provider (PCP) to coordinate care after securing permission from the Patient. While a referral from a PCP is not required to access clinical and behavioral health care service, Carisk policy requires that network Providers establish communication with the PCP and considers it essential in promoting and ensuring safe, quality care. Communication and the coordination of care between clinical and behavioral health clinicians and PCPs improves the quality of Patient care by:
    a. Minimizing potential adverse medication interactions
    b. Promoting early detection of medical conditions that might be contributing to or causing symptoms

c. Providing more efficient and effective treatment

d. Promoting early identification of non-compliance with treatment

Continuity and Coordination among all levels and practitioners of behavioral health care and primary care physicians (PCPs) is considered a reasonable standard of practice, and is monitored and expected by Carisk.

a. For inpatient admissions, continuity and coordination starts with the notification of the admission to the Patient's PCP and then at discharge by providing the PCP with the discharge summary. Should the discharge plan include a referral to Partial Hospital Program, IOP (intensive outpatient program), or outpatient counseling or treatment, the PCP needs to be informed by progress reports or summaries at each level of care by the practitioner(s) at that level of care.

b. Continuity and coordination with the PCP is essential if the Patient accesses outpatient visits and does not require more intensive levels of behavioral healthcare. The frequency required for outpatient practitioner's coordination is dependent on the diagnosis and treatment.

c. Coordination with the PCP is essential when medication is prescribed and/or modified.

d. Continuity and coordination between behavioral health and PCPs is essential in reporting the results of psychiatric consultations performed at hospitals and nursing homes. The attending physician requesting the consult benefits from the timely receipt of the report of the psychiatric consultation and may need or wish to discuss the consult with the Psychiatrist.

2. **High-risk communication criteria:** Circumstances in which communication between clinical and behavioral health practitioners/Providers and medical care Providers/specialists should occur to promote optimal, safe and effective clinical and behavioral health care include:

a. Patients with a pre-existing medical condition treated by their PCP with medications that may impact psychiatric symptoms

b. Patients with clinical or behavioral symptoms that may be a side effect of prescribed medication(s) or that may be masking an underlying undiagnosed/untreated medical disease (e.g.: metabolic disease, neurological disorder or other medical condition that need to be ruled out and treated, if present)

c. Patients prescribed psychotropic medications by their PCPs

d. Patients prescribed psychotropic medications by their Psychiatrist

e. Patients with a history of substance abuse – especially a history of abusing prescribed medications

f. Patients whose safety may be at risk – suicidal/homicidal/other impulses

g. Patients whose mental status suddenly changes for the worse

h. Patients with a history of recent falls (especially an elderly client)

i. Patients who fail to improve or show sufficient response to clinical and behavioral treatments

3. **Communication Between Clinical and Behavioral Health Providers:** Carisk requires the exchange of information between clinical and behavioral health practitioners who are providing concurrent care. Patients should be educated early in treatment about the importance of providing a signed informed consent to release confidential information and authorize this essential communication during their episode of care.

4. **Request for Authorization of Psychological Testing:** Psychological testing or standardized tests, when determined to be medically necessary, are considered to be a routine part of the assessment process for any clinical and behavioral health service.

   Psychological testing and psychosocial issues may play an important role in determining the appropriate course of treatment when the normal assessment process, such as clinical interview, mental status exam, medical and psychiatric history, or bio-psychosocial assessment (including prior clinical assessments) has not provided sufficient evidence to make a substantiated diagnosis, develop appropriate interventions, and formulate a meaningful treatment plan.

   All psychological evaluation/testing must be based on medical necessity for the purpose of appropriately treating a medical condition, must be pre-authorized dependent on plan requirements and must be conducted by a qualified licensed psychologist trained and experienced in administering the testing tool. Some of the considerations a Carisk Manager will take into account when determining authorization include, but are not limited to:

   a. Will the evaluation yield answers to diagnostic questions when other means of assessment (e.g.: clinical interview, etc.) have been ruled out or exhausted?
   b. Will the evaluation help clarify the most appropriate diagnosis when presenting symptoms suggest two or more possible diagnoses?
   c. Is the testing integral to effective treatment planning and might it yield new information regarding the best form of treatment (testing that yields information that will not be applicable to treatment goals is discouraged)?
   d. Is it confirmed that the testing is not for purposes of research, educational evaluation, medical procedures or career placement?

5. **The Role of the Care Manager in Concurrent Reviews:** A Carisk Manager (a qualified clinical and/or behavioral health professional, duly licensed to practice), with oversight by the Chief Medical Officer and Director of Utilization Management, will review the updated information. The review will take into consideration the clinical information provided, the information contained in the utilization management database regarding the Patient's episode of care, and other relevant information. The decision-making process will apply the medical necessity (clinical) as well as the benefit coverage criteria.

   The Care Manager may contact a Provider to gather additional clinical information, and will collaborate with Providers in ways that promote Patient safety and enhance positive outcomes to discuss aspects of care, such as: communication and coordination of Patients' care with their PCP, possible risk factors and their management, additional and/or alternative treatment options, clinical approaches or modalities, community resources to consider, discharge/termination criteria and planning process, aftercare considerations, and any other pertinent aspects of care that can contribute successful, effective treatment.

Carisk's Manager can serve as a resource to Providers to:

a. Help identify Patients who are, or may be, at risk and collaborate to coordinate and deliver the appropriate care

b. Facilitate communication and exchange of information between medical and behavioral health Providers, with Patient consent

c. Offer clinical consultations with medical staff

d. Provide references for web-based resources and tools that can support informed decision-making involving care (e.g.: relevant evidenced based techniques, treatment options, innovative practices, ancillary community resources, etc.)

e. Provide information regarding clinical practices that can promote stabilization and recovery, engage Patient's active participation in treatment and increase the likelihood of positive treatment outcomes.

G. ACUTE INPATIENT AUTHORIZATIONS & OTHER INTENSIVE LEVELS OF TREATMENT

1. **Initial Authorization:** Except in the case of a clinical or behavioral health emergency, inpatient acute care and intensive levels of care require pre-authorization. All requests are coordinated through Carisk's Acute Care Department with oversight by the Chief Medical Officer and supervision by the Director of Utilization Management. As in requests for outpatient services, determinations are based on the Patient's plan eligibility and coverage at the time of the request and medical necessity.

2. **Authorization for Continued Care/Stay:** Requests for authorization to continue acute inpatient levels of treatment require a concurrent review that is conducted telephonically. The review is performed by an Acute Care Manager or onsite by a Carisk Manager. These reviews are scheduled in advance with the facility's utilization review staff / designee and may be conducted 24/7. The reviewer will gather sufficient information to enable a care determination, including an update on Patient's clinical and behavioral presentation and symptoms, level of function, treatment progress, and discharge planning. At minimum, when authorized, the services will be approved through the next business day for inpatient or urgent care initial review or concurrent review cases. Confirmation of certification/ authorization for continued hospitalization or services will include the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

3. **Coordination of Hospital Discharge Planning:** The concurrent review process for acute inpatient (hospital) treatment and care includes the coordination of discharge planning for admissions to ensure inclusion of appropriate post-discharge care. Appropriate discharge planning, at minimum, must include, but is not limited to Patients, who are admitted to and discharged from an acute care facility (inpatient hospital), shall receive appropriate follow-up services with seven (7) days of discharge from the acute care facility, provided that the facility notified Carisk it had provided services to the Patient.

H. NOTICE OF AUTHORIZATION

Once Carisk has pre-authorized care, Carisk's service authorization systems shall automatically fax, email or mail to the Provider a Notice of Authorization, including the authorization number and effective dates for authorization.

It is important to confirm the accuracy of the information contained in the *Notice of Authorization*, including that the Providers identifying information is correct and that the authorization reflects the specific service(s) they will be providing. If an error is detected, Providers must contact Carisk immediately to rectify the information. Failure to do so may render a denial of payment. Carisk will not grant retrospective authorizations for non-emergency, routine care.

I. NOTICE OF DENIAL OF SERVICES

1. All utilization management reviews consistently apply The Mihalik Group's Medical Necessity Manual for Behavioral Health. Carisk also refers to the Medicare Local Coverage Determination and National Coverage Determination criteria, and the Carisk Medicaid Level of Care criteria (LOC).
2. All decisions to deny a service authorization request, or limit a service in amount, duration, or scope that is less than requested, are made by health care professionals who have the appropriate clinical expertise in treating the Patient's condition or disease. Only Carisk's Chief Medical Officer, a licensed Physician Advisor or Peer Reviewer can issue a service denial. The review shall be part of the UM process and not part of the clinical review, which may be requested by a Provider or the Patient, after the issuance of a denial.
3. Carisk shall provide written confirmation of all denials of authorization to Providers, the Patient and the health plan.

V. UTILIZATION MANAGEMENT (UM) PROGRAM: Clinical Criteria and Utilization Review (UR) Processes

A full written description of Carisk Clinical and Behavioral Health Utilization Management (UM) Program is available upon request.

A. UM PROGRAM OVERVIEW

Carisk's UM Program is a part of the Quality Improvement Program and overseen by the Chief Medical Officer in collaboration with the Clinical Services Executive, and the Director of Quality Improvement. The Program's main goals are to provide for fair and equitable care-decisions include assuring care is:

1. Medically necessary and clinically appropriate,
2. Provided in a safe, timely manner, and
3. Cost effective (of value)

These goals and objectives are accomplished through two key components:

1. By developing and adopting clinical standards and medical necessity criteria to inform and guide the care utilization decision-making process, promote their consistent use (within the organization and among network Providers/facilities), identifying patterns of under/overutilization and ensuring Patients have equitable access to needed care across the spectrum of network service programs, care facilities and practitioners.
2. By monitoring Network utilization and claims practices to identify patterns and trends that may be incongruent with Carisk's established utilization criteria and accepted national and community standards; assessing and intervening when these suggest Providers activities

outside the scope of ethical practices, and/or may be suggestive of improper/illegal activity–fraud, waste and abuse.

The UM Program and its respective policies and procedures are reviewed annually and revised as needed as an integral part of our Quality Improvement Program.

B. KEY UM PROGRAM MONITORING COMPONENTS

The Program's monitoring activities may include, but are not limited to the following processes:

1. Outpatient and Inpatient utilization
2. Triage and Referral
3. Intensive Care Advocacy: High Risk Cases
4. Emergency Clinical and Behavioral Health Care Services
5. Concurrent Review
6. Denials and Appeals
7. Assessment of acuity and level of care
8. Drug Utilization Review
9. UM Program Evaluation
10. Inter-rater reliability for Medical Necessity Criteria
11. Evaluation of new clinical technology and applications for existing clinical technologies
12. Patterns of over and under utilization
13. Care Coordination and Care Advocacy
14. After-Hours Coverage
15. Authorizations
16. Retrospective Review
17. Discharge Planning
18. Satisfaction Surveys (re: UM Process)
19. Staff training

C. PROGRAM COMPLIANCE WITH FEDERAL & STATE REGULATIONS

The UM Program has the duty to monitor and evaluate the safety, timeliness, medical necessity, clinical appropriateness and integrity of services provided by Carisk and its Providers Network. The UM Program is consistent with 42 CFR 456, including but not limited to:

1. Establishing procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses.
2. Reporting fraud and abuse information identified through the UM Program to AHCA's Program Integrity unit.
3. Providing mechanisms and processes that include:

a. Protocols for prior authorization and denial of services that include consultation with the requesting Provider, when appropriate and independent peer reviewer, as needed

b. Service authorization systems that provide the authorization number and effective dates for authorization to Providers and non-participating Providers and written confirmation of all denials of authorization to Providers

c. A process for:

   i. i. Review of authorization requests that do not delay service authorization if written documentation is not available in a timely manner. (This does not, however, imply that Carisk is required to approve claims for which it has received no written documentation.)

   ii. Evaluation of prior and concurrent authorizations

   iii. Retrospective reviews of both inpatient and outpatient claims

   iv. Hospital discharge planningAssuring Patients are able to obtain a second medical opinion and payments of claims for such services are authorized (in accordance with Federal and State regulations where Carisk operates)

   v. Physician profiling

d. Mechanisms that provide for assurance that:

   i. Review criteria for authorization decisions are consistently applied

   ii. Only the Chief Medical Officer, a licensed Physician Advisor or Peer Reviewer is authorized to issue a denial for an initial or concurrent authorization of any request for clinical and behavioral health services and that the review be part of the UM process and not part of the clinical review (which may be requested by a Provider or the Patient, after the issuance of a denial)

   iii. Compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Patient

D. UM PROGRAM STAFF – AVAILABILITY AND QUALIFICATIONS

Qualified Reviewers: All utilization reviews are conducted by qualified, licensed clinical and behavioral health professionals whose education, training and experience are commensurate with the UM reviews they conduct. Their overriding responsibility consists of ensuring that Patient's available clinical and behavioral health benefits are appropriately used and/or maximized. In some cases, when the clinical judgment needed is highly specialized, Carisk may call on an outside expert for consultation.

E. MEDICAL NECESSITY AND LEVEL OF CARE CRITERIA

Clinical care determinations are based on medical necessity criteria, adopted level of care (LOC) and evidence-based practice guidelines. Carisk actively involves practicing practitioners in the review, revision and adoption of medical necessity criteria, including procedures for applying the criteria.

1. **Medical Necessity:** Carisk defines medical necessity as services provided by a qualified

clinical and behavioral health practitioner or Provider organization to identify or treat an illness that has been diagnosed, or is suspected, due to reported symptomatology.

a. Medically necessary services or allied care services/goods furnished must meet the following conditions:

   i. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain

   ii. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Patient's needs

   iii. Be consistent with generally accepted professional medical standards as determined by the program, and not experimental or investigational

   iv. Be 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

   v. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the Providers

b. "Medically necessary" or "medical necessity" for inpatient hospital or CSU services requires that those services furnished in a hospital could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a Provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

2. **Medical Necessity for Acute Inpatient:** In determinations for authorizing inpatient hospital services, additional considerations include, but are not limited by, evaluating the following:

   a. Is the service necessary to protect life, prevent significant illness and/or significant disability?

   b. Can the attending clinician provide sufficient clinical information for an adequate care-determination?

   c. Does clinical information provided indicate a history of inpatient admissions with failure to sustain gains on discharge?

   d. Is another inpatient admission likely to improve the Patient's condition or symptomatology?

3. **Medical Necessity Manual:** Carisk has procedures for applying Evidence Based Medical Necessity Criteria, based on *The Mihalik Group's Medical Necessity Manual for Behavioral Health* the individual needs of the Patient, as well as the capabilities of the local delivery system. When a Patient's needs fall beyond the definition and scope of the criteria, the case is referred to a Peer Reviewer. Peer Reviewers are expected to make a clinical determination through a thorough and careful review of each case consistent with the standards of good medical practice and medical necessity criteria. Clinical determinations also take into account the individual clinical and psychosocial circumstances of the Patient

and actual resources available. If the local delivery system cannot meet the needs of the Patient, Carisk authorizes a higher level of care to ensure that services will meet the Patient's needs for safe and effective treatment.

Carisk's clinical mission is to ensure that Patients are provided clinically relevant care that is appropriate and timely. Its policy is that care must be provided in the least restrictive environment in order to empower Patients to address their symptoms and help utilize their strengths to work towards independence in daily activity and functioning. Care must also be focused on building resiliency and effective coping mechanisms that will lead to a healthier life.

Carisk does not reward or offer incentives to encourage any type of non-authorization or underutilization of clinical and behavioral health services.

4. **Level of Care Guidelines:** Appropriate level of care determinations are founded on the principle that care must be provided in the safest, least intrusive, least restrictive and least disruptive setting and manner that can be reasonably expected to effectively treat the Patients injury, illness, intensity of acute symptoms and Patient's functioning. At any level of care, Carisk emphasizes individualized treatment, where Patients may enter treatment at any level and be moved to more or less-intensive levels of care. Treatment interventions must be evidence- based and not experimental in nature. Outpatient treatment must be based on solution-focused models of care.

   Carisk's UM Program has adopted Care and Coverage Guidelines, Level of Care Criteria (these include the ASAM) and treatment guidelines by nationally recognized sources for acute and chronic clinical and behavioral health and substance abuse conditions. The Quality Improvement Committee is responsible for the development, review and revision of these tools. The guideline selection process includes annual identification of high risk/ high volume Patient demographic data obtained from claims. At least every two (2) years, the Carisk Level of Care Criteria and the Care and Coverage and treatment guidelines are reviewed and when applicable, updated by the Committee. When new scientific evidence or nationally recognized standards are published before the two-year review date, the committee reviews the guidelines at the time the new scientific evidence and/or nationally recognized resource is published and revisions to the guidelines are made when indicated.

   Contact Carisk for more information on medically necessary criteria, its UM Program, or QI Program.

F. FUM PROGRAM DECISIONS AND TIME FRAMES

1. **Pre-service and Concurrent Reviews:** Carisk makes timely care decisions that will promote ease of access to care and minimize disruptions to the delivery of services to Patients, starting at the time a request is received for initial or continued care authorization. The timeframes for UM decisions, which comply with State and/or Federal guidelines, are dependent on and responsive to the nature of need and/or the type of service requested.

Care Decision Timeframes		
REQUEST: (Verbal or Written Notification / Request)	**Pre-Service:** Any care or service that Carisk must review to determine authorization, in whole or in part, in advance of the Patient obtaining care.	**Concurrent:** Any care or service that Carisk must review to determine authorization, in whole or in part, during the course of the Patient's treatment
Urgent Care	**Pre-service *urgent care* request:** The review is conducted and completed as soon as possible and no later than **seventy-two (72) hours** from the date and time of receipt of the request.	**Concurrent urgent care request:** The review is conducted and completed within **twenty-four (24) hours** of the date and time of the request
Non-Urgent Care	**Pre-service *non-urgent* care request:** The review is conducted and completed within **fourteen (14) calendar days** from the date of receipt of the request	**Concurrent non-urgent care request:** The review is conducted and completed are reviewed and completed within **fourteen (14) calendar days or less** from the date of receipt of the request

Notifications of both urgent and non-urgent concurrent care decisions include the new total days or services authorized, the date of admission or onset of services, the number of days or units of service approved and the next anticipated review point.

2. **Post-service Reviews (a/k/a Retrospective Reviews):** These UM reviews are conducted after the completion of a course of treatment. The services were neither pre-authorized nor denied by Carisk. Post-service review determinations and notifications are made within ***fourteen (14) calendar days***. Retrospective reviews require the complete treatment record for the dates of service under review. Providers have ***forty-five (45) calendar days*** from receipt of the notice requesting submission of the information.
3. **Peer Reviews:** When a Patient's needs fall beyond the definition and scope of the criteria, the case is referred to a Peer Reviewer. Peer Reviewers are expected to make a clinical determination by conducting a thorough, careful and independent/objective review of each case consistent with the standards of good medical practice and medical necessity criteria.
4. **Consideration of the Individual's Circumstances:** UM clinical determinations also take into account the individual clinical circumstances of the Patient and the actual resources available. If the local delivery system cannot meet the needs of the Patient, Carisk may authorize a higher level of care to ensure that services will meet the Patient's needs for safe and effective treatment.
5. **Drug Utilization Review:** The Drug Utilization Review (DUR) process is carried out in collaboration with treating physicians and is designed to encourage coordination between a Patient's PCP and a prescriber of a opioids, psychotropic or similar prescription drug for clinical and behavioral health problems. It aims to identify those medications for

other serious medical conditions (such as hypertension, diabetes, neurological disorders, or cardiac problems), where there is a significant risk to the Patient posed by potential drug interactions between drugs for these conditions and clinical and behavioral-related drugs. When it identifies the potential for such problems, the DUR process notifies all related prescribers that certain drugs may be contra-indicated due to the potential for drug interactions and shall encourage the prescribers to coordinate their care. Notice may be provided electronically or via mail, or by telephonic or direct consultation, as the deemed appropriate by Carisk's reviewer.

6. **In making all UM decisions, Carisk:**
    a. Does not encourage decisions that result in under-utilization
    b. Does not provide financial incentives for UM decision-makers
    c. Does not reward practitioners contingent on their issuing of denials
    d. Decision-making is based only on the appropriateness of care and available benefits
    e. Is very focused on addiction avoidance

G. DENIALS AND APPEALS

Carisk makes every reasonable effort to avoid disagreements with Patients and Network Providers regarding utilization management decisions. If attempts to negotiate a mutually acceptable outcome are not successful the Patient, treating Provider or practitioner acting on the Patient's behalf or a designated Patient representative has the right to file a complaint or grievance with Carisk. Carisk's care management workflow allows it to maintain a detailed record of reviews and determinations so that the process is timely and sensitive to needs of those involved. This process ensures timely follow-up, and peer reviews.

Providers can call Carisk's UM/Care Coordination Department for assistance on how to proceed with any formal complaint, grievance, or request for reconsideration/appeal of a UM determination. Depending on the plan, Grievances and Appeals may be handled through the health plan and not delegated to Carisk.

H. CARISK'S OUTREACH PROGRAM AND PATIENT ADVOCACY SERVICES

1. **Patient Advocacy Program:** The Patient Advocacy Program exists to bring recognition to the voice and individualized needs of the Patient, while simultaneously providing for a designated company representative who works to create an alliance with local community service agencies. Three specific areas of service are included:
    - Patient Support
    - Community Outreach
    - Interdepartmental Relations

    This component is adjusted and individually tailored toward empowering Patients and providing for a higher quality of life, while decreasing recidivism.

    Patients can be referred to the Patient Advocate by Carisk Managers when a Patient expresses he/she is experiencing barriers in complying with follow-up services as a result of a, has a limited support system, clinical and community-based services are not meeting

the Patient's needs, and when the Patient is non-compliant with follow up care or refusing follow-up services.

Upon referral, the Carisk Patient Advocate contacts the Patient to discuss his/her request for assistance. The Patient Advocate can serve as an intermediary between the Patient and the service Providers to expedite service delivery and ensure that Patient's needs are being met and providing assistance to high risk Patients.

Patient Support: The Patient Advocate will provide the following supportive services to our Patients:

- Educate Patients in accessing and obtaining services
- Educate Patients in emphasizing the need to maintain well-being and developing proactive skills to aid in their recovery aimed at preventing an inpatient admission
- Focus on individualized services needed to ensure that quality care is provided to our Patients in addition to needed resources that are essential for them to begin recovery/ reintegration on an outpatient basis
- Conduct outreach to those Patients who are non-compliant with treatment and do not comply with follow up appointment
- Provide support for families of Patients

I. INTEGRATED CARE COORDINATION PROGRAM

The mission of the Integrated Care Coordination Program is to coordinate and to create a network of services that wrap around the Patient, to meet his/her individualized needs, and to facilitate and encourage the high risk Patient's adherence to follow up treatment from an in-Patient admission. The program also serves Patient's identified to be high risk who present with Special Care Needs (severe psychosocial stressors, severe mental illness, severe medical comorbidity, etc.) The goals of the Integrated Care Coordination Program are to reduce recidivism among the high-risk population, including reducing the rate of hospital readmissions.

Carisk's Integrated Care Coordination Program is responsible for coordinating, tracking, verifying, and ensuring that all high risk Patients have continued access to follow-up services and community resources within 7 and 30 days of discharge from an inpatient facility. High-risk Patients are those who have experienced an inpatient admission and have co-morbidities. High-risk Patients are differentiated into two tiers. Tier one high risk Patients are those who have experienced more than one admission within a given month or those Patients who have a history of multiple admissions without follow up compliance to their outpatient services. Patients who have had an inpatient admission but who do not meet criteria for Tier One are categorized as Tier Two.

1. **Welcome Home Program:** Through Carisk's Welcome Home Program, all Patients discharged from an inpatient admission receive a call or visit from a Carisk Integrated Care Coordinator Specialist. The Carisk staff ensures that a post-discharge appointment is scheduled, that the Patient is reminded of the appointment, and subsequently verifies that the Patient has attended.

   Carisk Integrated Care Coordinators work with the inpatient facilities and Providers to develop and manage an individualized outpatient treatment plan following hospital discharge. This collaborative approach helps the Patient receive the most appropriate post

hospital treatment.

The Welcome Home Program process begins at the inpatient level with a visit or telephonic communication with the facility's discharge planner to inform him/her about the Patient's prior outpatient treatment and to offer Provider referrals. The Integrated Care Coordinator also takes this opportunity to be of assistance to the discharge planner with the tentative aftercare plan.

The Integrated Care Coordinator calls the Provider's office after the scheduled date of the aftercare appointment to verify that the Patient attended the appointment. If the Patient did not attend the outpatient appointment, the Integrated Care Coordinator contacts the Patient to offer assistance in rescheduling the appointment, attempting to engage or even accompany the Patient into the treatment process. If the Coordinator is unable reach the Patient by phone, a follow up letter is sent to the Patient's address listed upon discharge and a care coordinators visit will be attempted.

The Patient's compliance with the outpatient follow-up appointment is documented to allow evaluation of program effectiveness.

2. **Complex Case Management Programs:** Patients must give informed verbal consent to participate in the Complex Case Management Programs. Based on the severity of symptoms and level of functioning Patients are assigned an acuity level that corresponds to a frequency of contacts. As Patients show improvement, their acuity level and the frequency of contacts should decrease until they meet the discharge criteria of the program they have been assigned to.

    a. **The Complex Medical Needs Program:** The mission of the Complex Medical Needs Program is to facilitate effective coordination of care services, between medical and clinical and behavioral, for Patients suffering from co-morbid diagnoses or Patients who experience other barriers to positive treatment outcomes. The goal of this program is to assist the Patient in receiving the best quality clinical and behavioral-medical care coordination possible so that they experience a successful treatment outcome.

    Patients who have been diagnosed with co-morbid medical and behavioral health diagnoses that are identified as requiring more intensive coordination of services are eligible for the program. Patients who may also be included in this program are those who encounter barriers to getting needed care and need help navigating the healthcare system; those who receive treatment from many different Providers, those who have problems following treatment plans, and those who have competing psychosocial concerns.

    Patients are discharged from the program when there is evidence that they are well-established and successful in outpatient care.

    b. **Integrated Care Coordination Staff Roles and Responsibilities:** With daily oversight by the Chief Medical Officer, the Manager of the Integrated Care Coordination Department has the primary responsibility to oversee the day to day care coordination related to all of our high risk populations. The Integrated Care Coordination Staff consists of licensed clinical and behavioral health professionals, certified substance abuse counselors, and support staff.

    The Integrated Care Coordination Staff are responsible for tracking and monitoring the

aftercare compliance for Patients assigned to them as well as the coordination of care for other high risk Patients.

The Patient Advocacy Representative helps develop and implement an advocacy protocol designed to assist, educate, and advocate for the best interests of Patients.

c. **Evaluating Effectiveness:** Carisk's Service Coordination Program, including the services provided by the Patient Advocate, is evaluated by measuring:

- Rates of ambulatory follow-up following inpatient admission
- Patient complaints
- Patient satisfaction

J. SATISFACTION WITH THE UM PROCESS

Carisk measures Patient and Providers satisfaction with the UM Program processes annually. Its Provider and Patient Satisfaction Surveys include questions specific to the UM Program. Carisk also reviews reported Provider and Patient complaints regarding its UM Program. When these measures identify opportunities for improvement, the Quality Improvement Director presents the findings to the Quality Improvement Committee. Changes to UM policies, procedures and processes may be recommended by the Committee and Carisk's Director of Utilization Management is responsible for their implementation. Input from health plan Patients and Network Providers is always appreciated.

VI. QUALITY MANAGEMENT AND QUALITY IMPROVEMENT (QI) PROGRAM

A full description of Carisk Clinical and Behavioral Health Quality Improvement (QI) Program and a progress report in meeting its goals is available upon request.

A. QI PROGRAM OVERVIEW

1. Carisk is committed to the continuous improvement of the quality of care that Patients receive, as evidenced by the outcomes of their care. It aims to meet or exceed the needs and expectation of those who use its services by ensuring that:
   a. Treatment provided incorporates evidence based, effective practices
   b. Treatment and services are appropriate to the needs of each individual served, and available when needed
   c. Safety is priority – managing/reducing/eliminating risk to Patients, Providers and staff takesprecedence; preventing medical errors and complications are of primary importance
   d. The Patient's individual needs and expectations, or those they designate as representative are respected; they are given the opportunity to participate in treatment decisions; services are provided with sensitivity, compassion, and cultural competence
   e. Treatments and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and service Providers
2. Carisk's QI Program philosophy recognizes that quality management and improvement are key to success. The Program is guided by a *quality management philosophy* that believes

all systems, processes and activities can be continuously improved through the application of techniques and quality-building strategies, including:

a. **Discovery:** The formal process of systematically and objectively monitoring and reviewing care; actively collecting information, data, and feedback; analyzing findings and identifying trends, strengths and opportunities for improvement

b. **Remediation:** The formal process of implementing corrective actions to overcome barriers to quality care, resolve specific problems and/or remedy deficiencies; ensuring follow-up to assess the effectiveness of the corrective actions taken; problems identified are resolved based on the prevailing community practices and professional standards of care

c. **Continuous Improvement:** The formal process of utilizing the information obtained through QI monitoring processes in ways that lead to specific quality enhancements

B. PROVIDER PARTICIPATION

1. Carisk is committed to fulfilling its commitment to excellence and seven QI principles, with Providers' support:

   a. **Patients Come First:** Carisk is Patient-driven. Its services must be responsive and designed to meet the needs/requirements of Patients. It places emphasis on identifying and understanding their needs, requirements, preferences, and expectations and sets out to meet or exceed them. Ultimately, those who use its services and receive care are best positioned to evaluate and determine their quality. Patient feedback is valuable in helping Carisk drive quality improvement initiatives and the design and implementation of new services.

   b. **Recovery Oriented Services:** Carisk is committed to promoting recovery-focused, strength- based services that empower Patients by focusing on their strengths and potentials. It encourages Providers to teach Patients the skills necessary to utilize their existing natural support systems and access supportive community services. It encourages the use of interventions that preserve wellness and expand choice and self-determination.

   c. **Data Informed Practice.** Successful QI processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions. Tools and methods that turn data into information and foster knowledge and understanding are used to inform Carisk's quality-care decisions.

   d. **Quality Improvement is Continuous:** Carisk, network Providers, and Patients need to be accountable. In order to achieve the highest levels of quality and performance excellence, improvement needs to be a regular part of daily work. Small incremental changes make an impact and Providers can almost always find an opportunity to make things better in how they deliver their services. A continual process of data-gathering, measuring, and analysis is essential to measuring performance, identifying service 'gaps' and performance barriers, determining root causes, implementing improvement strategies and testing their outcome.

   e. **Quality Improvement Involves Everyone:** Quality improvement spans across the full extent of the organization. Carisk's work is a process and part of an interrelated / interdependent system: Each department and staff fulfills an essential function and

role in quality care. Everyone influences the outcomes and contributes to building and developing quality to produce the outcomes desired. When deficiencies or barriers are identified the QI Program focuses on processes rather than individuals.

f. **Leadership Involvement in QI is Instrumental:** Strong leadership, direction and support of quality improvement activities by the governing body (QIC and Board of Directors) and CEO are key to performance improvement. Their involvement assures that quality improvement initiatives are consistent with Carisk's mission, goals and strategic plan.

g. **Prevention Over Correction:** Carisk seeks to design good processes to achieve excellent outcomes rather than fix processes after the fact.

2. As a Carisk Network Provider, you have agreed to collaborate with Carisk's QI processes and activities, including, but not limited to:

   a. Participating and cooperating with all relevant aspects of the QI Program

   b. Adhering to clinical practice guidelines, all applicable State and Federal laws, regulations and accreditation care standards

   c. Protecting Patients' privacy and their Protected Health Information (PHI) by maintaining their records secured, their information private and confidential and appropriately using and disclosing Patient information according to HIPAA regulations

   d. Helping identify early on in treatment, at-risk Patients, complex cases and collaborating with Carisk's Care Managers in planning appropriate services and safe and effective levels of care

   e. Providing Patients with prompt appointments, and rapid follow-up upon discharge from inpatient care, as per our established access to care standards and timeframes

   f. Promoting continuity and coordination of Patients' care by effectively communicating and collaborating with Patients' PCP and other treating clinicians and/or facilities, with Patient's written consent

   g. Cooperating with on-site audits and chart review of Patients' medical/clinical records

   h. Cooperating with Carisk in addressing Patient complaints and helping to resolve them in a timely fashion

3. Cultural competence allows for care that is sensitive and responsive to cultural differences. Providers should be aware of the impact of culture and possess skills to help provide services that respond appropriately to a person's unique cultural differences, including race and ethnicity, national origin, religion, age, gender, sexual orientation, language, family systems, or physical disability. The practice of continuous self-assessment and community awareness is strongly encouraged and expected. There are certain treatment approaches that have been identified as effective in providing culturally sensitive care. One in particular – with multiple other outcome related benefits - is the Person-Centered Approach.

   Carisk's Cultural Competency Plan is available online at www.cariskbh.com.

C. COMPLAINTS AND GRIEVANCES

QI monitors, trends and assesses Provider and Patient complaints and grievances. The categories

for complaints and grievances include, but are not limited to:

- Access to Care
- Benefit Plan
- Claims
- Clinical Care
- Providers
- Quality of Care
- Quality of Service (Attitude and Service)
- Quality of Service (Financial and Billing)
- Quantity
- Service Provision
- Type of Service
- Timeliness

To present a complaint, grievance or appeal, including complaints regarding claims issues, Patients and Providers may call Carisk at 1-855-541-5300, or 305-514-5300 during regular business hours. Complaints, grievances or appeals may also be mailed to Carisk at 10685 N. Kendall Drive, Miami, FL 33176. All Provider complaints are received and reviewed by the Provider Relations Department.

D. PATIENTS' RIGHTS AND RESPONSIBILITIES (42 CFR 438.100)

Carisk is committed to maintaining quality care and service of the clinical and behavioral healthcare needs of its Patients and ensuring that Patients' rights and responsibilities be clearly outlined. We ask that you review the Patients' Rights and Responsibilities with your Carisk Patients. This information is also available in Spanish on our website at: www.cariskbh.com/members.

Members Have A Right To:

- Easily access care, including telephone access to care coordinators and clinicians 24 hours a day, 7 days a week, including interpreter and TTY services
- Be treated with respect and recognition of their dignity and need for privacy
- Fair and equal treatment, regardless of their race, religion, gender, ethnicity, age, or disability
- Access a quality Provider network that is reviewed by Carisk's on-site visits, medical record reviews, access monitoring, annual satisfaction surveys and Provider profiling
- Participate with Providers in decision-making regarding their treatment planning
- Candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage
- Receive information on the clinical guidelines used in providing and/or managing their care
- Timely claims adjudication and processing
- Voice complaints or appeals about Carisk or the care provided
- Make recommendations regarding Carisk's member rights and responsibilities policies
- Receive information about Carisk's services in a language they can understand
- Participate in the decision making process of Carisk's policies and quality improvement activities
- Receive information about advocacy and community groups and prevention services
- Private handling of medical records and, unless otherwise required by law, the right to approve or refuse their release

- Choose an Advanced Directive to designate the kind of care they want to receive should they become unable to express their wishes
- Access Employee Assistance Program (EAP), an online service offering confidential screenings, referral services and convenient access to 24-hour information and support

Members Have A Responsibility To:

- Provide information to the extent possible that Carisk and its Providers and facilities need in order to care for them
- Follow the plans and instructions for care that they have agreed upon with their Providers
- Participate to the extent possible in understanding their behavioral health problems and developing mutually agreed upon treatment goals
- Keep appointments or notify their Provider as soon as possible regarding a missed appointment
- Discuss any difficulty in regard to fee payment with their Provider
- Inform Providers about any living will, medical power of attorney or other directive that can affect their care
- Treat all health care Providers, staff and others involved in the delivery of care and services with respect

E. RISK MANAGEMENT

The Carisk Risk Management Program is designed to support Carisk's mission and vision as it pertains to clinical risk, Patient, visitor, third party, volunteers, and employee safety, and also as related to potential business, operational, and property risks. In order to promote quality of care provided by Carisk, evidence-based practices that improve Patient safety, reduce risks and prevent critical events are continuously researched, evaluated and if applicable, implemented.

The Risk Management Program provides a conceptual framework that guides the implementation of risk management and Patient safety initiatives and activities. This program supports Carisk's philosophy that Patient safety and risk management is everyone's responsibility.

Program features and activities:

- Investigation, analysis and trending of the frequency and causes of types of incidents/ adverse events and claims
- Orientation and annual training of all staff on risk management, risk prevention and reporting of incidents
- Claims management
- Complaint/grievance resolution
- Confidentiality and release of information
- Adverse and critical incident reporting and analysis
- Event investigation, root-cause analysis and follow-up
- Providers and staff education, competency validation and credentialing requirements

F. PATIENT SAFETY

The safety of Patients is an overriding priority. Carisk will thoroughly review all Critical Incidents to determine root cause(s). All Critical Incidents will be reported immediately to the Health Plan client or AHCA as contractually stipulated. A monthly summary will also be provided.

G. INCIDENT REPORTING

To help Carisk identify areas of improvement and minimize potential safety risks and hazards, Carisk requires Network Providers to report critical incidents. These are events that occur while receiving treatment at a network Provider's office, agency or facility or within a specified time after discharge. Network inpatient facilities are expected to report critical incidents within two (2) hours of its occurrence / discovery; outpatient Providers and practitioners are expected to report as soon as possible and not later than twenty-four (24) hours of becoming aware of its occurrence. Training regarding incident reporting is available on the Carisk Portal or by request.

Events / Incidents Requiring Report

- Patient Death
- Patient Injury or Illness
- Providers Medication Errors
- Patient Suicide Attempt
- Other reportable incidents

H. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Carisk requires that all of its staff, agents, Providers and facilities protect the confidentiality of Member information and records. It adheres to Health Insurance Portability and Accountability Act (HIPAA) guidelines and requirements to ensure that all data and information received and used by Carisk to deliver health care services is kept confidential and secure.

Under HIPAA rules, Carisk is generally permitted to use or disclose Protected Health Information (PHI) in these situations:

- Provide to the individual or his/her authorized personal representative as required when the individual makes a formal request for access (per 45 CFR 164.524, 528)
- Use for treatment, payment or other health care operations, without any specific legal permission, or in compliance with an optional consent (per 45 CFR 164.506)
- Use other purposes, in compliance with an authorization (per 45 CFR 164.508) or other agreement (per 45 CFR 164.510)
- For research, provided an Institutional Review Board (IRB) or Privacy Board has approved a waiver of authorization (per 45 CFR 164.514)
- In compliance with uses and disclosures permitted for law enforcement, judicial or administrative proceedings, public health activities or health system oversight, and other purposes (per 45 CFR 164.512)
- To avert a serious, imminent threat to public health or safety (per 45 CFR 164.514)
- To provide to the Secretary of DHHS for investigations of complaints or general compliance reviews as required when DHHS makes a formal request (per 45 CFR 160.306, 308)
- For fundraising or marketing (as limited by 45 CFR 164.514)
- When the PHI has been adequately identified (per 45 CFR 164.514)

With some exceptions (e.g.: information exchanged between/among Providers for treatment), such uses and disclosures must adhere to a minimum necessary standard.

a. Protected Health Information (PHI). Member-identifiable, or protected health information (PHI), includes data such as name, Social Security number, member number, address, telephone number, and date of birth. Carisk considers this data to be confidential. This data is used for verifying eligibility, managing benefits, coordinating

care, paying claims, reporting quality assurance, determining practitioner performance, and complying with health care regulations.

b. PHI Routine Uses and Disclosures. Carisk has several policies in place to protect member-identifiable information and ensure privacy for its Members and subscribers. Carisk is responsible for managing mental health and chemical dependency treatment benefits for Members. In order to carry out these responsibilities, it receives and uses information about the individuals who are eligible to receive these benefits. When an eligible individual uses his or her behavioral health benefits, Carisk usually needs to obtain and use additional information about that individual to deliver the required health care.

   Carisk uses information about Members and their dependents (if applicable):

   i. For treatment, payment, and health care operations, such as enabling us to verify eligibility for services
   ii. To authorize treatment
   iii. To pay claims
   iv. To coordinate care
   v. To resolve inquiries, complaints and appeals
   vi. To improve the care and service rendered by Carisk and its network of practitioners and facilities
   vii. To meet regulatory requirements and accreditation standards

   If Carisk uses information for reasons other than treatment, payment, and health care operations, it will change or remove any portions of the information that could allow someone to identify the Member or his/her dependent or we will contact the Member or his/her legal representative to ask for written authorization to use the information. Members may contact the Carisk Chief Privacy Officer at any time to find out how their PHI is being used to manage their behavioral health benefits. Members may also contact the Chief Privacy Officer if they feel their PHI is incorrect or requires additional explanation.

c. Use of Authorizations. Carisk obtains special authorization to disclose (PHI). The following individuals can, in most cases, give authorization for the disclosure of PHI:

   i. An adult Member
   ii. The natural or adoptive parents of a minor Member on behalf of the minor
   iii. A legally-authorized representative of an Member

   Members have the right to authorize or deny the release of PHI beyond uses for treatment, payment, or health care operations.

d. Access to PHI. Members have the right to inspect and obtain a copy of their PHI, which is kept in a Designated Record Set that is in Carisk's possession. In general, the Designated Record Set includes the following:

   i. Member demographic and insurance information
   ii. Claims explanation of benefits

iii. Authorizations of care

iv. Clinical event documentation

v. Written utilization management records

Members must make requests to inspect and obtain a copy of the Designated Record Set in writing to the Carisk Privacy Officer. Carisk may deny a member access to the Designated Record Set in the following circumstances:

i. Psychotherapy notes kept separate from the Medical Record

ii. Information that is gathered for use in a civil, criminal, or administrative proceeding

iii. Information that was provided to Carisk by someone under a promise of confidentiality

iv. When a licensed health care professional has determined that harm would be caused to the Member or others if access to the information was granted

Members may request a review of the denial of access.

e. Internal Protection of Oral, Written, and Electronic PHI.

i. Carisk's agents, contractors, employees, and staff may not discuss PHI or confidential data and information in any area where individuals who do not have the right to know about the information may overhear it.

ii. Printouts with PHI are secured in locked file cabinets in locked file rooms, accessible only to the staff members who need to see them. Faxed information is sent out with a cover sheet that has a confidentiality notice, and mailed information is marked "Confidential." When not hand-carried and personally delivered to the recipient, printouts containing PHI and confidential data and information are placed in a sealed envelope marked "Confidential."

iii. Computer files with PHI are kept on computers that are password-protected. These files are only available to staff members who need to have access to them to perform their job responsibilities. Data sent electronically (e.g.: through e-mail) is encrypted or coded and password-protected, and the e-mail message contains a confidentiality notice.

iv. Any information that is no longer required for business purposes is destroyed. Printouts are shredded, computer files are permanently erased, and computer media is destroyed.

f. Provider Protection of Oral, Written and Electronic PHI. Providers keep Member medical records in their offices in medical records, appointment books, correspondence, lab results, billing records, and treatment records. Carisk requires Providers to have privacy, security, and confidentiality practices to keep PHI secure, including:

i. PHI must be stored in locked cabinets or in a locked area, and computer files should be password-protected

ii. Information submitted electronically (e.g.: through e-mail) must be encrypted or coded, and bear a prominent confidentiality statement

iii. Faxed information should be sent out with a cover sheet that has a confidentiality notice, and mailed information should be marked "Confidential"

g. Protection of Information Disclosed to Plan Sponsors or Employers. Carisk does not share PHI with employers without specific consent of the subscriber, Member, or the Member's legal representative. If Carisk must release Member-identifiable data or PHI to an employer (self-insured or fully insured), we require that the employer agree in writing to protect all data and information from being used in any decisions affecting the Member, and allow Members to access and/or amend their PHI. Summarized data without PHI will be provided to employers, if possible.

Contact Carisk for more information regarding its privacy and confidentiality policies. For more information about HIPAA, please visit www.hhs.gov/ocr/hipaa.

VII. CLAIMS

Carisk is committed to ensuring the accuracy, timeliness and completeness of claims processing, payment and reporting. It abides by all applicable State and Federal regulations, reporting requirements, accreditation standards and guidelines of its organizational clients.

A. CLAIMS SUBMISSION

1. **Clean Claims:** When a claim form is properly and thoroughly completed – when all the required fields contain the information needed – you have successfully submitted a "clean claim." "Clean claims" allow Carisk to fulfill its commitment to timely and accurate processing and reimbursement. When a claim is submitted incomplete or is improperly filled out, it is referred to as an "unclean" or "contested claim." Delays in payment occur when the Claims Department needs additional information from any party external to Carisk to process a claim.
2. **Timely Claims Submission:** Claims must be submitted within 180 days of the date of service. Claims received after 180 days will be denied.
3. **Mailed Claims Submission:** Outpatient services must be billed on a CMS-1500 (08/05). Inpatient services must be billed on a UB-04. All paper claims should be submitted to:

   Carisk Partners
   P.O. Box 211277
   Eagan, MN 55121

4. **Electronic Claims Submissions:** Carisk accepts electronically-transmitted claims from outpatient Providers (in HIPAA compliant formats). You can submit electronic claims through Carisk's Provider Portal at www.cariskbh.com

   a. Carisk uses Smart Data Solutions, SDS (https://www.sdata.us) for clearinghouse purposes. If you use a different clearinghouse, verify with them that they have an agreement with SDS to exchange claims. The Carisk Payor ID is 33632.

   b. Providers may also submit electronic claims through Availity (https://www.availity.com). The Carisk Payor ID is 33632.

B. CLAIM FILING TIPS

For prompt processing and payment of claims:

1. *Complete All Fields.* Include all the required itemized information requested in each of the required fields. Carisk's *Notice of Authorization* that was emailed, faxed or mailed to a Provider on the day after the authorization was issued has much of the information the claim form requires, including:
    a. The Patient's identifying information, include: name, date of birth, subscriber ID number (use the applicable health plan Patient ID, not the Medicaid ID or the Provider's internal ID), address, phone
    b. The diagnosis (codified: DSM-IV, ICD-10), include all digits
    c. The date(s) of service, and duration
    d. The place of service(s)
    e. The type of service(s)/ procedure(s) provided – use CPT code(s) / revenue code(s) for each service and/or procedure
    f. The authorization number issued by Carisk for the service(s) (if authorization is required)
    g. The Provider/Practitioner name, credentials, tax ID, and NPI numbers, mailing/billing address, and address where service was rendered
2. *Check for Accuracy.* Ensure that:
    a. Date(s) of service corresponds to the authorization effective date(s) or date range found on the *Notice of Authorization*
    b. Service codes/type of service correspond to those detailed on the *Notice of Authorization*
    c. Print/type the information clearly, legibly
    d. Sign and date the claim form

C. CLAIMS PROCESSING AND PAYMENT

1. **Reimbursement Amount** - Carisk reimburses Providers for the delivery of authorized services at the negotiated fee/rate agreements contained in the Provider's contract.
2. **Appeals** - Providers have **30 days** from notice of claim denial to appeal the denied claim. Contact Carisk for assistance with this process.
3. **Claim Correction** - Providers have **35 days** to resubmit a corrected claim.
4. **Contact Carisk** If a payment or denial is not received at your office within the time allotted per applicable State and/or Federal law, contact Carisk immediately so that it may resolve the issue in a timely manner.

D. CLAIMS FOR EMERGENCY SERVICES

It is Carisk's policy that claims for emergency treatment and/or urgently needed services do not require previous authorization and should be paid on a timely basis.

E. ADDITIONAL BILLING PRACTICE INFORMATION

Engaging in any of the following practices is considered improper and may be ground for

terminating a Provider contract:

1. **Billing for Missed Appointments:** Medicaid prohibits Providers from billing their Patients for "missed" appointments– this includes charging 'late cancelation fees'.
2. **Balance Billing:** Balance billing Patients is strictly prohibited. Balancebilling is defined as the practice of requesting payment from the Patient for the difference between Carisk's contracted rate and the Provider's usual/customary fees for the service. The contracted rates listed in the schedule of your Carisk contract include any applicable co-payment. You may collect only applicable co-payments and/or deductibles directly from the Patient but never engage in the following billing practices that are strictly prohibited by Carisk.
3. **Billing for Charges Denied/Unauthorized Services:** Under no circumstances is a Carisk Patient to be charged for failure to have a service pre-authorized or a claim paid by our organization.

F. FRAUD, WASTE AND ABUSE PREVENTION

Through its Compliance Program, Carisk complies with all applicable State and Federal billing requirements for all government sponsored and commercial plans including State False Claim laws, Federal False Claims Act, applicable "whistleblower" protection laws, the Deficit Reduction Act of 2005, and the American Recovery and Reinvestment Act of 2009

Carisk conducts both prospective and retrospective searches and analyses to seek potential fraud and abuse using resources such as (but not limited to) claims, utilization management, quality management, grievance/appeals, complaints, and random chart audits. Its goal is to use a collaborative approach to prevent, detect, and correct any violations. Pursuant to regulations, in the event of suspected fraud and/or abuse, chart audits may be conducted without prior notice. Findings suggestive of fraud and abuse will be reported to the appropriate agencies as needed and appropriate enforcement measures will be taken when necessary. Providers must comply with all aspects of Carisk's Compliance Program and its fraud and abuse plan/requirements.

Carisk routinely monitors the Health and Human Services (HHS) Office of the Inspector General's List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM) (which includes the former Excluded Parties List System [EPLS], Medicaid Termination lists, State Department of Health (DOH) license notifications, AHCA Final Orders, and other sources to identify individuals excluded from participation in State Medicaid. Providers must notify Carisk immediately if they become ineligible to participate in federally funded programs or receive federal money.

G.

MEDICAID DEFINITIONS – PROVIDERS ABUSE	
Abuse	Abuse means Providers practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary, coded incorrectly on the claim, or that fail to meet professionally recognized standards for health care. Abuse includes recipient activities that result in unnecessary cost to the Medicaid program. Abuse may also include a violation of state or federal law, rule or regulation. Note: See the Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook for information regarding recipient overutilization or fraud of prescription drugs.
Overpayment	Overpayment includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claims, unacceptable practices, fraud, abuse or mistake.
Providers Fraud	• Billing for services not performed • Billing duplicate times for one service • Falsifying a diagnosis • Billing for a costlier service than performed • Accepting kickbacks for Patient referrals • Billing for a covered service when a non-covered service was provided • Ordering excessive or inappropriate tests • Prescribing medicines that are not medically necessary or for use by people other than the Patient
Fraud	Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable State or Federal law. AHCA may require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.
Person	"Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a Provider of health care, under whose supervision they were furnished, or the person causing them to be furnished.

VIII. PROVIDER SERVICES

Carisk's Provider Service Department serves as a liaison between the company and its network of contracted Providers. The Department is committed to building and maintaining Carisk's Clinical

and Behavioral Health Network contingent on the clinical and behavioral health needs of its clients. Carisk offers a comprehensive range of services and an ample number, mix and geographic distribution of Providers to enhance timely and appropriate access to care for Patients.

Carisk contracts with independent clinical and behavioral health practitioners, group practices, agencies, community mental health centers, hospitals and other clinical and behavioral health care facilities to provide a full range of services.

A. NETWORK ADEQUACY

The adequacy of the Carisk network is essential to ensuring Patients access to the care they need in a timely manner. Network adequacy includes:

1. A sufficient number of clinical and behavioral health care practitioners and Providers so that Patients seeking care and/or services can do so in a timely manner
2. An adequate geographic distribution of practice and service locations to provide Patients with care that is convenient and easy to access
3. An adequate number and variety of clinical professional levels, disciplines, specialties and types of services to meet the Patient's continuum of clinical and behavioral care needs
4. An adequate mix of expressed ethnicity, cultures and languages in the Network to meet the related needs and preferences of Patients and promote culturally sensitive and competent clinical and behavioral health care

B. OVERVIEW OF CREDENTIALING PROGRAM

1. The independent formal credentialing and re-credentialing process is ongoing and involves obtaining and verifying Provider information for appointment and reappointment to the Carisk panel of network Providers. The process is intended to obtain and verify appropriate Provider information, according to applicable laws and accreditation standards that will enable the Credentialing Committee (CC) to make informed peer review decisions regarding initial appointments and reappointments.
2. The credentialing staff monitors and processes credentialing and re-credentialing applications and forwards completed applications to the Chief Medical Officer for review. The Manager of Credentialing reports all credentialing and re-credentialing issues and concerns to the Chief Medical Officer. Following the Chief Medical Officer's review, the application is presented to the CC for review and action. All decisions of the CC are forwarded to the QIC for review and approval, and the Board of Directors for final approval.
3. Under the supervision of the Chief Medical Officer, and with the assistance of the Manager of Credentialing, Carisk credentialing staff completes the primary source verification of qualifications and credentials of prospective and current Providers for initial and subsequent credentialing. Carisk uses a three-year reappointment cycle. A re-credentialing schedule is established and monitored by the Manager of Credentialing under the supervision of the Chief Medical Officer.
4. Appointment and reappointments are non-discriminatory and based on documented evidence of the following:
    a. Current licensure

b. Relevant education, training and experience

c. Provider competency, as indicated by relevant findings of the QI and UM Programs and reasonable indicators of current qualifications (Drug Enforcement Agency (DEA), Board Certification, work history etc.)

d. Information obtained through primary source verification

e. Formal application completed by the Provider

f. Proof of professional liability insurance in the required limits

5. All documentation and verification relative to the credentialing and re-credentialing of Providers is filed in a credentialing file individually designated for each Provider. Credentialing files are maintained in a securely in the Credentialing Department, and access is controlled by the Manager of Credentialing. Providers are notified within sixty (60) calendar days of the committee's credentialing or re-credentialing decisions. Providers have the right, upon request, to be informed of the status of their credentialing or re-credentialing application. Providers also have the right to review information submitted to support their credentialing application and to correct erroneous information.

6. The CC meets bimonthly, in addition to its members being available for ad hoc telephone meetings during business hours, to implement the following components of the credentialing program:

   a. Review and approve all relevant policies and procedures of the Carisk Credentialing program, prior to submission to the QIC for review and approval and the Board of Directors for final approval.

   b. After the policies and procedures have been approved internally at Carisk they are submitted to the health plan. The health plan then submits Carisk's policies and procedures to AHCA for final review and approval prior to implementation.

   c. Review of Provider credentials and information initially, and every two (2) years thereafter, and make recommendations for participation, rejection or termination based on Carisk's credentialing criteria.

   d. Review facility assessments initially and reassessments every three (3) years thereafter, and make recommendations for participation, rejection or termination based on Carisk's credentialing criteria.

   e. Monitor complaints and sanctions between credentialing cycles, and make recommendations for participation, rejection, or termination based on Carisk's credentialing criteria.

   f. Review Provider office site visit results and take action, as appropriate to the findings.

   g. Review performance data at re-credentialing for at least Patient complaints and QI activities including under- and over-utilization.

   h. Review and investigate Provider performance in the following areas as part of the re-credentialing process.

      i. Clinical and behavioral health services not in compliance with community accepted standards of practice

      ii. Failure to comply with Carisk policies or procedures

iii. Practice patterns which fall outside accepted norms

iv. Professional conduct or performance that may be detrimental to a Patient's health or safety, or to Carisk's reputation

v. The Credentialing program, including credentialing and re-credentialing criteria and processes, is reviewed at least annually by the CC to ensure that it continually meets the organization's objectives. Policies may be added, revised or retired, as needed, at any time with the approval of the QIC and the Board of Directors

i. Clinical and behavioral health delivery organizations that want to join Carisk's Provider network are also reviewed by the CC to ensure that Carisk's assessment of, and contracting with, such Providers include consideration of all factors specified in regulatory requirements, as well as all applicable accreditation standards recognized by Carisk (JCAHO, NCQA, CARF, AAAHC, COA). These clinical and behavioral health delivery organizations include, but are not limited to, hospitals, physicians, physical and drug rehabilitation facilities, intensive outpatient programs, community mental health centers, and residential treatment centers.

C. PROVIDER APPLICATION AND ATTESTATION

1. **The Application Process:** Providers interested in being credentialed by Carisk must complete and submit the Provider Credentialing Application or the Council for Affordable Quality Healthcare (CAQH) application and accompanying forms and attestation. Applications can be obtained by calling Carisk's Providers Service Department. Once the application is completed, you may mail it accompanied by all the required supporting documentation to Carisk's Miami office.

   a. **Required Information from Individual providers:**

      i. Practice locations, specialty areas, cultural and ethnic backgrounds, and languages spoken

      ii. Five year malpractice history and proof of current professional liability insurance (coverage face sheet for the minimum amounts of $250,000/$750,000 or Malpractice Insurance Statement)

      iii. A copy of current state professional license

      iv. Medicare, Medicaid and NPI numbers

      v. DEA and CDS (Controlled Dangerous Substances) certificates (physicians only)

      vi. Board Certification (physicians only)

      vii. One Peer Reference

      viii. Controlling Interest Form

      ix. Executed Business Associate Agreement

      x. Education and professional training

      xi. An updated resume or curriculum vitae, with five (5) year work history and explanation of gaps longer than 6 months

xii. Reasons for an inability to perform any functions of your profession

xiii. History of sanctions, disciplinary actions and loss of privileges

xiv. History of loss of license and any felony convictions

xv. Commitment to no illegal drug use

xvi. Signature on the application confirming that the information provided is true and correct

xvii. W-9 form

b. **Required Information from Community Mental Health Centers (CMHC) and Targeted Case Management Agencies** - Carisk also contracts with community mental health centers that may provide crisis stabilization and outpatient mental health and substance abuse services:

i. Accreditation certificate or Medicaid participation letter if non-accredited

ii. Medicaid Providers enrollment form, if not accredited

iii. State license

iv. Medicare letter, if applicable

v. Copy of the AHCA certificate for Targeted Case Management (TCM) program, if applicable

vi. Malpractice certificate of insurance

vii. Ownership and Controlling Interest form

viii. W-9 form

ix. CMHC Staff Roster

x. TCM Staff roster and signed attestation form, if applicable

xi. Copy of TCM training certification, if applicable

xii. Carisk Application

c. **Required Information from Applied Behavioral Analyst Agencies:**

i. Medicaid participation letter

ii. Medicaid Providers enrollment form

iii. Malpractice certificate of insurance

iv. Ownership and Controlling Interest form

v. W-9 form

vi. Staff Roster

vii. Carisk Application

d. **Required information from Board Certified Behavior Analyst (BCBA)/Board Certified Assistant Behavior Analyst (BCaBA):**

i. Copy of Current Board Certification

ii. State Licensure (if applicable)

iii. Copy of Resume

iv. Copy Liability Insurance (even if covered under group policy)

v. Copy of Background Screening Summary Report

e. **Required information from Behavior Assistants (BA):**

i. Signed Certificate of 40 hours of Autism Training

ii. Copy of School Transcripts (showing courses in Behavior Analysis)

iii. Copy of Resume

iv. Copy of Liability insurance (even if covered under group policy)

v. Copy of Background Screening Summary Report

f. **Required Information from Facilities:** In addition to credentialing and contracting clinical and behavioral health practitioners, Carisk also contracts with facilities that provide inpatient and outpatient mental health and substance abuse services:

i. A current and valid state license

ii. Proof of accreditation

iii. General and Professional Liability insurance certificates

iv. W-9 forms

v. Disclosure Ownership Form

vi. Signed malpractice claims statement/history

vii. Staff roster, including attending physicians

viii. Hours of Operation

ix. Program descriptions

x. Providers billing information

D. PROVIDER CREDENTIALING

1. **Verification:** When you complete and submit your Credentialing Application to Carisk, along with all the required supporting documentation, the credentialing process begins. While Carisk strives to make a credentialing determination in **less than ninety (90) days**, it may take longer since the process involves obtaining information from third parties. Your application will be reviewed and critical information will be validated. Prior to the initial credentialing process, the Provider Service Department shall conduct primary source verification of applicant's credentials, including a query using the cumulative Medicare and Medicaid Sanctions and Reinstatement Report, or by individual queries using the **System Award Management (SAM)**. If the applicant practitioner and/or Provider appear on the SAM they shall not be credentialed as a Carisk network practitioner and/or Provider.

2. **Credentialing Criteria:** Carisk's credentialing process is based on the criteria set forth in Carisk's Credentialing Policies and Procedures and derived from the standards and requirements established by the QI Programand QIC. These requirements include

standards as indicated by: Centers for Medicare and Medicaid Services (CMS), the Agency for Health Care Administration (AHCA), and are in accordance to State and Federal Accreditation Organizations. Primarily, Provider selection decisions are made based on the needs of the Patient populations and the Provider's qualifications. Annually, if not more frequently, Carisk uses mapping software to conduct network analyses; however, availability and proximity standards are analyzed on an ongoing basis throughout the year. This process includes determining Network needs based on scope of practice and the cultural and language needs of the Patients. Additionally, we make determinations based on Patient complaints, peer reviews, site visits and record reviews. The Members of the Credentialing Committee, which includes representation by network Providers, arrive at a consensus on credentialing and re-credentialing decisions to ensure that the process is fair and non-discriminatory.

3. **Your Rights:** You have the right to review the information Carisk obtains about you through the credentialing process unless it is peer review protected. Carisk also cannot share information obtained from the National Practitioner's Data Bank (NPDB) or other databanks. You must query the databanks yourself. You have the right to correct erroneous information by submitting written corrections to Carisk within **ten (10) days** of our notification of any discrepancy. All credentialing information is stored in secure electronic format and only accessible to Credentialing staff by unique user login.
4. **The Credentialing Committee:** The Credentialing Committee meets at least four (4) times per year to review applications with issues, but ad hoc meetings are held as needed. Within **fifteen (15) days** of a credentialing decision, Providers will receive a letter detailing the outcome.
5. **Provider Trainings:** Your contract with Carisk becomes effective the day you are approved by our Credentialing Committee. All Medicaid Providers will receive training within 30 days of network approval. Providers may also access the Providers Manual online via the Provider Portal at our website: www.cariskbh.com. The Provider Manual includes elements such as:
    a. Using the Provider Manual
    b. Provider responsibilities
    c. Maintaining credentialing files current
    d. Practitioner/Provider change in status procedures
    e. The Authorization Process
    f. Medical Necessity
    g. Verifying Patient eligibility
    h. Case management processes and forms
    i. HIPAA information
    j. Claims submission and electronic billing
    k. Carisk contact information for specific questions

E. RE-CREDENTIALING

1. **Provider Re-credentialing:** Re-credentialing of network Providers occurs **every three (3) years**. Carisk will notify you in advance and provide a re-credentialing Application for you to complete and return with the supporting documents required. You must respond within **thirty (30) days** of receipt of the packet or Carisk is required to terminate its contract with you in order to maintain its credentialing standards.

   The following documentation, no more than **one hundred and eighty (180) days** old at the time of review by the credentialing committee, is required for re-credentialing:

   a. A completed Re-Credentialing Application
   b. Proof of current professional liability insurance and/or a Malpractice Insurance Statement
   c. A copy of current state license
   d. DEA and/or CDS Certificate (physicians only)
   e. An updated resume or curriculum vitae

   During credentialing and re-credentialing cycles, and as needed between cycles, Carisk queries the web-based Council for Affordable Quality Healthcare (CAQH), the National Providers Data Bank (NPDB) and other databanks. Carisk also monitors network Provider sanctioning using the cumulative Medicare and Medicaid Sanctions and Reinstatement Report, or by means of individual queries using the List of Excluded Individuals and Entities (LEIE). If a network Provider appears on the LEIE they shall be terminated for breach of contract.

   Carisk's use of CAQH's Universal Providers Data Source to obtain the data needed for Provider credentialing and re-credentialing streamlines the processes by allowing you to complete your application online. This service is free to Providers and is available 24/7. You can work on your application on your own schedule and save your work as needed. Once completed, CAQH stores the application online and enables you to make updates to your information. By keeping your information current, future re-credentialing is quick and easy.

   At the end of the application, you will be asked to sign an attestation and release of information granting Carisk access to information pertaining to your professional standing. This is required for primary verification and/or review of your records.

2. **Facility Re-credentialing:** Re-credentialing of Carisk's network facilities, agencies and clinics occurs once every three (3) years when Carisk confirms that the accredited institution continues to be in good standing with State and Federal regulatory bodies and accrediting agencies.

F. OFFICE SITE VISITS

1. Carisk conducts office site visits to the offices of all Providers when its threshold for Patient complaints has been met. The assessment of the office site helps to ensure the Patient and Carisk that the quality of the site, including physical accessibility, physical appearance, adequacy of the waiting and examining room space, as well as the availability of appointments and appropriate medical/treatment record keeping practices is safe and meets Carisk standards.

2. The Carisk office site visit instrument includes questions to assess the following elements:
    a. Physical appearance of the office
    b. Physical accessibility of the office
    c. Adequacy of Patient space, including the waiting area and examining room
    d. Compliance with regulatory requirements for the establishment of a business office (Business Tax Receipt / Occupational license)
3. For scores less than 85%, the site visit reviewer requests a corrective action plan (CAP) in collaboration with the practitioner or his/her representative.

G. PROVIDER RESPONSIBILITIES

Carisk Providers are expected to adhere to the terms outlined on its Providers Agreement:

1. 1. Adhere to all applicable State and Federal laws, and professional regulations and standards. This includes,
    a. Having a copy of the summary of Florida's Member's Bill of Rights and Responsibilities , in accordance with s. 381.026, F.S. in the member area.
    b. Having a complete copy of the Florida Member's Bill of Rights and Responsibilities, available upon request by a member at the practice site.
2. Treat Patients in a non-discriminatory and timely fashion
3. Maintain treatment records on all Carisk Patients (see Treatment Record Guidelines and Standards)
4. Protect and safeguard Patients' rights to confidentiality according to HIPAA standards
5. Coordinate care with the Patient's PCP and document this in the Patient's record (subject to applicable laws of confidentiality)
6. Fully participate in credentialing, utilization management and quality improvement processes
7. Allow, with reasonable notice, Carisk to review services provided to Patients to assure quality
8. Make treatment records available to Carisk for concurrent review compliant with HIPAA Federal regulations and State regulations
9. Continue to meet credentialing standards
10. Notify Carisk immediately of any adverse incidents
11. Notify Carisk of any change in your status, including:
    a. Name change or merger
    b. Change of address, or other demographic change
    c. Change of Tax ID Number
    d. Any lapse or change in professional malpractice liability coverage - new, renewed, or expired malpractice insurance (updates)

e. New, renewed, or expired licenses

f. DEA/controlled substance registrations (if applicable)

g. American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board certifications (if applicable)

h. Any condition resulting in temporary closure of a facility or office

i. Short-term hold on referrals

j. Leaves of absence

k. Any legal action pending for professional negligence

l. Any indictment, arrest, or conviction for a felony or for any criminal charge related to an individual's or a facility's practice

m. Revocation, suspension, restriction, termination, or voluntary relinquishment of any licenses, authorizations, accreditations, certifications, medical staff Patient ship or clinical privileges

12. Operate their practice in a safe and sanitary environment with—including but not limited to—infection prevention and control, appropriate hand hygiene, programs to reduce injuries and medication errors, and protocols to manage potential threats/hazards.

13. When notifying Carisk of any of these changes by phone you must follow-up with a formal written notification letter on your company letterhead. To notify Carisk of a change or addition of address, or changes to the payment information (such as changes to your Tax Identification Number or Payment Address) you may contact Carisk's Provider Relations Department to obtain the Change of Address and Payment Information Form.

H. TREATMENT RECORD GUIDELINES AND STANDARDS

Carisk's guidelines for treatment record documentation, standards for availability of treatment records, and performance goals define its expectations for Providers. Carisk assesses treatment records to ensure they comply with the following guidelines and standards:

1. A unique treatment record for each Patient.
2. Treatment record notes maintained in chronological order.
3. An organized system for maintaining documents for each Patient. For example, all diagnostic reports maintained together in a section of a folder.
4. An organized filing system that provides easy access to unique Patient files. For example alphabetical filing or filing by unique Patient identifier such as Social Security Number.
5. Treatment records must be available as appropriate, to Providers and staff other than the treating Provider (for example, a covering Provider).
6. There is a practice site specific process for assuring treatment record availability whether the records are maintained centrally or in the treating Provider's office.
7. Treatment record documentation occurs as soon as possible after the encounter. Special status situations, such as imminent harm, suicidal ideation, or elopement potential, are prominently noted.

8. Providers must have a process for communicating information to the Patient's PCP and other health care Providers within the behavioral health continuum and within the non-behavioral medical delivery system.
9. The Provider may use a specific form, letter, verbal communication, or other appropriate process to communicate information to other caregivers.
10. The content and date of the communication with other Providers must be documented in the treatment record.
11. Treatment records must be maintained in a secure and locked location with limited access to ensure confidentiality.
12. Documentation is required of appropriate:
    a. Consent to release of information.
    b. Informed consent for services.
13. Carisk does not require use of specific forms for release of information and consent for services.
14. Treatment record maintenance requires that:
    a. Errors are corrected by drawing a line through the error and initialing it.
    b. Errors are always readable after correction.
    c. White out is never used in the treatment record.
    d. Entries are made only in ink.
    e. Abbreviations, if used, are standard or readily identifiable to others.

I. SUPPLEMENTAL PROVIDER INFORMATION

1. **Provider Portal:** Carisk encourages its Providers to visit the Provider Portal via its website at www.cariskbh.com. If you have not yet registered for the Provider Portal follow the steps below:
    1. Go to https://www.providerlogin.net
    2. Click on the log in link.
    3. If you haven't registered in the portal, click on the link "Click here" to set up an account. Confirm with your Provider Relations representative that your contract is active in Carisk's production system. Enter your NPI and Tax ID.
    4. If your NPI and tax ID matches the info in Carisk's system, the user will be prompted to enter his/her contact info.
    5. The user will receive an email with a temporary password and a link to change for password.
    6. Click on the link to reset the password.
    7. Read and accept the Agreement.
    8. User will be granted access to the Provider Portal)
2. **Leave of Absence:** Individual clinicians may request to be made unavailable for new

referrals for up to **one hundred and eighty (180) calendar days**. You are required to notify the Provider Services Department **thirty (30) calendar days** prior to your lack of availability. You will be sent a letter confirming that your request has been processed. It is imperative that Patients be advised of the intended leave early enough to process the termination of care or be smoothly transitioned to another Carisk participating Provider. When you have been unavailable for **one hundred fifty (150) calendar days**, Carisk will send you a letter or notice reminding you that you will be returned to active status within **thirty (30) calendar days**. You may request an extension. Group practices or facilities that wish to be made unavailable should contact the Provider Services Department.

3. **Failure to meet Carisk's performance standards:** Carisk will notify you in writing in the event of failure to meet any performance standard. Carisk will explain the reason for the action and together develop a corrective action plan (CAP) to be reviewed in **six (6) month** intervals until performance standards are met. If the performance threshold is not met, you may be suspended or terminated from its network. You have the right to a formal appeal within **forty-five (45) calendar days** of the decision.
4. **Failure to comply with our contract:** A Carisk Provider Services representative will contact you to determine how it might be of assistance in helping you become compliant. If this does not work, you may be issued a written warning that explains further noncompliance will result in more severe sanctions. Alternatively, you may be suspended or terminated from the Carisk network.
5. **Terminating the Agreement:** Both parties have the right to terminate the Agreement, upon written notice, pursuant to the terms of the Agreement.
    a. If Carisk initiates the termination of your Agreement, or places a restriction on your Network participation, you may be eligible to request an appeal. If you are eligible for an appeal, Carisk will notify you of this in writing within **ten (10) calendar days** of the adverse action. Your written request for an appeal must be received by Carisk within **thirty (30) calendar days** of the date on the notification letter advising you of the termination and/or restriction. Failure to request the appeal within this time frame constitutes a waiver of all rights to appeal and acceptance of the adverse action. The appeal process includes a formal hearing before at least three clinicians appointed by Carisk. The Committee Members are not in direct economic competition with you, and have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. You may be represented by a person of your choice, including legal counsel, at the appeal hearing. At the conclusion of the hearing, you have **five (5) business days** to submit further documentation for consideration. The Committee's decision is reached by a majority vote of the Members. The decision of this Committee is final, and may uphold, overturn or modify the recommendation of Carisk. A certified letter with the specific reasons for the decision is sent to you within **thirty (30) calendar days** of your documentation submission deadline.
    b. If a Network Provider, group practice and/or agency decides to terminate their Agreement and withdraw from the Carisk network, they must notify Carisk in writing **ninety (90) calendar days** prior to the effective date of termination, unless otherwise stated in your Agreement or required by State law. With the exception of terminations due to quality-related issues, suspected fraud, waste or abuse or change in license status, clinicians are obligated to continue to provide treatment for all Carisk Patients

under their care and to inform the Patient as soon as possible of their decision. The timeline for continued treatment is up to **six (6) months** from the effective date of the contract termination, as outlined in the Providers Agreement or until one of the following conditions is met, whichever occurs earliest:

i. The Patient is transitioned to another Carisk Providers

ii. The period of care has been completed

iii. The Patient's Carisk benefit is no longer active. To ensure continuity of care, Carisk will notify Patients affected by the termination at least **thirty (30) calendar days** prior to the effective date of the termination whenever feasible. Carisk will assist these Patients in selecting a new clinician, group or agency.

c. If a Network facility decides to terminate their Agreement with Carisk and withdraw from its Network they must notify Carisk in writing **ninety (90) calendar days** prior to the date of termination, unless otherwise stated in the Agreement or required by State law. To ensure that there is no disruption in a Patient's care, Carisk has established a **ninety (90) calendar day** transition period for voluntary terminations. The Care Advocate may continue to issue authorizations for treatment during the termination period at the Carisk contracted rate. In the event that a facility's participation is terminated due to quality-related issues, fraud or change in license status requiring immediate transfer of a Patient to another facility, Carisk and the facility will coordinate to ensure a safe and effective transition of care.

In some cases, the treating Provider at the facility and the Carisk Advocate may determine it is in the best interest of a Patient to extend care beyond these time frames. Carisk will arrange to continue authorization for such care at the contracted rate. You may continue to collect all applicable co-payments and deductible amounts. The facility continues under contract at the existing rates through the completion of the period of care at any level of care provided by the facility. Patients may not be balance billed. If you need further clarification on how to terminate your Agreement with Carisk, please contact the Provider Services Department.

Appendices

APPENDIX A: Covered Service Requirements

Inpatient Hospital Services

Medically necessary behavioral health services provided in a hospital setting. The inpatient care and treatment services that an enrollee receives must be under the direction of a licensed physician with the appropriate medical specialty requirements.

Crisis Stabilization Units (CSU)

May be used as a downward substitution for inpatient psychiatric hospital care to be determined to be medically appropriate. These bed days are calculated on a two-for-one basis. Beds funded by the DCF SAMH cannot be used for enrollees if there are non-funded clients in need of the beds.

Outpatient Hospital Services

Outpatient hospital services are medically necessary behavioral health services provided in a hospital setting. The outpatient care and treatment services that an enrollee receives must be under the direction of a licensed physician with the appropriate specialty.

Emergency Services – Behavioral Health Services

Crisis intervention services include intervention activities of less than twenty-four (24) hour duration (within a twenty-four (24) hour period) designed to stabilize an enrollee in a psychiatric emergency.

Post-stabilization care services include any of the mandatory services that a treating physician views as medically necessary, that are provided after an enrollee is stabilized from an emergency mental health condition in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e) to improve or resolve the enrollee's condition.

Physician Services

Physician services are those services rendered by a licensed physician who possesses the appropriate medical specialty requirements, when applicable. A psychiatrist must be Florida licensed and certified as a psychiatrist by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or have completed a psychiatry residency accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada. Physician services include specialty consultations for evaluations. A physician consultation shall include an examination and evaluation of the enrollee with information from family enrollee(s) or significant others as appropriate. The consultation shall include written documentation on an exchange of information with the attending provider. The components of the evaluation and management procedure code and diagnosis code must be documented in the enrollee's medical record. A hospital visit to an enrollee in an acute care hospital for a behavioral health diagnosis shall be documented with a behavioral health procedure code and behavioral health diagnosis code. All procedures with a minimum time requirement shall be documented in the enrollee's medical record to show the time spent providing the service to the enrollee. The Health Plan shall be responsive to requests for consultations made by the PCP. Physicians are required to coordinate medically necessary behavioral health services with the PCP and other providers involved with the enrollee's care.

Community Mental Health Services

General Provisions

- Community mental health services include behavioral health services that are provided for the maximum reduction of the enrollee's behavioral health disability and restoration to the best possible

functional level. Such services can reasonably be expected to improve the enrollee's condition or prevent further regression. Carisk will provide *medically necessary* community mental health services rendered or *recommended by a physician or psychiatrist and included in a treatment plan.* (See General Medical Necessity Criteria) – admission, continuing stay, and discharge, for all mandatory and optional services). Specific age and services level criteria are in process of development; they will be made available upon completion to all Providers)

- Services must be provided to enrollees of all ages
- Services should emphasize the value of early intervention, be age appropriate, and be sensitive to the enrollee's developmental level. The term "community" is not intended to suggest that the services must be provided by state-funded facilities or to preclude state-funded centers from providing these services.
- Services shall meet the intent of those covered in the Florida Medicaid Community Mental Health Services Coverage and Limitations Handbook.

Treatment Plan Development and Modification

Treatment planning includes working with the enrollee, the enrollee's natural support system, and all involved treating providers to develop an individualized plan for addressing identified clinical needs. A behavioral health care provider must complete a face-to-face interview with the enrollee during the development of the plan. In addition to the Handbook requirements, the individualized treatment plan shall:

- Be recovery-oriented and promote resiliency;
- Be enrollee-directed;
- Accurately reflect the presenting problems of the enrollee;
- Be based on the strengths of the enrollee, family, and other natural support systems;Provide outcome-oriented objectives for the enrollee;
- Include an outcome-oriented schedule of services that will be provided to meet the enrollee's needs;
- Include the coordination of services not covered by the Health Plan such as school-based services, vocational rehabilitation, housing supports, Medicaid fee-for-service substance abuse treatment, and physical health care; and
- For enrollees in the child welfare system the individual treatment plans shall be coordinated with and complement the goals of the child welfare case plan.

Individualized treatment plan reviews shall be conducted at six (6) month intervals to assure that the services being provided are effective and remain appropriate for addressing individual enrollee needs. Additionally, a review is expected whenever clinically significant events occur or when treatment is not meeting the enrollee's needs. The provider is expected to use the individualized treatment plan review process in the utilization management of medically necessary services. For further guidance, see the most recent Community Behavioral Health Services and Coverage Handbook.

Evaluation and Assessment Services

- Evaluation and testing services include psychological testing (standardized tests) and evaluations that assess the enrollee's functioning in all areas. Evaluations completed prior to provision of treatment shall include a holistic view of factors that underlie or may have contributed to the need for behavioral health services. Diagnostic evaluations are included in this category. Diagnostic evaluations shall

be comprehensive and must be used in the development of an individualized treatment plan. All evaluations shall be appropriate to the age, developmental level and functioning of the enrollee. All evaluations shall include a clinical summary that integrates all the information gathered and identifies the enrollee's needs. The evaluation shall prioritize the clinical needs, evaluate the effectiveness of any prior treatment, and include recommendations for interventions and mental health services to be provided. All new enrollees who appear for treatment services shall receive an evaluation unless there is sufficient collateral information that a new evaluation would not be necessary.

- Evaluation services, when determined medically necessary, shall include assessment of mutual status, functional capacity, strengths and service needs by trained mental health staff.
- Before receiving any community mental health services, children ages 0-5 shall have a current assessment (within one year) of presenting symptoms and behaviors; developmental and medical history; family psychosocial and medical history; assessment of family functioning; a clinical interview with the primary caretaker and an observation of the child's interaction with the caretaker; and an observation of the child's language, cognitive, sensory, motor, self-care, and social functioning.

Medical and Psychiatric Services

- These services include medically necessary interventions that require the skills and expertise of a psychiatrist, psychiatric ARNP, or physician.
- Medical psychiatric interventions include the prescribing and management of medications, monitoring the side effects associated with prescribed medications, individual or group medical psychotherapy, psychiatric evaluation (for diagnostic purposes and for initiating treatment), psychiatric review of treatment records for diagnostic purposes, and psychiatric consultation with an enrollee's family or significant others, PCPs, and other treating providers.
- Interventions related to specimen collections, taking vital signs, and administering injections are also a covered service.
- Treatment services are distinguished from the physician services outlined above in that they are provided through a community mental health provider. Psychiatric or physician services must be conducted at sites where substantial amounts of community mental health services are provided.

Behavioral Health Therapy Services

- Therapy services include individual and family therapy, group therapy and behavioral health day services. These services may include psychotherapy or supportive counseling focused on assisting enrollees with the problems or symptoms identified in an assessment. The focus should be on identifying and utilizing the strengths of the enrollee, family, and other natural support systems. Therapy services shall be geared to the individual needs of the enrollee and shall be sensitive to the age, developmental level, and functional level of the enrollee.
- Family and marital therapy are also included in this category. Examples of interventions include those that focus on resolution of a life crisis or an adjustment reaction to an external stressor or developmental challenge.
- Behavioral health day services are designed to enable enrollees to function successfully in the community in the least restrictive environment and to restore or enhance ability for social and pre-vocational life management services. The primary functions of behavioral health day services are stabilization of the symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care, to provide transitional treatment after an acute episode, or to provide a level of therapeutic intensity not possible in a traditional outpatient setting.

Community Support and Rehabilitative Services

- These services include psychosocial rehabilitation (PSR) services and clubhouse services. Clubhouse services are excluded from the Health Plan's coverage but are covered under fee-for-service Medicaid. Psychosocial rehabilitation services may be provided in a facility, home, or community setting. These services assist enrollees in functioning within the limits of a disability or disabilities resulting from a mental illness. Services focus on restoration of a previous level of functioning or improving the level of functioning. Services must be individualized and directly related to goals for improving functioning within a major life domain.
- The coverage must include a range of social, educational, vocational, behavioral, and cognitive interventions to improve enrollees' potential for social relationships, occupational/educational achievement and living skills development. Skills training development is also included in this category and includes activities aimed toward restoration of enrollees' skills and abilities that are essential for managing their illness, actively participating in treatment, and conducting the requirements of daily independent living. Providers must offer the services in a setting best suited for desired outcomes, i.e., home or community-based settings.
- Psychosocial rehabilitative services may also be provided to assist enrollees in finding or maintaining appropriate housing arrangements or to maintain employment. Interventions should focus on the restoration of skills/abilities that are adversely affected by the mental illness and supports required to manage the enrollee's housing or employment needs. The provider must be knowledgeable about TANF and is responsible for medically necessary mental health services that will assist the individual in finding and maintaining employment.

Therapeutic Behavioral On-Site Services (TBOS) for Children and Adolescents

- TBOS services are community services and natural supports for children/adolescents with serious emotional disturbances. Clinical services include provision of a professional level therapeutic service that may include teaching problem solving skills, behavioral strategies, normalization activities and other treatment modalities that are determined to be medically necessary. These services shall be designed to maximize strengths and reduce behavior problems or functional deficits stemming from the existence of a mental health disorder. Social services include interventions designed for the restoration, modification, and maintenance of social, personal adjustment and basic living skills.
- TBOS services are intended to maintain the child/adolescent in the home and to prevent reliance upon a more intensive, restrictive, and costly mental health placement. They are also focused on helping the child/adolescent possess the physical, emotional, and intellectual skills to live, learn, and work in the home community. Coverage shall include the provision of these services outside of the traditional office setting. The services shall be provided where they are needed: in the home, school, childcare centers or other community sites.

Day Treatment Services

- *Adult day treatment services* include therapy, rehabilitation, social interactions, and other therapeutic services that are designed to redevelop, maintain, or restore skills that are necessary for enrollees to function in the community. The provider must have an array of available services designed to meet the individualized needs of the enrollee, and which address the following primary functions:
    - Stabilize symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care;
    - Provide a level of therapeutic intensity between traditional outpatient and an inpatient or partial

hospital setting;

- Provide a level of treatment that will assist enrollees in transitioning from an acute care or institutional settings;
- Assist enrollees in redeveloping the skills required to maintain a living environment, use community resources, and conduct activities of daily living and/or live independently in the community.

- *Children/adolescent day treatment services* include therapy, rehabilitation and social interactions, and other therapeutic services that are designed to redevelop, maintain, or restore skills that are necessary for children/adolescents to function in their community. The approach shall take into consideration developmental levels and delays in development due to emotional disorders. If the child/adolescent is school age, the services shall be coordinated with the school system. All therapeutic day treatment interventions for children/adolescents shall have a component that addresses caregiver participation and involvement. Services for all children/adolescents should be coordinated with home care to the greatest extent possible. Day treatment services shall include an array of programs with the following functions:
    - Stabilize the symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care;
    - Provide transitional treatment after an acute episode, admission to an inpatient program, or discharge from a residential treatment setting;
    - Provide a therapeutic intensity not possible in a traditional outpatient setting; and
    - Assist the child/adolescent in redeveloping age-appropriate skills required to conduct activities of everyday living in the community.
- Staff providing adult or children/adolescent day treatment services must have appropriate training and experience. Behavioral health care providers shall be available to provide clinical services when necessary.

Services for Children Ages 0 through 5 Years

- Services include behavioral health day services and therapeutic behavioral on-site services for children ages 0 through 5 years.
- Prior to receiving these services, the enrollees in this age group must have an assessment that meets the criteria in the Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

Behavioral Health Targeted Case Management (TCM)

Targeted case management services will be provider to children/adolescents with serious emotional disturbances and adults with a severe and persistent mental illness as defined below. TCMs go through the TCM certification program. (Medical criteria and clinical are in the process of being developed and will be disseminated upon completion.) At a minimum, case management services are indicated to incorporate the principles of a strengths-based approach. Strengths-based case management services are an alternative service modality for working with individuals and families. This method stresses building on the strengths of individuals that can be used to resolve current problems and issues, countering more traditional approaches that focus almost exclusively on individual's deficits or needs.

Target Populations. Behavioral health targeted case management services shall be available to all enrollees:

- who require numerous services from different providers and also require advocacy and coordination to implement or access services;
- who would be unable to access or maintain consistent care within the service delivery system without case management services;
- who do not possess the strengths, skills, or support system to allow them to access or coordinate services;
- who may benefit from case management but lack the skills or knowledge necessary to access services; or who do not meet these criteria but may still be eligible for limited targeted case management services by meeting exception criteria contained in the Medicaid Targeted Case Management Coverage and Limitations Handbook.

Carisk will ensure that case management services are available to children/adolescents who have a serious emotional disturbance (SED), which is a defined mental disorder with a level of functioning that requires two or more coordinated behavioral health services to be able to live in the community and puts the child/adolescent at imminent risk of an out-of-home placement for behavioral health treatment.

Carisk will also coordinate case management services for adults with a severe and persistent mental illness (SPMI), for adults who have been denied admission to a long-term mental health institution or residential treatment facility, or adults who have been discharged from a long-term mental health institution or residential treatment facility. Carisk is not required to seek approval from the SAMH Program Office for client eligibility or behavioral health targeted case management agency or individual provider certification.

Required Services

- Behavioral health targeted case management services include working with the enrollee and the enrollee's natural support system to develop and promote a service plan. The service plan reflects the services or supports required to meet the needs identified in an individualized assessment of the following areas: education or employment, physical health, mental health, substance abuse, social skills, independent living skills, and support system status. The approach used shall identify and utilize the strengths, abilities, cultural characteristics, and informal supports of the enrollee, family, and other natural support systems. Targeted case managers focus on overcoming barriers by collaborating and coordinating with providers and the enrollee to assist in the attainment of service plan goals. The targeted case manager takes the lead in both coordinating services/treatment and assessing the effectiveness of the services provided.
- When targeted case management recipients enrolled in the Health Plan are hospitalized in an acute care setting or held in a county jail or juvenile detention facility, Carisk shall document efforts to ensure that contact is maintained with the enrollee and shall participate actively in the discharge planning processes.
- Case managers are also responsible for coordination and collaboration with the parents or guardians of children/adolescents who receive mental health targeted case management services. The Health Plan shall monitor case management activities to assure that case managers routinely include the parents or guardians of enrollees in the process of providing targeted case management services. Integration of the parent's input and involvement with the case manager and other providers shall be reflected in medical record documentation and monitored through the Carisk/Health Plan's quality of care monitoring activities. Involvement with the child/adolescent's school and/or childcare center must also be a component of case management with children/adolescents.
- Carisk will coordinate behavioral health targeted case management services to children/adolescents in

the care or custody of the state who need them. Carisk will document efforts to develop a cooperative agreement with DCF, or its provider of community-based services, to address how to minimize duplication of case management services and to promote the establishment of one case manager for the child/adolescent and family whenever possible. *Additional Requirements for Targeted Case*

- Caseloads set to achieve the desired results. Size limitations must clearly state the ratio of enrollees to each individual case manager. The limits shall be specified for children/adolescents and adults, with a description of the clinical rationale for determining each limitation. If the Health Plan permits mixed caseloads (i.e., children/adolescents and adults), a separate limitation is expected along with the rationale for the determination. Ratios must be no greater than the requirements set forth in the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook;
- A system to manage caseloads when positions become vacant;
- A description of the modality of service provision and the location at which services will be provided;
- The expected frequency, duration and intensity of the service with service limits and criteria no more restrictive than those in Medicaid policy;
- Issues related to recovery and self-care, including services to help enrollees gain independence from the behavioral health and case management system;
- Services based on individual needs of the enrollees receiving the service. The service system shall also address the changing needs and abilities of enrollees; and
- Case management staff with expertise and training necessary to competently and promptly assist enrollees in working with Social Security Administration or Disability Determination in maintaining benefits from SSI and SSDI. For enrollees who wish to work, case management staff must have the expertise and training necessary to help enrollees access Social Security Work Incentives.

Intensive Case Management

Intensive case management is intended for highly recidivistic adults who have a severe and persistent mental illness. The service is intended to help enrollees remain in the community and avoid institutional care. Care criteria for this level of case management shall address the same elements required above, as well as expanded elements related to access and twenty-four (24) hour coverage as described below. Additionally, the intensive case management team composition shall be expanded to include enrollees selected specifically to assist with the special needs of this population.

Carisk will coordinate this service for all enrollees for whom it is determined to be medically necessary, to include any enrollee who meets the following criteria:

- Has resided in a state mental health treatment facility for at least six (6) of the past thirty-six (36) months;
- Resides in the community and has had two (2) or more admissions to a state mental health treatment facility in the past thirty-six (36) months;
- Resides in the community and has had three (3) or more admissions to a crisis stabilization unit, short-term residential facility, inpatient psychiatric unit, or any combination of these facilities within the past twelve (12) months.

Community Treatment of Enrollees Discharged from State Mental Health Treatment Facilities

Carisk will coordinate and authorize medically necessary behavioral health services to enrollees who have been discharged from any state mental health treatment facility, including, but not limited to, follow-up

services and care. All enrollees who have previously received services at a state mental health treatment facility must receive follow-up care. The plan of care shall be aimed at encouraging enrollees to achieve a high quality of life while living in the community in the least restrictive environment that is medically appropriate and reducing the likelihood that the enrollees will be readmitted to a state mental health treatment facility.

Community Services for Medicaid Recipients Involved with the Justice System

Carisk will make every effort to coordinate and authorize medically necessary community-based services for Health Plan enrollees who have justice system involvement, and provide psychiatric services within twenty- four (24) hours of release from jail, juvenile detention facility, or other justice facility to assure that prescribed medications are available for all enrollees.

Treatment and Coordination of Care for Enrollees with Medically Complex Conditions

Carisk will ensure that appropriate resources are available to address the treatment of complex conditions that reflect both mental health and physical health involvement. The following conditions will be addressed:

- Mental health disorders due to or involving a general medical condition, specifically ICD-9-CM diagnoses 293.0 through 294.1, 294.9, 307.89, and 310.1; and
- Eating disorders – ICD-9-CM diagnoses 307.1, 307.50, 307.51, and 307.52.

Carisk will provide medically necessary community mental health services to enrollees who exhibit the above diagnoses and shall develop a plan of care that includes all appropriate collateral providers necessary to address the complex medical issues involved. Clinical care criteria shall address modalities of treatment that are effective for each diagnosis. Carisk's provider network will include appropriate treatment resources necessary for effective treatment of each diagnosis within the required access time periods

Coordination of Children's Services

- The delivery and coordination of child/adolescent mental health services will be provided for all who exhibit the symptoms and behaviors of an emotional disturbance. The delivery of services must address the needs of any child/adolescent served in an SED (severely emotionally disturbed) or EH (emotionally handicapped) school program. Developmentally appropriate early childhood mental health services must be available to children from birth to five (5) years and their families.
- The delivery of services for all children/adolescents will be provided within a strengths-based, culturally competent service design and services must be family-driven and include the participation of family, significant others, informal support systems, school personnel, and any state entities or other service providers involved in the child/adolescent's life.
- For all children/adolescents provider shall work with the parents, guardians, or other responsible parties to monitor the results of services and determine whether progress is occurring. Active monitoring of the child/adolescent's status shall occur to detect potential risk situations and emerging needs or problems.
- When the court mandates a parental behavioral health assessment, and the parent is an enrollee, the provider must complete an assessment of the parent's mental health status and the effects on the child. Time frames for completion of this service shall be determined by the mandates issued by the court.

Evaluation and Treatment Services for Enrolled Children/Adolescents

Carisk will coordinate and authorize all medically necessary evaluations, psychological testing and

treatment services for children/adolescents referred to the Health Plan by the Department of Children and Families (DCF), the Department of Juvenile Justice (DJJ) and by schools (elementary, middle, and secondary schools) and will provide court-ordered evaluation and treatment required for child/adolescent enrollees. See specifications in the Medicaid Community Behavioral Health Services Coverage & Limitations Handbook. Adolescents will be referred to DCF when residential treatment is medically necessary.

Psychiatric Evaluations for Enrollees Applying for Nursing Home Admission

Carisk will, upon request from the SAMH offices, promptly arrange for and authorize psychiatric evaluations for enrollees who are applying for admission to a nursing facility pursuant to OBRA 1987, and who, on the basis of a screening conducted by Comprehensive Assessment and Review for Long term Care (CARES) workers, are thought to need mental health treatment. The examination shall be adequate to determine the need for specialized treatment under OBRA. Evaluations must be completed within five (5) working days from the time the request from the DCF SAMH office is received.

Assessment and treatment of Mental Health Residents Who Reside in Assisted Living Facilities (ALF) that hold a Limited Mental Health License

- The provider must develop and implement a plan to ensure compliance with s, 394.4574, F.S., related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. A cooperative agreement, as defined in s. 429.02, F.S., must be developed by the ALF with the enrollee's Health Plan if an enrollee is a resident of an ALF. The provider must ensure that appropriate assessment services are provided to enrollees and that medically necessary behavioral health services are available to all enrollees who reside in this type of setting.
- A community living support plan, as per contract description, will be developed for each enrollee who is a resident of an ALF, and it must be updated annually. The Health Plan or its designee's behavioral health care case manager is responsible for ensuring that the community living support plan is implemented as written.

Individuals with Special Health Care Needs

- Carisk will implement mechanisms for identifying, assessing and ensuring the existence of an individualized treatment plan for individuals with special health care needs, as defined in Attachment II, Section I, Definitions and Acronyms. Mechanisms will include evaluation of risk assessments, claims data, and CPT/ICD-9 codes. Additionally, the Health Plan shall implement a process for receiving and considering provider and enrollee input.
- In accordance with this Contract and 42 CFR 438.208(c)(3), an individualized treatment plan for an enrollee determined to need a course of treatment or regular care monitoring must be:
    - Developed by the enrollee's direct service mental health care professional with enrollee participation and in consultation with any specialists caring for the enrollee;
    - Approved by the Health Plan in a timely manner if this approval is required; and
    - Developed in accordance with any applicable Agency quality assurance and utilization review standards.

Newly managed services under the Medicaid contract for behavioral health:

- Substance Abuse Therapeutic Group Home. Therapeutic Group Home services are specialized therapeutic services provided to recipients under the age of 21 with mental health, substance use, and co-occurring mental health and substance use disorders.

- Therapeutic Foster Care Services - Specialized therapeutic foster care (STFC) services include clinical interventions by the specialized therapeutic foster parent, the primary clinician and a psychiatrist. STFC services enable a recipient to manage and to work toward resolution of emotional, behavioral, or psychiatric problems in a highly supportive, individualized, and flexible
- Residential Care – For Pregnant Women
- Statewide Patient Psychiatric Program (SIPP) - The Statewide Inpatient Psychiatric Program (SIPP) is an inpatient psychiatric residential treatment setting providing active, individualized, family-centered mental health treatment with a recipient and family. The service requires extensive aftercare planning and coordination from the time of admission
- Behavioral Health Overlay Services - Child Welfare Settings - Behavioral Health Overlay Services provide mental health, substance abuse, and supportive services, including therapy, behavior management, and therapeutic support to children in group home settings licensed by the Department of Children and Families.
- Comprehensive Behavioral Health Assessments - A comprehensive behavioral health assessment (CBHA) is an in-depth, detailed assessment of a recipient's emotional, social, behavioral, and developmental

APPENDIX B: Hospital Discharge Planning Guidelines

Six Essential Components in Effective Discharge Planning:

1. **Timeliness.** Discharge planning begins at time of admission and continues throughout the duration of the hospitalization.
2. **Enrollee Engagement.** Promotes enrollees' participation in identifying their post-discharge needs, potential (non-clinical) barriers to discharge, and selecting options for aftercare.
3. **Involvement of Support System.** Requires active input and participation from (as available):
    a. Family/significant other(s)/parents/custodian/legal guardian/caretaker, in the case of minors, or a person adjudicated incompetent, as applicable and appropriate
    b. Enrollees of the hospital treatment team
    c. Community case manager or forensic specialist/forensic case manager (when applicable)
4. **Comprehensive and Specific**. Addresses and specifies the support and services a person will need and want when returning to their home and community, allowing for informed choice. Depending on the needs identified, the services may include:
    a. Placement/Housing. Provides the enrollee with information regarding available residential/housing options.
    b. Social Support. Provides the enrollee with information regarding available options in the community for additional support/structure/socialization opportunities upon discharge.
    c. Social Service Assistance. Provides the enrollee with information regarding available social service agencies that can provide assistance with needs such as meals, temporary financial aid, vocational training, employment assistance, devices/aid for physical handicaps. Ensures the enrollee has sufficient identification (Driver's license, birth certificate, marriage certificate(s), driver's license, current passport, or U.S. Military-issued photo ID, or State-issued ID card) to support the application for any needed social service benefit/assistance.
    d. Proper Preparation. Encourages the person to take as much responsibility as possible for addressing their medical and psychiatric needs upon discharge and provides information regarding diagnosis/illness and medications (including possible side effects and the benefits/risks of compliance), strategies for symptom management; crisis/relapse prevention; signs of relapse/symptoms; and/or signs of condition worsening and appropriate steps to take.
5. **Follow-Up Appointment.** Ensures an aftercare / post-discharge appointment has been secured with the enrollees' outpatient provider within the required timeframe (for Medicaid – 24-hours post discharge).
6. **Discharge Instruction.** Provides enrollee with written discharge instructions, recommendations, including discharge medications and follow-up appointment(s) with date, time, and contact information.

APPENDIX C: Service Vision and Core Treatment Values

Service Vision

Providing enrollees the necessary services and support to attain and maintain the most dignified life and highest level of functioning possible.

Ten Core Treatment Principles and Values

1. All individuals have a basic human right to be treated with dignity and respect.
2. Quality is maintained by ethical and compassionate care.
3. Professional relationships are founded on authenticity, honesty, and integrity.
4. Sound, professional judgment guided by the enrollee's best interest.
5. Treatment and placement must always be provided in the safest, least restrictive environment reasonably expected to lead to the best treatment outcome.
6. Coordination and communication with the enrollee's Primary Care Provider (PCP) and other care providers are essential to ensuring safe, effective and efficient care.
7. Providing clinically appropriate treatment requires meeting the enrollee's physical and emotional needs and taking into consideration their cultural preferences and linguistic needs.
8. An empowering, enrollee-centered, strength-based, recovery-focused approach to care is the core of quality care.
9. The inclusion of enrollee's family and natural/community support system in the treatment process is critical to positive, more enduring outcomes.
10. Professionalism is enhanced with a commitment to increasing our knowledge and skill level through continued educational opportunities, including knowledge of the nature of social diversity (race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability).

APPENDIX D: Enrollee-Centered Care: Overview and Educational Resources

The Institute of Medicine identifies enrollee centeredness as a core component of quality health care. They describe enrollee centeredness as encompassing: ***"qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual enrollee."***[1]

The Institute defines enrollee centeredness as:

[H]ealth care that establishes a partnership among practitioners, enrollees, and their families (when appropriate) to ensure that decisions respect enrollees' wants, needs, and preferences and that enrollees have the education and support they need to make decisions and participate in their own care.[2]

The enrollee-centered approach includes:

- *Viewing the enrollee as a unique person, rather than focusing strictly on the illness*
- *Building a therapeutic alliance based on the enrollee's and the provider's perspectives.*

Enrollee-centered care is supported by good provider-enrollee communication so that enrollees' needs and wants are understood and addressed, and enrollees understand and participate in their own care. The approach to care has been shown to improve enrollees' health and health care. Unfortunately, many barriers exist to good communication. Providers also differ in communication proficiency, including varied listening skills and different views from their enrollees' of symptoms and treatment effectiveness.[9]

Additional factors influencing enrollee centeredness and provider-enrollee communication include:

- *Language barriers*
- *Racial and ethnic concordance between the enrollee and provider*
- *Effects of disabilities on enrollees' health care experiences*
- *Providers' cultur*al competency

Efforts to remove these possible impediments to enrollee centeredness are underway within the Department of Health and Human Services (HHS). For example, the Office of Minority Health has developed a set of Cultural Competency Curriculum Modules that aim to equip providers with cultural and linguistic competencies to help promote enrollee-centered care.[10] [*Available at: www.thinkculturalhealth.hhs.gov*] These modules are based on the National Standards on Culturally and Linguistically Appropriate Services. The standards are directed at health care organizations and aim to improve the enrollee centeredness of care for people with limited English proficiency (LEP).

Another example, which is being administered by the Health Resources and Services Administration, is Unified Health Communication, a Web-based course for providers that integrates concepts related to health literacy with cultural competency and LEP.

The importance of translation and interpretation services has been noted as essential in facilitating communication between the healthcare provider and the enrollee.

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APPENDIX E: Promoting Cultural and Linguistic Competence

Self- Assessment Checklist for Providers

DEVELOPED BY: T. Goode, National Center for Cultural Competence, Georgetown University **National Center for Cultural Competence**, 3307 M Street, NW, Suite 401, Washington, DC 20007

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TARGET GROUP: Healthcare workers

PURPOSE:

- To increase individual awareness of practices, beliefs, attitudes and values that promotes and hinders cultural and linguistic competence in the delivery of health care.
- To identify training needs.

DISTINGUISHING CHARACTERISTICS: Divided into 3 categories:

1. Physical Environment, Materials, and Resources
2. Communication Styles
3. Values and Attitudes

RATING SCALE: Each item is rated on a 3-point scale

SELF-ASSESMENT CHECKLIST

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices, which foster cultural and linguistic competence at the individual or practitioner level.

DIRECTIONS: Select A, B, or C for each item listed below.

A = Things I do frequently

B = Things I do occasionally

C = Things I do rarely or never

I. PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

1. 1l display pictures, posters, artwork and other décor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.
2. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.
3. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.
4. I insure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

II. COMMUNICATION STYLES

1. When interacting with individuals and families who have limited English proficiency, I always keep in mind that:
    a. *Limitations in English proficiency is in no way a reflection of their level of intellectual functioning.*
    b. *Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.*
    c. *They may or may not be literate in their language of origin or English.*
2. I use bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.
3. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.
4. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.
5. When possible, I insure that all notices and communiqués to individuals and families are written in their language of origin.
6. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method.

III. VALUES & ATTITUDES

1. I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
2. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.
3. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors which show cultural insensitivity, racial biases and prejudice.
4. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
5. I understand and accept that family is defined differently by different cultures (e.g. extended family enrollees, fictive kin, godparents).
6. I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g. who makes major decisions for the family).
7. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).
8. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.
9. I recognize that the meaning or value of medical treatment and health education may vary greatly

among cultures.

10. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.
11. I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.
12. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.
13. I understand that grief and bereavement are influenced by culture.
14. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.
15. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.
16. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.
17. I am aware of the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my program or agency.
18. I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.
19. I avail myself of professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health care delivery programs.

APPENDIX F: Web-based Resources for Cultural Competence Training

Web links to Cultural Competence Resources

- The U.S. Department of Health and Human Services, Office of Minority Health (includes access to the 14 CLAS standards; http://minorityhealth.hhs.gov.)
- The Agency for Healthcare & Human Services – Cultural and Linguistic Competency site at: http://www.ahrq.gov/path/compath.htm.
- The National Center for Cultural Competence (NCCC), Georgetown University Center for Child and Human Development at: http://nccc.georgetown.edu.
- NAMI STAR Center and The University of Illinois at Chicago, National Research and Training Center at: http://www.consumerstar.org/pubs/SC- Cultural_Competency_in_Mental_Health_Tool.pdf.
- CLAS Institute (Culturally & Linguistically Appropriate Services) at: clas.uiuc.edu.
- Department of Human Services (DHS) Oregon, "Cultural Competence & Diversity", at DHS – Toolkit for Managers) at: http://www.dhs.state.or.us/tools/diversity/tools/cctools- managers.pdf.
- UCLA, "Cultural Diversity and Health Care" – a PowerPoint presentation (with specific communication examples, tips on working with translators at: healthcare.ucla.edu.

APPENDIX G: Medical Records Standards: Chart Review Guidelines

Consistent, current and complete documentation in the treatment record is essential.

Identification and Legibility:

- Each page of the medical record should have the enrollee name and/or an enrollee ID number and all entries should be dated and legible to someone other than the writer.
- The record includes:
    a. Biographical information including date of birth, gender, marital/civil status, and legal guardianship, if applicable.
    b. Demographic information: including home address and telephone and/or cell numbers, employer and work phones, if applicable, and emergency contact name and phone number.
    c. Appropriate signed dated and witnessed authorization and consent forms.

The clinician and his/her credentials are identified on each entry.

- All entries in the treatment record include the responsible clinician's name, and licensure. Name or first initial and last name should follow each entry in the record. First and last initials can be used if they are referenced and explained somewhere in the record. Relevant provider identification number may also be included, if applicable.

Advance Directives-Documentation (MD services; applicable to Adults 18 and over)

- Documentation that the Enrollee was provided written information concerning advance directives and documentation as to whether or not the enrollee has executed an advance directive *(as per Florida Statute 765.110 and Medicaid contract 20.13 Medical record requirements; Michigan Medicaid CHCP Contract requiring compliance with 42 C.F.R. 434.28 & Public Act 386 recognizing the Durable Power of Attorney for Healthcare (DPAHC)*; (Applies to).

Enrollee Rights/Responsibilities are available.

- Enrollee rights and responsibilities are available in the facility or practitioner site for receipt, posted for viewing, and/or reviewed with the enrollee.

Presenting Problems:

- The presenting problems, along with relevant psychological and social conditions affecting the enrollee's medical and psychiatric status and the results of the mental status exam are documented.
- The documentation of presenting problem shows evidence of screening for domestic violence, abuse and/or neglect (in the case of minors, elderly and the disabled), and abuse of substance.
- If abuse and/or neglect have been identified, there is documentation of report to / contact with Florida Abuse (DCF).

Special Status/Safety Risk factors are prominently noted, documented, and revised

- Special situations may include imminent risk of harm, suicidal ideation, elopement potential, etc. This may be addressed in the notes or in the treatment plan.
- Danger to self or others is acted upon by the practitioner/provider with the appropriate level of urgency.

Medical and psychiatric histories are documented. (This applies to both inpatient and outpatient records)

- The record includes a documented medical and psychiatric history, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information, history of alcohol use/abuse and evidence of impact daily functioning and mental status exam.

A DSM diagnosis (es) is documented.

- The diagnoses address all five Axes and reflect significant clinical findings or the evaluation/assessment processes are identified in initial psychiatric history and evaluation.
- The record shows a minimum of symptoms to support the diagnoses.
- The GAF score positively increases as a result of treatment (for outpatient services, over a period of 3 months of treatment).

Prescribed Medications are listed.

- The listing of medications includes drug names, dosages, frequency, prescribing provider (and their contact information) and dates of initiation for each; refills are clearly documented;
- A history of adverse drug reactions, significant side effects, and/or sensitivities is documented and adverse reactions / side effects identified are posted in a prominent place in the chart. If the enrollee is allergic to a medication, this is expected to be on the front of the chart (applies to MDs and ARNPs) and if the record is inpatient it is expected that the information also be noted on the medication sheet.
- Medication information is recorded on the initial evaluation/assessment and updated in the progress notes/Rx order sheet/special medication record sheet, as changes occur
- History of compliance with medication is documented; issues of irregular and/or non-compliance with Rx are included in the treatment plan.

Health Issues and Allergies

- The medical history is documented; any medical condition identified is included under the Axis III diagnosis; the information is updated when changes occur.
- Relevant medical issues identified are appropriately addressed as part of the care plan.
- The history includes allergies and/or lack of known allergies and their presence/absence is clearly documented; (inpatient records) recorded outside of the chart (NKA, sticker)

Developmental History (Children & Adolescents)

- A developmental history is documented. including prenatal events, milestones, psychological, social, intellectual, and academic achievements and/or challenges
- For enrollees 12 and over, the history includes past and present use (or non-use) of cigarettes and alcohol, prescribed and over-the-counter medications, and illicit drugs.

Appropriate Treatment Planning

- The treatment plan is consistent with diagnosis and has measurable goals and estimated time frames for attainment.
- Treatment interventions are consistent with the diagnosis and treatment plan goals.
- The enrollee has signed the treatment plan; there is supporting documentation that the enrollee participated in the development of the treatment plan, was given education regarding interventions and options, and gave informed consent.

- The enrollee's strengths and limitations are identified (if not included in the care plan, found in the assessment and reflected in progress notes).
- Enrollees who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care. (For instance, an agitated enrollee may need to be secluded. A suicidal enrollee in outpatient treatment may need to be transferred to an inpatient facility based on results of a risk assessment).
- The treatment record documents supportive and preventive services, such as AA/NA, relapse prevention, case management services, job placement, stress management, wellness programs, housing, food banks, etc.
- The treatment record reflects continuity and coordination of care among behavioral health clinicians, consultants, ancillary providers, and health care institutions.
    - This refers to communication between behavioral health providers and practitioners, exchange of information regarding medication, management of co-existing behavioral/medical disorders (i.e., obesity, pain, and/or exchange of information following a referral to behavioral health from medical) with written consent from the enrollee.
    - For example: the enrollee may be seeing a therapist and an MD, so communication is expected between them. Release of information should be offered to the enrollee to allow the exchange of information to appropriate practitioners.
    - Non-psychiatrist behavioral health practitioners should have psychiatrist feedback documented in their treatment records.
    - There is a signed release obtaining consent for the exchange of information between providers outside of the facility in the case of a hospital stay. If enrollee refuses to sign there should be documentation of the refusal.
    - Health education and wellness promotion services, whether they occur within the context of a clinical visitor or not, are referenced or documented in the clinical record.

Appropriate Discharge (D/C) Planning

- The treatment plan documents an ongoing D/C planning process from onset of services through termination.
- Upon D/C or termination of services, the enrollee receives D/C instructions and/or aftercare recommendations consistent with the level of care/treatment needs.
- The dates of follow-up appointments for continued treatment after hospitalization meet the timeframe standards **(OP appointment scheduled within 7 days following discharge from inpatient facility)**.

The PCP was notified of hospitalization/treatment/medications/discharge plan/termination and follow-up recommendations.

- Release of information should be offered to the enrollee to allow the exchange of information to appropriate practitioners. Credit is given if there is a signed release obtaining consent and is documented in the record. Enrollee may refuse to sign and, if so, there should be documentation of the refusal.
- If enrollee claims no PCP or treating professional, no credit is given as provider should be proactive in obtaining a PCP for enrollee (unless enrollee is a PPO enrollee).

APPENDIX H: Site Survey Tools

Practitioner Site Survey Assessment Tool

Provider's Name _____ Date _____

Practice _____

I. Physical Accessibility	Yes	No	N/A	Comments
1. Complies with state and local requirements? (Occupational license and professional license posted)	☐	☐	☐	
2. Is the office handicapped accessible?	☐	☐	☐	
3. Are office hours posted?	☐	☐	☐	
4. Are member rights and responsibilities posted in the office and a copy made available to patients upon request?	☐	☐	☐	
II. Physical Appearance	**Yes**	**No**	**N/A**	**Comments**
5. Facility is safe, clean, properly maintained and free of hazards?	☐	☐	☐	
6. Well-lit waiting room	☐	☐	☐	
7. Are there fire extinguisher and/or sprinklers?	☐	☐	☐	
III. Adequacy of Waiting & Examining Room Space	**Yes**	**No**	**N/A**	**Comments**
8. Adequate seating	☐	☐	☐	
9. Are examining rooms and consulting offices designed for privacy?	☐	☐	☐	
IV. Adequacy of treatment record keeping: (at least one blinded record must be reviewed)	**Yes**	**No**	**N/A**	**Comments**
10. Are the medical records maintained in a secure/confidential filing system?	☐	☐	☐	
11. Are records easily located? Are file markers legible?	☐	☐	☐	
12. Is there a process to make records available to other treating practitioners at the site?	☐	☐	☐	
13. Is there a procedure for release form of medical records, including release of information on minors when applicable?	☐	☐	☐	
14. Is the member name/ID # on all pages and member demographic information documented?	☐	☐	☐	
15. Is there a treatment record for each patient and are entries signed/dated/legible?	☐	☐	☐	
V. Appointments for Behavioral Healthcare	**Yes**	**No**	**N/A**	**Comments**
16. Does the practitioner meet with the 24-hour life-threatening emergency coverage?	☐	☐	☐	
17. Are there available appointments for Urgent Care within 48 hours?	☐	☐	☐	
18. Are there appointments available for non-life threatening emergencies within 6 hours?	☐	☐	☐	
19. Are there appointments for routine care within 10 business days?	☐	☐	☐	
20. Is there a disaster plan in place regarding the scheduling or re-scheduling appointments?	☐	☐	☐	
Is the staff bilingual? If "yes" please note language(s) spoken in comments.	☐	☐	☐	
Is there evidence of a safety program and emergency preparedness plan?	☐	☐	☐	

Practitioner Site Survey Assessment Tool SCORING

Provider's Name _____ Date _____

Practice _____

Scoring:

YES = 5 Points, NO= 0 Points

- Physical Accessibility _____
- Physical Appearance _____
- Adequacy of Waiting & Examining Room Space _____
- Adequacy of treatment record keeping _____
- Global score _____

A score below 85% requires a corrective action plan (CAP) to be implemented prior to Credentialing Committee review.

CORRECTIVE ACTION PLAN (CAP)

	YES	NO
1. CAP required (circle one)	☐	☐
2. Date CAP requested (attach copy of written request)	☐	☐
3. Date CAP received *(attach copy of CAP)*	☐	☐
4. Date of Chief Medical Officer review	☐	☐
5. Date of Credential Committee review	☐	☐
6. Date documents placed in credential file	☐	☐
7. Re-assessment date (if CAP requires re-assessment, must be in 6 months)	☐	☐

Reviewer's Name _____ Date _____

Date documents placed in credential file _____

Facility Site Survey Assessment Tool

Provider's Name _____ Date _____

Practice _____

Site Review Criteria:

I. Physical Accessibility	Yes	No	N/A	Comments
1. Complies with state and local requirements? (Occupational license and professional license posted)	☐	☐	☐	
2. Is the office handicapped accessible?	☐	☐	☐	
3. Are office hours posted?	☐	☐	☐	
4. Are member rights and responsibilities posted in the office and a copy made available to patients upon request?	☐	☐	☐	
II. Physical Appearance	**Yes**	**No**	**N/A**	**Comments**
5. Facility is safe, clean, properly maintained and free of hazards?	☐	☐	☐	
6. Well-lit waiting room	☐	☐	☐	
7. Are there fire extinguisher and/or sprinklers?	☐	☐	☐	
III. Adequacy of Waiting & Examining Room Space	**Yes**	**No**	**N/A**	**Comments**
8. Adequate seating	☐	☐	☐	
9. Are examining rooms and consulting offices designed for privacy?	☐	☐	☐	
IV. Adequacy of treatment record keeping: (at least one blinded record must be reviewed)	**Yes**	**No**	**N/A**	**Comments**
10. Are the medical records maintained in a secure/confidential filing system?	☐	☐	☐	
11. Are records easily located? Are file markers legible?	☐	☐	☐	
12. Is there a process to make records available to other treating practitioners at the site?	☐	☐	☐	
13. Is there a procedure for release form of medical records, including release of information on minors when applicable?	☐	☐	☐	
14. Is the member name/ID # on all pages and member demographic information documented?	☐	☐	☐	
15. Is there a treatment record for each patient and are entries signed/dated/legible?	☐	☐	☐	
V. Appointments for Behavioral Healthcare	**Yes**	**No**	**N/A**	**Comments**
16. Does the practitioner meet with the 24-hour life-threatening emergency coverage?	☐	☐	☐	
17. Are there available appointments for Urgent Care within 48 hours?	☐	☐	☐	
18. Are there appointments available for non-life threatening emergencies within 6 hours?	☐	☐	☐	
19. Are there appointments for routine care within 10 business days?	☐	☐	☐	
20. Is there a disaster plan in place regarding the scheduling or re-scheduling appointments?	☐	☐	☐	
VI. Facility's Current Credentialing Process (at least one sample file must be reviewed)	**Yes**	**No**	**N/A**	**Comments**
21. Does your facility perform credentialing verification on all its practitioners?	☐	☐	☐	
22. Is your credentialing process conducted internally or contracted?	☐	☐	☐	

23. Is a confidential file maintained for all practitioners?	☐	☐	☐	
24. Is there ongoing monitoring of licenses/certifications and/or training?	☐	☐	☐	
25. Does your agency conduct appropriate employment screening as required by Florida Statute 435? **Check Level:** ☐ **Level 1** ☐ **Level 2**	☐	☐	☐	
Is the staff bilingual? If "yes" please note language(s) spoken in comments.	☐	☐	☐	
Is there evidence of a safety program and emergency preparedness plan?	☐	☐	☐	

Facility Site Survey Assessment Tool SCORING

Provider's Name _____ Date _____

Practice _____

Practitioner name: _____ Survey date: _____

Office location: _____

Scoring:

YES = 5 Points, NO= 0 Points

- Physical Accessibility _____
- Physical Appearance _____
- Adequacy of Waiting & Examining Room Space _____
- Adequacy of treatment record keeping _____
- Global score _____

A score below 85% requires a corrective action plan (CAP) to be implemented prior to Credentialing Committee review.

CORRECTIVE ACTION PLAN (CAP)

	YES	NO
1. CAP required (circle one)	☐	☐
2. Date CAP requested (attach copy of written request)	☐	☐
3. Date CAP received *(attach copy of CAP)*	☐	☐
4. Date of Chief Medical Officer review	☐	☐
5. Date of Credential Committee review	☐	☐
6. Date documents placed in credential file	☐	☐
7. Re-assessment date (if CAP requires re-assessment, must be in 6 months)	☐	☐

Reviewer's Name _____ Date _____

Date documents placed in credential file _____

Site Survey Assessment Tool (based on Provider Site Quality Complaint)

Provider's Name _____ Date _____

Practice _____

Member's Complaint Summary:

_____

_____

_____

_____

_____

Site Review Criteria:

I. Physical Accessibility	Yes	No	N/A	Comments
1. Complies with state and local requirements? (Occupational license and professional license posted)	☐	☐	☐	
2. Is the office handicapped accessible?	☐	☐	☐	
3. Are office hours posted?	☐	☐	☐	
4. Are member rights and responsibilities posted in the office and a copy made available to patients upon request?	☐	☐	☐	
II. Physical Appearance	**Yes**	**No**	**N/A**	**Comments**
5. Facility is safe, clean, properly maintained and free of hazards?	☐	☐	☐	
6. Well-lit waiting room	☐	☐	☐	
7. Are there fire extinguisher and/or sprinklers?	☐	☐	☐	
III. Adequacy of Waiting & Examining Room Space	**Yes**	**No**	**N/A**	**Comments**
8. Adequate seating	☐	☐	☐	
9. Are examining rooms and consulting offices designed for privacy?	☐	☐	☐	
IV. Adequacy of treatment record keeping: (at least one blinded record must be reviewed)	**Yes**	**No**	**N/A**	**Comments**
10. Are the medical records maintained in a secure/confidential filing system?	☐	☐	☐	
11. Are records easily located? Are file markers legible?	☐	☐	☐	
12. Is there a process to make records available to other treating practitioners at the site?	☐	☐	☐	
13. Is there a procedure for release form of medical records, including release of information on minors when applicable?	☐	☐	☐	
14. Is the member name/ID # on all pages and member demographic information documented?	☐	☐	☐	
15. Is there a treatment record for each patient and are entries signed/dated/legible?	☐	☐	☐	
V. Appointments for Behavioral Healthcare	**Yes**	**No**	**N/A**	**Comments**
16. Does the practitioner meet with the 24-hour life-threatening emergency coverage?	☐	☐	☐	
17. Are there available appointments for Urgent Care within 48 hours?	☐	☐	☐	

18. Are there appointments available for non-life threatening emergencies within 6 hours?	☐	☐	☐	
19. Are there appointments for routine care within 10 business days?	☐	☐	☐	
20. Is there a disaster plan in place regarding the scheduling or re-scheduling appointments?	☐	☐	☐	
Additional Items	**Yes**	**No**	**N/A**	**Comments**
Is the staff bilingual? If "yes" please note language(s) spoken in comments.	☐	☐	☐	
Is there evidence of a safety program and emergency preparedness plan?	☐	☐	☐	

Site Quality Survey Assessment Tool SCORING

Provider's Name _____ Date _____

Practice Address _____

Scoring:

YES = 5 Points, NO= 0 Points

- Physical Accessibility _____
- Physical Appearance _____
- Adequacy of Waiting & Examining Room Space _____
- Adequacy of treatment record keeping _____
- Global score _____

A score below 85% requires a corrective action plan (CAP) to be implemented prior to Credentialing Committee review.

CORRECTIVE ACTION PLAN (CAP)

	YES	NO
1. CAP required (circle one)	☐	☐
2. Date CAP requested (attach copy of written request)	☐	☐
3. Date CAP received *(attach copy of CAP)*	☐	☐
4. Date of Chief Medical Officer review	☐	☐
5. Date of Credential Committee review	☐	☐
6. Date documents placed in credential file	☐	☐
7. Re-assessment date (if CAP requires re-assessment, must be in 6 months)	☐	☐

Reviewer's Name _____ Date _____

Date documents placed in credential file _____

APPENDIX I: Practitioner Communications

Practitioner Communication Letter for New Practitioner Welcome Packet

Date

Dear Practitioner:

Carisk Behavioral Health (Carisk) would like to remind you about our website (http://www.cariskbh.com) and Provider Portal, where we include information about many topics of interest, including a Provider Manual.

- Information about Carisk's Quality Improvement Program including goals, processes and outcomes as related to care and service.
- Information about Carisk's behavioral health care screening programs, including how to use the services and how Carisk works with a practitioner's patients in the program. The website has screening tools for Patients to use for:
- Alcohol Use Disorder Identification Test (AUDIT)
- Patient Health Questionnaire (PHQ9)
- The process to refer Patients to case management.
- Information about how to obtain or view copies of Carisk's adopted clinical practice guidelines, including those for:
    - Body Mass Index (BMI)
    - Stop Smoking
    - Alcohol
    - Depression
- Information about Carisk's medical necessity criteria, including how to obtain or view a copy.
- Information about the availability of staff to answer questions about UM issues.
- The toll-free number to contact staff regarding UM issues.
- The availability of TDD/TTY services for Patients.
- Information about how Patients may obtain language assistance to discuss UM issues.
- Carisk's policy prohibiting financial incentives for utilization management decision-makers.
- A description of the process to review information submitted to support a practitioner's credentialing application, correct erroneous information and, upon request, to be informed of the status of the credentialing or recredentialing application status.
- Carisk's Member rights and responsibilities statement.

If you have any questions about accessing our website and Provider Portal, or if you would like more information about any of the above items, please call the Provider Relations Department at 1-855-541-5300. The most recent information about Carisk and our services is always available on our website.

Thank you,

Carisk Behavioral Health
Provider Relations Department

Annual Practitioner Communication Letter

Date

Dear Practitioner:

Carisk Behavioral Health (Carisk) would like to remind you about our website (http://www.cariskbh.com) and Provider Portal, where we include information about many topics of interest, including a Provider Manual.

1. Information about Carisk's Quality Improvement Program including goals, processes and outcomes as related to care and service.
2. Carisk's efforts to measure the availability of practitioners, facilities and treatment programs and actions taken to improve availability.
3. Carisk's Cultural Competency Plan.
4. Carisk's efforts to measure the accessibility of care and service for our Members (such as how long it takes to get an appointment) and actions taken to improve accessibility.
5. Information about the overall findings of Carisk's Member satisfaction activities (such as our annual Member satisfaction survey), including what we did to improve satisfaction.
6. Information about how to obtain copies of Carisk's clinical practice guidelines and process to measure adherence to the guidelines, including those adopted from the APA for:

   Major Depression Disorder (MDD), Panic Disorder, Bipolar Disorder, Suicide, Schizophrenia, and Substance Use Disorders (including alcohol); those adopted by the AAP for Attention-Deficit Hyperactivity Disorder (ADHD) and for Autism; and the policies for psychiatric consults adopted from the American Academy of Psychosomatic Medicine.
7. Carisk's expectations for exchange of information with PCPs and within the behavioral health continuum to facilitate continuity and coordination of care.
8. Carisk's Medical Necessity Criteria, including how to obtain or view a copy.
9. The process to refer Members to case management.
10. The availability of TDD/TTY services for Members .
11. The availability of staff to answer questions about the UM process.
12. The toll-free number to contact staff regarding UM issues.
13. Information about how Members may obtain language assistance to discuss UM issues.
14. The availability of, and process for, contacting an appropriate Carisk Peer Reviewer to discuss utilization management decisions.
15. A description of the independent external appeals process for utilization management decisions made by Carisk.
16. Carisk's policy prohibiting financial incentives for utilization management decision-makers.
17. A description of the process to review information submitted to support a practitioner's credentialing application, correct erroneous information and, upon request, to be informed of the status of the credentialing or re-credentialing application.
18. Carisk's Member rights and responsibilities statement.

19. Carisk's Notice of Privacy Practices and confidentiality policies including what a "routine consent" is and how it allows Carisk to use information about enrollees; their right to approve the release of personal health information not covered by the "routine consent;" how they may request restrictions on the use or disclosure of personal health information or records, amendments to personal health information, access to their medical records, or an accounting of disclosures of personal health information; protections for physical facility access, protections for electronic access, media device controls, physical safeguards for workstations, and procedures for allowing impermissible uses or disclosures of sensitive information, taking action when protections prove insufficient.
20. Information about Carisk's behavioral health screening programs:
    - Alcohol Use Disorder Identification Test (AUDIT)
    - Patient Health Questionnaire (PHQ9)
21. Information about Carisk's self-management tools, which are designed to help Members stay healthy:
    - Body Mass Index (BMI)
    - Stop Smoking
    - Alcohol
    - Depression
22. Information about promoting patient safety and improving safe clinical practices
23. Carisk's treatment record policies regarding confidentiality of treatment records, documentation standards, systems for organization of treatment records, standards for availability of treatment records at the practice site, and performance goals.

If you have any questions about accessing our website or if you would like more information or paper copies of any of the above items, please call the Provider Relations Department at 1-855-541-5300.

Thank you,

Carisk Behavioral Health

Provider Relations Department