Concordia Behavioral Health

Easy Reference Manual for Providers

"Delivering Responsive and Compassionate Behavioral Health Care"

TABLE OF CONTENTS

I. INTRODUCTION TO CONCORDIA BEHAVIORAL HEALTH

Welcome to Concordia Behavioral Health! We would like to thank you for choosing to actively participate in our Provider Network and for sharing our commitment to ensure that our members have access to high-quality compassionate behavioral healthcare.

This Provider Manual has been developed to help inform and guide your relationship with us and with our Concordia Behavioral Health ("Concordia") members. This Manual aims to describe our: mission, values and philosophy, expectations, relevant aspects of our services, and policies and procedures essential to delivering effective, quality care to our members. You will find that our policies and procedures are based on State and Federal regulations and standards set and established by accrediting agencies, the healthcare industry and Concordia's Health Plan clients. There are times when Concordia will issue and disseminate updates and amendments to our Provider Manual in response to regulatory changes and/or internal (organizational) policy revisions. Concordia will notify you of these changes in a timely manner and will provide you with a summary of the changes. Our updated Provider Manual will also be available to you on our website at www.concordiabh.com to download in .PDF format.

We hope you will find our Manual user-friendly. It hopes to address some of the most commonly asked questions providers have. If you ever have any question about our processes or need to reach us, we are a phone call or email away. We welcome comments and suggestions.

Main Phone Number:	Local (Miami-Dade): 305-514-5300 TYY: 305-514-5399	Toll Free: 855-541-5300
Via Email:	Care Coordination and Advocacy: Provider Services: Credentialing Claims:	advocacy@concordiabh.com providers@concordiabh.com credentialing@concordiabh.com claims@concordiabh.com

Our business hours are Monday through Friday 8:30 AM to 5:30 PM. Additionally, there is always a Concordia Care Advocate available to you 7 days a week, 24 hours a day for urgent and emergency situations, benefit decisions, appeals (when delegated to Concordia by the health plan) and other care related questions. They can be reached after hours, on weekends and holidays through our main office phone number.

We look forward to building a strong and effective partnership with you and always welcome your questions, comments and suggestions.

MISSION AND VISION

To provide a more responsive and compassionate behavioral health care experience to the people we serve.

CORE VALUES

Compassion

Do unto all persons as you would have them do unto you.
Walk in the shoes of those we partner with or serve.

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 in all we do.

PHILOSOPHY, EXPECTATIONS AND GOALS

At Concordia we are dedicated to administering an ***integrated*** care delivery system that ensures all behavioral healthcare services are clinically responsive, safe, timely, cost-effective, and delivered in a compassionate manner. We hold ourselves to the highest of standards and strive to be a socially conscious company that makes a positive difference in the lives of those we serve and with whom we work. We are committed to continually reviewing and improving *every* process and system to ensure excellent behavioral care outcomes for the members we serve.

The founders of Concordia have been involved in all aspects of the healthcare system. While recognizing that our principal commitment is to the health and well-being of our members, we are ultimately guided by a genuine interest in the satisfaction of ALL who are involved in the care delivery process and aim to exceed the expectations of our members and Provider-partners. At Concordia, we want to ensure that all members receive the most appropriate behavioral healthcare services available in the least restrictive environment possible. We will exercise flexibility in the utilization of resources in order to achieve a good clinical result. We will work to establish a collegial, cooperative and collaborative relationship with our Network of Practitioners and Providers. Among the benefits you will find in partnering with us are:

- A Company that aims to support the growth of our Provider Partners and that will work to minimize the time our Providers spend on non-client centered practices (e.g., excessive paperwork or waiting for responses)

- A Provider Services Department and staff that is responsive to the needs of our Providers and strives to foster respectful, mutually beneficial partnerships

- A Utilization Management (UM) team and clinical staff that sees our Network Providers as colleagues – healthcare professionals whose clinical judgment is valuable, who share a vested interest in the care of our members and whose time is honored and respected

- Care Coordinators who are trained to process initial member calls and always ready to facilitate the referral and pre-authorization process

- Care Advocates (Licensed Clinicians) who are accessible 7 days a week, 24 hours a day to manage requests for service, facilitate referrals and authorizations, assist and help guide level of care transitions, make care and utilization determinations fairly, effectively and efficiently, and answer any coordination of care or UM question that may arise

- A Claims department and personnel dedicated to the timely and accurate processing and payment of claims submitted by our Providers for covered authorized services

- A Concordia team that is open to studying and embracing innovative methods for delivering effective and responsive behavioral healthcare to members through an active partnership with Network providers while tackling the dilemma of rising health care costs. This means that we are willing to introduce new methods as we grow our company and discover better ways of doing things

At Concordia we hold one overriding expectation of our Network Providers – that they join us in promoting high-quality, cost-conscious, compassionate care to our members. We believe that instilling trust in our members through our actions and empowering them to make informed decisions regarding their treatment are basic aspects of quality care. This enhances their recovery process, contributes to treatment compliance and improves the outcome. Our members need to know that when it comes to their behavioral health care, our Network Providers listen attentively, remember their individual stories, respond compassionately, welcome their questions and invite their active participation in the planning of care.

Concordia believes that collaboration and coordination of care by treating practitioners contributes to the delivery of safe, effective and clinically appropriate treatment. Communicating with the member's Primary Care Physician (PCP) is a central piece of this process. We request that our Providers explain the importance of this process to our members so that they provide written consent for these communications early in treatment. Concordia Providers can avail themselves to our forms designed to aid this process, or use their own.

II. PROVIDER SERVICES DEPARTMENT

Please use the contact information below if you have any questions related to Provider Services.

Provider Services: Local (Miami-Dade): 305-514-5330 Toll Free: 855-541-5300 ext.5330

Fax Numbers: Local (Miami-Dade): 305-514-5331

Emails: providers@concordiabh.com

credentialing@concordiabh.com

Mailing address: Concordia Behavioral Health
Attn: Provider Services Department
7190 SW 87th Avenue
Suite 204
Miami, FL 33173

Concordia's Provider Service Department is committed to building and maintaining our Behavioral Health Network contingent on the needs of our Commercial, Medicaid, and Medicare members and serve as a liaison between our company and its network of contracted providers. We contract with independent behavioral health practitioners, group practices, agencies, community mental health centers, hospitals and other health care facilities to provide a full range of services that include, but are not limited to inpatient care, partial hospitalization programs, residential treatment, intensive outpatient programs, the full spectrum of substance abuse treatment services, and outpatient treatment. Our Network of practitioners is comprised of multiple professional disciplines including psychiatrists, psychologists, clinical social workers, mental health counselors, nurse practitioners and addictions specialists. All behavioral health professionals with whom we contract must be at the Master's degree level or above. Concordia does not discriminate against any practitioner based on any characteristic protected under State or Federal discrimination laws. In fact, we hold diversity as an asset and nurture awareness of the global community by being open to people of differing races, nationalities, cultures, languages, ages, genders, abilities, economic and social backgrounds, political beliefs and religions, family styles and sexual orientation. Concordia strives to be an accepting and respectful environment for all. Furthermore, all credentialing and re-credentialing decisions are based on objective criteria.

APPLICATION AND CREDENTIALING

The Application Process: Practitioners interested in being credentialed by Concordia must complete and submit the Practitioner Credentialing Application or the CAQH application and accompanying forms and attestation. Applications can be obtained by calling our Provider Service Department at our main phone number. Once the application is completed, you may mail it accompanied by all the required supporting documentation to our main address.

Required Information from Practitioners: We are required to obtain the following information from applicants seeking to join our Network of credentialed Practitioners:

- Practice locations, specialty areas, cultural and ethnic backgrounds, and languages spoken
- 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)
- A copy of current state professional license
- Medicare, Medicaid and NPI numbers
- DEA (Drug Enforcement Agency) and CDS (Controlled Dangerous Substances) certificates (physicians only)
- Board Certification (physicians only)
- Two (2) Peer References
- Controlling Interest Form
- Executed Business Associate Agreement
- Education and professional training

- An updated resume or curriculum vitae, with five (5) year work history and explanation of gaps longer than 6 months
- Reasons for an inability to perform any functions of your profession
- History of sanctions, disciplinary actions and loss of privileges
- History of loss of license and any felony convictions
- Commitment to no illegal drug use
- Your signature on the application confirming that the information you provided is true and correct
- W-9

Required Information from Facilities: In addition to credentialing and contracting behavioral health practitioners, Concordia also contracts with facilities that provide inpatient and outpatient mental health and substance abuse services. We are required to obtain the following information from these entities:

- A current and valid state license
- Proof of accreditation
- General and Professional Liability insurance certificates
- W-9 forms
- Disclosure Ownership Form
- Signed malpractice claims statement/history
- Staff roster, including attending physicians
- Daily program schedules
- Program descriptions
- Facility billing information form

The Credentialing Process: When you complete and submit your Credentialing Application to us, along with all the required supporting documentation, the credentialing process begins. While Concordia 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 List of Excluded Individuals and Entities (LEIE). If the applicant practitioner and/or provider appear on the LEIE they shall not be credentialed as a Concordia network practitioner and/or provider.

Our credentialing process is based on the criteria set forth in Concordia's Credentialing Policies and Procedures and derived from the standards and requirements established by our Quality Improvement Program (QIP) and Quality Improvement Committee (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 our member populations and the provider's qualifications. Annually, if not more frequently, we use 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 our members. Secondarily, we make determinations based on member complaints, peer reviews, site visits and record reviews. The members of the Credentialing Committee, which includes representation by network practitioners, arrive at a consensus on credentialing and re-credentialing decisions to ensure that the process is fair and non-discriminatory.

You have the right to review the information we obtain about you through the credentialing process unless it is peer review protected. We 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 Concordia within **ten (10) days** of our notification of any discrepancy. All credentialing information is kept in a confidential credentialing file that does not leave our facility and is stored in a locked cabinet.

The Credentialing Committee meets at least 6 times per year to review applications but ad hoc meetings are held as needed. Within **ten (10) to sixty (60) days** of a credentialing decision, providers will receive a letter detailing the outcome.

Provider Training: Your contract with Concordia becomes effective the day you are approved by our Credentialing Committee. Once you are credentialed and receive your welcome letter, you may access the Provider Training Module online via the Provider Portal at our website: www.concordiabh.com. The module includes elements such as:

- Using the Provider Manual
- Provider responsibilities
- Maintaining credentialing files current
- Practitioner/Provider change in status procedures
- Our authorization Process
- Verifying member eligibility
- Care advocacy processes and forms
- HIPAA information
- Claims submission and electronic billing
- Concordia contact information for specific questions

SITE VISITS

Concordia will periodically conduct site visits. If we select your practice or facility for a visit, you will be notified ahead of time so that a convenient time can be scheduled. We will visit the offices of all practitioners when its threshold for member complaints has been met. When conducting site visits, Concordia uses a standardized scoring tool to assess the practice site. Among some of the things we will be looking for are: physical appearance and accessibility, adequacy of waiting and examining areas, record-keeping and confidentiality practices, and

availability of appointments.

For scores less than 85% of the office site criteria, the site visit reviewer requires a corrective action plan (CAP) in collaboration with the practitioner or his/her representative. If a practitioner relocates to a site that has already been visited, Concordia is not required to visit the site again. Instead, we must simply document the results of the site visit previously performed.

For accredited facilities, Concordia may accept a survey report or a letter from the accrediting body rather than conduct a site visit. However, Concordia must document that the accrediting body's survey criteria meets Concordia's quality assessment criteria.

RE-CREDENTIALING

Re-credentialing of our Network Practitioners occurs every 3 years. We will notify you ahead of time and provide you with a Re-credentialing Application for you to complete and return to us with the supportive documents required. You must respond within **thirty (30) days** of receipt of the packet or Concordia is required to terminate its contract with you in order to maintain its credentialing standards. All information and verification cannot be older than **one hundred and eighty (180) days** at the time of review by the credentialing committee.

The following documentation is required for re-credentialing:

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

During credentialing and re-credentialing cycles, and as needed between cycles, Concordia queries the web-based Council for Affordable Quality Healthcare (CAQH), the National Provider Data Bank (NPDB) and other databanks that we work with certification and licensing agencies. We also monitor network practitioner 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.

Our use of CAQH's Universal Provider Data Source to obtain the data needed for provider credentialing and re-credentialing streamlines the processes by allowing you to complete your applications online. This service is free to practitioners and is available **twenty-four (24) hours per day, seven (7) days-a-week**. 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 Concordia access to information pertaining to your professional standing. This is required for primary verification and/or review of your records.

Re-credentialing of our Network Providers occurs at a minimum once every three years when we confirm that the institution (agencies, accredited facilities) continues to be in good standing with state and federal regulatory bodies and accrediting agencies.

PROVIDER RESPONSIBILITIES

Concordia Network Providers are expected to adhere to the terms outlined on our Provider Agreement. Listed below is an overview of these commitments. You must:

- Adhere to all applicable state and federal laws, professional regulations and standards
- Treat members in a non-discriminatory and timely fashion
- Maintain treatment records on all Concordia patients
- Protect and safeguard patients' rights to confidentiality
- Coordinate care with the member's primary care physician and document this in the member's record (subject to applicable laws of confidentiality)
- Fully participate in credentialing, utilization management and quality improvement processes
- Allow, with reasonable notice, Concordia to review services provided to our members to assure quality
- Make treatment records available to Concordia for concurrent review compliant with HIPAA federal regulations and state regulations
- Continue to meet credentialing standards
- Notify Concordia Behavioral Health immediately of any adverse incidents (Adverse incidents include: members that have died from any cause, or who have suffered serious injury, or have committed suicide/homicide having caused serious injury to themselves or someone else.
- Notify Concordia of any change in your status, including:
    - Name change or merger
    - Change of address, or other demographic change
    - Change of Tax Id Number
    - Any lapse or change in professional malpractice liability coverage - new, renewed, or expired malpractice insurance (updates)
    - New, renewed, or expired licenses
    - DEA/controlled substance registrations (if applicable)
    - ABMS or AOA board certifications (if applicable)
    - Any condition resulting in temporary closure of a facility or office
    - Short-term hold on referrals
    - Leaves of absence
    - Any legal action pending for professional negligence
    - Any indictment, arrest, or conviction for a felony or for any criminal charge related to an individual's or a facility's practice
    - Revocation, suspension, restriction, termination, or voluntary relinquishment of any

licenses, authorizations, accreditations, certifications, medical staff membership or clinical privileges

When notifying us of any of these changes by phone you must follow-up with a formal written notification letter on your company letterhead.

Emergency Availability: You must make provisions to be available for members in emergency situations **twenty-four (24) hours per day, seven (7) days per week**. Members should be informed on how to reach you or a covering physician credentialed by Concordia for the same services that you provide. Your answering service or machine should give instructions to members about what to do in an emergency situation.

SUPPLEMENTAL PROVIDER INFORMATION

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 Concordia participating provider.

When you have been unavailable for one hundred fifty ~~(~~**150) calendar days**, Concordia 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.

Failure to meet Concordia's performance standards: Concordia will notify you in writing in the event of failure to meet any performance standard and/or any action we take. We will explain the reason for the action and together we will develop a corrective action plan to be reviewed in **6 month intervals** until performance standards are met. If the performance threshold is not met, you may be suspended or terminated from the network. You have the right to a formal appeal within **forty-five (45) calendar days** of the decision.

Failure to comply with a contract: First, a member of our Provider Services Department will contact you to determine how we 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 network.

Terminating the Agreement: Both parties have the right to terminate the Agreement, upon written notice, pursuant to the terms of the Agreement.

a) If Concordia 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, Concordia 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 Concordia 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 Concordia. 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 Concordia. 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 practitioner, group practice and/or agency decides to terminate their Agreement and withdraw form the Concordia Network, they must notify us 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 Concordia members under their care and to inform the member 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 Provider Agreement or until one of the following conditions is met, whichever occurs earliest:

   - The member is transitioned to another Concordia clinician
   - The period of care has been completed
   - The member's Concordia benefit is no longer active To ensure continuity of care, Concordia will notify members affected by the termination at least **thirty (30) calendar days** prior to the effective date of the termination whenever feasible. Concordia will assist these members in selecting a new clinician, group or agency.

c) If a Network facility decides to terminate their Agreement with us and withdraw from our Network they must notify Concordia 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 member's care, Concordia 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 Concordia 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 member to another facility, Concordia and the facility will coordinate to ensure a safe and effective transition of care.

   In some cases, the treating practitioner at the facility and the Care Advocate may determine it is in the best interest of a member to extend care beyond these timeframes. Concordia 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. Members may not be balance billed.

   If you need further clarification on how to terminate your Agreement with us, you may contact our Provider Services Department.

Provider Complaints: Your satisfaction is of paramount importance to us. Concordia monitors all provider complaints. Therefore, please direct these to the Provider Services Department so they can be properly addressed in a timely manner. If complaints are not satisfactorily resolved, you may consider filing a written grievance.

Member Complaints: Concordia will also review member complaints and information gathered from our quality improvement processes. When we obtain objective evidence of serious quality deficiencies, we will notify appropriate state and federal agencies, as required.

PROVIDER LINKS AND RESOURCES

In order to improve services for our providers and members, Concordia will have links and educational resources available on the website.

III. CARE COORDINATION, ADVOCACY AND ACCESS TO CARE

For all Access to Care and Care Coordination/Advocacy services, contact us at the following:

Care Advocacy:	Local (Miami-Dade): 305-514-5320 Toll Free: 855-541-5300 ext. 5320
	TYY: 305-514-5399
Fax Numbers:	Local (Miami-Dade): 305-514-5321
Email:	Care Coordination and Advocacy: advocacy@concordiabh.com
Mailing address:	Concordia Behavioral Health Attn: Care Coordination and Care Advocacy Department 7190 SW 87th Avenue Suite 204 Miami, FL 33173

ACCESS TO CARE STANDARDS

In our commitment to safe, quality, compassionate and affordable care to our members, Concordia has established a care access process that promotes convenient and timely access to behavioral care services and our Network Providers.

Three cornerstone principles serve as the foundation to our care standards – each contributing to our members' timely recovery:

1. The care must be accessible
2. The care must be appropriate
3. The care must be responsive

Our Access to Care process and practices meet national access to care standards. While guiding the access to care process, these established standards are not intended to replace sound clinical judgment.

Through our Quality Improvement (QI) and UM processes, Concordia continuously measures and evaluates adherence to these standards to ensure that we are meeting, enhancing or surpassing them. Moreover, we ask our contracted Network Providers to commit to meeting or exceeding the access standards we have established when accepting our referrals and setting up appointments for our members. These standards are divided as follows:

Concordia's Access To Care Standards		
Situation	**Description**	**Timeframe**
Life-Threatening Emergency	A member at risk of inflicting serious injury or death to him/herself or another without immediate intervention.	Life-threatening cases should be responded to immediately and receive care within **2 hours** of the initial call. Care should never be delayed due to lack of authorization. A licensed Care Advocate can assist in referring to the appropriate level of care. Concordia also highly recommends immediately calling 911.
Non Life-Threatening Emergency	A member at risk for deteriorating into a life-threatening situation if not receiving prompt intervention. Timeframe: These members should be seen within 6 hours of the initial call	Non Life-threatening Emergency cases should be seen within **6 hours** of the initial call.
Urgent	A member presenting significant psychiatric or substance abuse history, evidence of psychosis and/or significant distress.	Urgent assessments should occur within **48 hours** of the initial phone call. A licensed Care Advocate can help coordinate this process. The time frame is **24 hours** for Medicare/Medicaid members
Routine	A member seeking outpatient services who presents NO evidence of suicidal or homicidal ideation, psychosis, and/ or significant distress.	Routine assessments should occur within **10 business days** for commercial members and within **7 business days** for Medicare /Medicaid patients.
Psychiatric Consults		These should occur within **24 hours** for routine consults and **6 hours** for

		emergency consults.
Psychological Testing		Evaluations should be done within **30 days** for commercial, Medicare and Medicaid members.

(ROUTINE) OUTPATIENT SERVICE REQUESTS

Authorization for Initial Evaluation and Care (for non-emergency cases): All outpatient services require Concordia's pre-authorization. This means that any outpatient service provided to our members must have an authorization issued prior to the delivery of care. Authorizations are issued through our Care Coordination & Care Advocacy department's 24-hour service.

Members can access initial outpatient behavioral healthcare services in various ways. A member or a designated member representative (e.g., a family member) can contact Concordia directly. A member's Primary Care Physician (PCP), or a representative from the member's health plan, can contact Concordia to request services for the member. The Concordia Network Provider List is posted on our website (www.concordiabh.com) or can also be sent to members via fax or mail by request.

A Concordia Care Coordinator is the first line of contact on all requests for outpatient behavioral healthcare services. If the request is determined to present an emergency need, the Care Coordinator immediately transfers the member to a licensed Care Advocate who will arrange disposition and coordinate the appropriate level of care.

On all routine requests for outpatient services the Care Coordinator will:

- Confirm the member's contact information (name, phone, date of birth, and zip code)
- Verify the member's eligibility and benefits
- Inform and discuss with the member co-payments and any other financial obligation
- Determine the nature of routine requests and service needs
- Provide members with the names of Network Providers to review and choose the one best suited to meet their needs and special requests (i.e., appointment availability, language, specialty, geographic location, handicap accessibility, etc.)
- Issue an initial pre-authorization for care once the member has made a choice of provider and has an appointment to be seen

Concordia determines a member's eligibility for behavioral health services based on a member's current health plan eligibility and benefit coverage, type of service requested, and medical necessity / clinical criteria. Once Concordia has pre-authorized care, we will automatically fax, mail or email a *Notice of Authorization* to you by the closing of the next business day. We ask that upon receiving the Notice, you confirm that your provider information is accurate and that the authorization reflects the specific service(s) you will be providing. If you notice an error on your authorization, contact Concordia immediately to rectify the authorization. Failure to do so may render a denial of payment. When submitting claims to us you will need to include the authorization number(s) issued for the respective services. Since outpatient care is an appropriate level of care for routine, non-emergency needs, Concordia will not grant retroactive

authorizations for these services. Any service that is rendered without prior authorization is at risk for a denial of payment.

Authorizations for Continued Care: If the member's condition requires care beyond the services that Concordia initially authorized, we will require providers complete the Confidential Outpatient Care Advocacy Treatment Plan. This form will be available for download from our website or we can send it to you upon your request. Please note that the treatment plan urges you to communicate with the member's PCP to coordinate care after securing permission from the member. This is especially crucial whenever psychotropic medications are prescribed as part of the member's treatment.

The Confidential Outpatient Care Advocacy Treatment Plan may be submitted to us via US mail, fax or email with fax and email being the most expedient way to communicate with us. We ask that treatment plans be submitted for review before the authorized visits are exhausted and/or the expiration date has been reached.

Upon receipt of your treatment plan, a Concordia Care Advocate will be assigned to review it. Our Care Advocates are all Masters or Doctoral level licensed clinicians. The Care Advocate will conduct a concurrent review that will take into consideration the clinical information you provide, the information contained in the utilization management database regarding the member'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. On occasion, in the process of making a determination, the Care Advocate may contact you to gather additional relevant clinical information, discuss possible risk factors and other pertinent aspects of care as well as collaborate with you in ways that will promote safety and enhance positive outcomes. We ask that you respond to their requests in a timely manner that will assure continuity of care and prevent any interruptions of treatment.

We hope that, as you work with our Concordia Care Advocates, you will find that they can serve as a resource that you can constructively tap into. Our Care Advocates can contribute in the following ways:

- Helping identify members who are, or may be, at risk and collaborate with you to coordinate and deliver the appropriate care
- Facilitating communication and exchange of information between medical and behavioral health providers with member consent
- Offering clinical consultations with medical staff
- Referencing web-based information and other material for members and treating practitioners that can support informed decision-making involving care
- Referring to processes that positively impact a member's stabilization and recovery and promote the member's active participation in their own treatment and follow-up care
- Ensuring that members who are discharged from facility-based and/or intensive levels of care have appropriate discharge plans, understand and follow through with the plan, and access the recommended follow-up services in a timely fashion

The Care Advocates are available during business hours Monday thru Friday from 8:30 AM to 5:30 PM. Additionally, they are available 24 hours a day, including weekends and holidays, for urgent and emergency situations, benefit decisions, and other care related questions. To access a Concordia Care Advocate send an email to advocacy@concordiabh.com or call our main office phone number.

Concordia's Protocol on Providing Non-covered Services: On occasion, a member may request services that are not medically necessary or may not be covered under the member's benefit plan. The Network Provider or Practitioner may render these services at his/her discretion. Prior to providing such services to our members; however, Concordia requires that the practitioner obtain and keep on record a written statement signed by the client that assures the following conditions are met: (i) notifying the member in advance that it is a Non-Covered Service; (ii) advising the member that the insurance will not pay for the service; (iii) the Member consents to the service and agrees in writing to be responsible for the payment.

EMERGENCY MENTAL HEALTH (MH) / SUBSTANCE ABUSE (SA) SERVICES

Concordia is wholly committed to ensuring the safety of it all its members. We understand that a Mental Health/Substance Abuse emergency can arise any time of day or night and we are prepared to meet it with an immediate response. By calling our main number, assistance by a Care Advocate is always available to help coordinate and authorize care. In the event of an imminent, emergency situation requiring immediate medical attention, no prior authorization is needed. Member safety should never be jeopardized while waiting to obtain prior authorization. Emergency care will *never* be delayed for the purpose of securing authorization. A retrospective or post service review of the emergency care will consider the present symptoms as well as the discharge diagnosis. Payment of services will be granted based on this information and the member's belief that a true emergency existed regardless of the discharge diagnosis. Pre-authorization is required for any intensive service including acute inpatient, detoxification, residential, partial hospital, or intensive outpatient treatment. You or the member must call to obtain authorization for services.

A Mental Health/Substance Abuse emergency refers to the sudden onset of a condition manifesting in acute symptoms of sufficient severity that in the absence of immediate medical attention and/or behavioral health services could reasonably be expected by a prudent layperson to result in serious injury to life or limb, seriously jeopardize the patient's health or endanger the physical well-being of another person.

If a Concordia member presents to you in a crisis situation and is in need of immediate medical attention, 9-1-1 should be called. If the member's crisis does not need immediate medical attention, Concordia will authorize one evaluation session so that you can further assess the member's need, acuity of symptoms and make necessary treatment recommendations. 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 Concordia Care Advocate. If you determine that his/her condition and/or current mental state requires a higher level of care or more intensive treatment, such as a potential inpatient hospitalization, our Care Advocate will assist you in coordinating the hospitalization and in facilitating a timely, safe transfer. Member safety is our primary concern.

When a Concordia member has been admitted to an intensive or acute treatment setting, it is our policy that discharge planning begin at the time of their admission. Prior to their discharge,

we require that a member have an after-care appointment scheduled with a Network Provider within **7 calendar days** of discharge or **24 hours** for Medicaid members. Our licensed Care Advocates will follow-up with the member to remind him/her of the after-care appointment.

As part of Concordia's Network of Providers all MD practitioners are expected to be either directly accessible to our members in an emergency situation, have an on-call provider acting in their place for admitting purposes or a service that provides direction to a member seeking emergency services. Organizational providers must either be accessible or have an on-call staff available to members seeking emergency care. All other providers/practitioners must, at a minimum, have an after hours message that instructs members seeking emergency services how to obtain them. Ideally, all practitioners should have an on-call arrangement for their patients in crisis.

PSYCHOLOGICAL TESTING

Psychological testing is covered under certain conditions to obtain diagnostic clarity and enhance treatment planning. All psychological testing must be pre-authorized. To request psychological testing for one of our members, please complete the "Psychological Testing Authorization Request" form available through our website. Please fax or email the form and a Care Advocate will review the request to determine that clinical criteria have been met and will notify you of the determination.

The determination to utilize a psychological evaluation must be based on medical necessity for the purpose of appropriately treating a medical condition. Some of the criteria our Care Advocates will consider when determining whether to authorize psychological testing include:

- Will the evaluation yield answers to diagnostic questions when other means of assessment (e.g., clinical interview, etc.) have been ruled out or exhausted?
- Will the evaluation help clarify the most appropriate diagnosis when presenting symptoms suggest two or more possible diagnoses?
- 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)?
- Confirmation that the testing is not for purposes of research, educational evaluation, medical procedures or career placement.

MEMBERS' RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

- Be treated with courtesy, respect and with appreciation of your dignity by Concordia personnel, network doctors and healthcare professionals

- Receive information about Concordia Behavioral Health, our services, providers and members' rights and responsibilities
- Make recommendations regarding Concordia's member rights and responsibilities
- Voice concerns about the care or services you receive
- A prompt and reasonable response to questions, complaints and requests about your services
- Register complaints and appeals about your health plan and the care provided to you
- Participate in candid discussion with your doctor about medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- Be provided with timely access to doctors, health care professionals and healthcare facilities, as medically necessary
- Receive information about diagnosis, planned course of treatment, alternatives, risks and prognosis from your health care practitioner
- Refuse any treatment, except as provided by law
- Upon request and prior to treatment, obtain a reasonable estimate of charges for medical care
- Access medical treatment or accommodations, regardless of race, national origin, sexual orientation, religion, physical handicap or source of payment
- Private handling of medical records and, unless otherwise required by law, be given the chance to approve or refuse their release
- Privacy and confidentiality for treatments, tests and procedures you receive
- Have coverage decisions and claims processed according to regulatory standards, when applicable
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes

Members have the responsibility to:

- Know and confirm your benefits before receiving treatment
- Pay any necessary copayments at the time you receive treatment
- Give your health care provider, to the best of your knowledge, correct and complete information about present complaints, past illnesses, hospital stays, medications and other health matters
- Keep scheduled appointments or, when you are unable to attend, cancel with sufficient notice as agreed upon with your provider
- Understand your health problems and participate with your provider in developing and following a mutually agreed upon treatment plan
- Assure that the financial obligations of your health care are fulfilled as promptly as possible
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health
- Inform your health plan if you feel that your identification card has been misused, or if you suspect fraudulent activity by a member or provider

PRIVACY, SECURITY AND CONFIDENTIALITY

Concordia is responsible for overseeing and maintaining our privacy practices. We adhere to the:

- Health Insurance Portability and Accountability Act (HIPAA)

- Standards for Privacy of Individually Identifiable Health Information (Privacy Rule)
- Federal regulations "Confidentiality of Alcohol and Drug Abuse Records", Code 42, Chapter 1, Subchapter A, Part 2
- Florida Mental Health Act, Chapter 394.4615, "Clinical Records; Confidentiality".

As noted in the Office of Civil Rights Privacy Brief, Summary of HIPAA Privacy Rule, adherence to privacy practices assures that individuals' behavioral health information is properly protected while allowing the flow of information needed to coordinate, provide and promote high quality care and our members' recovery, health and well-being. Concordia is committed to requiring that all of its staff, agents and Provider and Practitioner Network protect the confidentiality of member information and records. Member-identifiable, or protected health information (PHI) includes data such as name, social security number, member number, address, telephone number, and date of birth. Ensuring that all data and information received and used by Concordia is kept and utilized with confidentiality and security is a priority.

Concordia has several policies in place to protect member-identifiable information and ensure privacy for our members and subscribers. The following items are covered under these policies and adhere to our privacy, confidentiality and security standards:

- Routine Uses and Disclosures of Protected Health Information
- Use of Authorizations
- Member Access to PHI
- Internal Protection of Oral, Written and Electronic PHI
- Protection of Information Disclosed to Plan Sponsors or Employers

If you would like additional information or a complete copy of the Concordia Privacy, Security and Confidentiality Policy and Procedure, please call Concordia. For more information about the Health Insurance Portability and Accountability Act (HIPAA), please visit the HIPAA information website at www.hhs.gov/ocr/hipaa.

As a Network Provider who keeps our member's medical/clinical records in your office/facility, we require that you have privacy, security and confidentiality practices in effect to keep our members' Personal Health Information (PHI) secure and in compliance with all federal and state regulations. Member's PHI can be found in your:

- Medical/clinical records
- Progress notes
- Care plans
- Appointment books
- Correspondence (mail, faxes)
- Phone voice mail
- Phone message notes/books/log
- Lab results
- Billing and claims records

This information must be stored in locked cabinets or in a secured area. Computer files must be password-protected. Information submitted electronically, should be sent via secure email, and have a prominent confidentiality statement. Faxed information should be sent out with a cover sheet that has a confidentiality notice, and mailed information should be marked "Confidential." The following is a sample confidentiality statement:

> PRIVACY NOTICE: This electronic mail message, and any attachments, are confidential and are intended for the exclusive use of the addressee(s) and may contain information that is proprietary and that may be Individually Identifiable or Protected Health Information under HIPAA. If you are not the intended recipient, please immediately contact the sender by telephone, or by email, and destroy all copies of this message. If you are a regular recipient of our electronic mail, please notify us promptly if you change your email address.

IV. UTILIZATION MANAGEMENT (UM)

Concordia's clinical perspective is to ensure that members are provided clinically relevant care that is appropriate and timely, and effective. We believe that treatment must be evidenced-based and not experimental in nature and that services should be provided in the least restrictive environment in order to empower members to address their symptoms, build resiliency, utilize their strengths, enhance their independence, restore their functioning and develop more effective coping mechanisms that will lead to a healthier life.

The Utilization Management (UM) department strives to ensure that high quality care is being delivered in a cost-effective manner.

UTILIZATION MANAGEMENT PROGRAM

Concordia's Utilization Management (UM) Program has the duty to monitor the quality, safety, and appropriateness of the clinical care and services rendered by our practitioner network. This is accomplished through two avenues:

1) by verifying that accepted national and community standards are being met within the scope of federal and state regulations and law, and
2) assuring that members have equitable access to care across the network

A written UM Program Description defines and clarifies the structure and function of the program and outlines authority and accountability for all UM functions. The UM Program and its respective procedures are reviewed annually and are an integral part of our Quality Improvement Program. The UM Program includes the activities listed below, but coverage of certain services are contingent on the member's benefit plan.

- Triage and Referral
- Care Coordination and Care Advocacy
- Intensive Care Advocacy: High Risk Cases
- Emergency Behavioral Health Care Services

- After-Hours Coverage
- Outpatient and Inpatient utilization monitoring processes, including over and under utilization monitoring
- Pre-authorization
- Concurrent Review
- Retrospective Review
- Denials and Appeals (when delegated to Concordia)
- Psychological Testing
- Psychiatric Consults
- Electro-Convulsive Therapy (ECT)
- Discharge Planning
- Acuity level and appropriate level of care
- Inter-rater reliability
- Evaluation of new clinical technology and new applications for existing clinical technologies
- Member satisfaction with UM processes
- Provider satisfaction with UM processes
- Staff training
- UM Program Evaluation

COMMUNICATION WITH CARE ADVOCACY STAFF

Our UM staff is composed of qualified behavioral health professionals whose education, training and experience are commensurate with the UM reviews they conduct. Concordia makes decisions to approve or deny payment for services based only on the appropriateness of the care or service and what is covered under the member's benefit plan. The final decision-maker for any denial on the basis of medical or clinical necessity is our Medical Director who is a licensed board certified psychiatrist. In some cases, when the clinical judgment needed is highly specialized, Concordia may call on an outside expert for consultation.

During our business hours (Monday through Friday, 8:30 AM to 5:30 PM) members and providers can reach our clinical staff via telephone, fax, or email.

After-hours access to our licensed Care Advocates for questions about our UM processes (inbound calls) is available 24 hours per day, 7 days per week via our main number. Non-urgent calls received after business hours are responded to by a licensed Care Advocate no later than **one (1) business** day from receipt of the call, unless otherwise agreed upon (outbound calls).

Bilingual (English / Spanish) staff members are available at Concordia and we accommodate all other non-English speaking members through a telephonic translation service. We also have a TYY line available for the hearing impaired.

MEDICAL NECESSITY AND LEVEL OF CARE CRITERIA

With oversight by the Medical Director and supervision by the Director of Clinical Operations, licensed Care Advocates conduct the pre-service urgent care, concurrent urgent care and non-urgent care reviews based on medical necessity and evidence-based treatment criteria. These standards of care are also used during the initial clinical review process. The Medical Director and the Director of Clinical Operations are available for clinical questions concerning the authorization of services.

Concordia defines medical necessity as services and/or supplies provided by a behavioral health practitioner or provider organization to identify or treat an illness that has been diagnosed, or is suspected, due to reported symptoms. Medically necessary services must contain the elements listed below:

Medically necessary services must contain the elements listed below:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition
2. Provided for the diagnosis or direct care and treatment of a medical condition
3. Within the standards of good medical practice within the organized medical community of the treating provider
4. Not primarily for the convenience of the Member, the Member's family or the treating provider
5. The most appropriate and cost effective services consistent with generally accepted medical standards of care
6. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the Member is receiving or the severity of the Member's condition, and that safe, cost effective and adequate care cannot be received as an outpatient or in a less intensive medical setting

Additionally, to determine medical necessity we evaluate that the service is necessary to protect life, and prevent significant illness or significant disability; that the attending clinician can provide sufficient clinical information for an adequate determination; we determine whether clinical information indicates a history of inpatient admissions with failure to sustain gains on discharge, and that it is not likely that another inpatient admission will improve the member's condition or symptoms.

The continued stay of a member at a particular level of service requires the continued stay criteria be met. At any level of care, Concordia emphasizes individualized treatment, where members 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. Treatment must be short-term and solution-focused.

Concordia has adopted the Mihalik Medical Necessity Manual for Behavioral Health. This level of care manual is a tool utilized in determining the medical appropriateness of all UM services performed. The comprehensive Manual is objective, evidence-based and reviewed on a yearly basis by a panel of behavioral health experts/peer reviewers. Additionally, we use all of the American Psychiatric Association Treatment Guidelines. If you would like a written copy of the

criteria, please visit our website (www.concordiabh.com) or contact us by phone. We always welcome your feedback.

To make UM determinations, we first identify the member's benefits and eligibility. Secondly, we carefully identify presenting signs and symptoms and complete an acuity assessment to determine the appropriate level of care and medical necessity. Lastly, we ascertain that all lesser levels of care would be detrimental to the safety or health of the member.

In making UM decisions, Concordia enforces several important standards:

1. We do not encourage decisions that result in under-utilization
2. We do not reward practitioners contingent on their issuing of denials
3. Concordia's decision-making is based only on the appropriateness of care and available benefits

COMMON BENEFIT EXCLUSIONS AND LIMITATIONS

The following is a list of the most common exclusions and limitations for mental health and chemical dependency services provided by Concordia. Please note that this list may vary in accordance with specific enrollee contracts and the individual member health plan.

- Any non-emergent Mental Health/Substance Abuse treatment that is not approved by Concordia.
- Marriage counseling, when such services extend beyond the period necessary for short-term evaluation or crisis intervention.
- Treatment of sexual offenders or treatment for sexual deviance (for example transvestitism, etc.)
- Mental illnesses and/or conditions which, according to generally accepted professional standards, are not amenable to short term, goal oriented treatment.
- Court ordered treatment not determined by Concordia to be medically/clinically necessary or at the level suggested by the court. However, in certain states honoring Court Orders from Family Court is required regardless of medical necessity.
- Services related to methadone treatment and care related to dependency created by methadone, including LAAM (chemical abbreviation for a methadone derivative that has duration of action of 72 hours), Cyclazocine or their equivalent.
- Psychiatric or psychological examination, testing or treatments for purposes of obtaining or maintaining employment or insurance, or relating to judicial or administrative proceedings.
- Remedial education, including services that are extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation disabilities.
- Speech therapy.
- Treatment for smoking; treatment for weight loss.
- Treatment of chronic pain other than by psychotherapy if it is determined such pain has psychological or psychosomatic origins.
- Treatment for mental retardation and/or development and learning disorders not amenable to short term therapy.
- Treatment for which military and/or other government or public programs are responsible.
- Treatment considered experimental in nature.

- Anesthesiology

UM DECISIONS AND TIME FRAMES

Our clock for care decisions starts at the time we receive a request. The set timeframes for UM decisions are dependent on and responsive to the nature of the need and/or type of service requested. These timeframes comply with the standards set by state and/or federal guidelines. It is our goal to make timely care decisions that will promote ease of access to care and minimize disruptions to the delivery of services to our members.

Definitions and Care Decision Timeframes:

Pre-Service Review: Any case or service that Concordia must approve in whole or in part, in advance of the member obtaining care.

1) Pre-service URGENT care decisions, including verbal and written notification, are completed as soon as possible, but no later than **seventy-two (72) hours** after receipt of the request. These decisions are made quickly because if one were to take longer, it could seriously jeopardize the life or health of the member or limit the member's ability to regain maximum function
2) Pre-service NON-URGENT care decisions are defined by what is not urgent. These determinations, including verbal and written notification and are completed within **fourteen (14) calendar days** of receipt of the request

Concurrent Review: A review conducted during the course of a treatment to ensure that the services being rendered continue to meet Concordia's adopted level of care clinical criteria (The Mihalik Medical Necessity Manual for Behavioral Health) and meet the definition of medical necessity. Urgent and non-urgent concurrent care decision notifications 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.

1) Concurrent URGENT care review decisions, including verbal and written notification of the determination, are made **within twenty-four (24) hours** of the request. These decisions are generally associated with inpatient, residential behavioral, or intensive outpatient care and are for an extension of a previously approved on-going course of treatment over a period of time or number of treatments.
2) Concurrent NON-URGENT review determinations, including verbal and written notification, are completed with **fourteen (14) calendar days** from receipt of the request.

Post-service Reviews (a/k/a Retrospective Reviews): Are conducted after the completion of a course of treatment. These reviews occur when services were neither authorized nor denied by Concordia. The Medical Director has oversight over all post-service review determinations. Post-service review determinations and notifications are made within **thirty** (**30) calendar days** of receipt of the request and/or all clinical information necessary to make a medical necessity decision. 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 to provide the requested information.

Peer Reviews: When a member'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 circumstances of the member and the actual resources available. If the local delivery system cannot meet the needs of the member, Concordia authorizes a higher level of care to ensure that services will meet the member's needs for safe and effective treatment. Concordia actively involves practicing practitioners in the review, revision and adoption of medical necessity criteria, including procedures for applying the criteria.

DENIALS AND APPEALS

Concordia makes every reasonable effort to avoid disagreement with members and Network Providers regarding utilization management decisions. If attempts to negotiate a mutually acceptable outcome are not successful the member, the treating provider acting on the member's behalf, or a designated member representative (including a family member) has the right to initiate an appeal of the decision through their health plan's appeals process.

SATISFACTION WITH THE UM PROCESS

At a minimum on an annual basis, Concordia measures member and provider satisfaction with the Utilization Management (UM) Process. Questions specific to the UM program are included in the Provider and Member Satisfaction Survey Instruments. Provider and member complaints regarding aspects of the UM process provide another channel for obtaining information about these stakeholders' satisfaction. Changes to the UM process may be driven based on areas of reported dissatisfaction, and when opportunities for improvement are identified through these sources.

V. CLAIMS

For all questions related to claims, please contact the Concordia Claims Department at:

Claims:	Local (Miami-Dade): 305-514-5340 Toll Free: 855-541-5300 ext. 5340
	TYY: 305-514-5399
Fax Numbers:	Local (Miami-Dade): 305-514-5341
Email:	Claims: claims@concordiabh.com

Concordia is committed to the accurate and timely processing of all claims. We abide by all applicable state and federal laws, reporting requirements and the mandates of our organizational clients. Yet, our ability to process your claims as efficiently and effectively as we intend to is largely in your hands. When the information you provide in your claim is thorough and all the required fields are properly completed, it is referred to as a "clean claim". "Clean claims" place us in an excellent position to fulfill our stated commitment – 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". Anytime our claim's department requires additional information from any party external to Concordia to process a claim, delays and

difficulties occur. Please read this section carefully. We hope that it will help you understand our claims processing. We invite you to call us if you need any assistance in filing your claims.

CLAIMS SUBMISSION

As a service Provider you have up to **one hundred and eighty (180) days** from the date service is rendered to submit your claims to us. Claims may be submitted in two (2) ways: *electronically* through Concordia's web portal or through U.S. Mail as a *'paper claim'*.

Electronic Submission: Presently, only CMS 1500 claims can be submitted electronically. To submit claims electronically you must go through the Provider Portal on Concordia's website (www.concordiabh.com) where you will find detailed instructions.

Paper Claims: Claims for outpatient services must be filed on standard claim form CMS-1500; claims for inpatient services must be filed using form UB-04. Paper claims are to be mailed to:

Concordia Behavioral Health
Attention: Claims Department
PO Box 431403
South Miami, FL 33043

Claim Filing Tips: For prompt processing and payment of claims, be sure to include all the required itemized information in their respective fields. The "Notice of Authorization" sent out by Concordia is an invaluable source for some of the information you will need to include in the claim form. In addition to finding the authorization number on this Notice, you will also have the authorized procedure codes and much of the necessary member's identifying information.

Before submitting your claims, please check that the following information has been included:

- Member's name, date of birth, subscriber ID number (use the applicable health plan member ID, not the Medicaid ID or the provider's internal ID), address, phone
- A diagnosis (codified: DSM-IV or ICD-9), all digits included
- The authorization number issued by Concordia for the service. (Please make sure that the dates of service and type of service correspond to those detailed on the authorization)
- The date of service(s) and duration, the place of service(s) the type of service(s)/ procedure(s) (CPT code, or revenue code), the charges and number of units
- The Provider/Practitioner name, credentials, tax ID, and NPI numbers, mailing address, address where service was rendered

Please keep the following in mind:

- ALL services must be pre-authorized by Concordia in order to be reimbursed. Concordia's Notice of Authorization is emailed, faxed or mailed to you on the day after the authorization is completed
- Billed services and their dates must match authorized services and dates
- Appeals for incorrect authorizations and/or denial of claims must be made **within (30) days** of receipt of the authorization or claim denial
- You have **thirty-five** (**35) days** to resubmit a corrected claim

CLAIMS PROCESSING TIMEFRAMES

Concordia adheres to the applicable timeframes set forth by state law. These timeframes vary depending on whether you submit electronic or paper claims.

- *Claims electronically submitted* [F.S. 641.3155(3)(a)(b)(e)]: Concordia provides electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim within **twenty-four (24) hours** beginning the next business day it receives the claim. We must pay the claim or notify the provider if a claim is denied or contested within **twenty** (**20) days** after receipt of the claim. Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred. Electronically submitted claims must be paid or denied within **ninety (90) days** after receipt of the claim. Failure to pay or deny a claim within **one hundred and twenty (120)** days after receipt creates an uncontestable obligation to pay the claim.
- *Claims submitted via U.S. mail (paper claims)* [F.S. 641.3155(4)(a)(b)(e): Concordia provides acknowledgment of the receipt of the claim within **fifteen (15) days** beginning the next business day it receives the claim. We must pay the claim or notify the provider if a claim is denied or contested within **forty (40) days** after receipt of the claim. Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed. Non-electronically submitted claims must be paid or denied within **one hundred and twenty (120) days** after receipt of the claim. Failure to pay or deny a claim within **one hundred and forty (140) days** after receipt creates an uncontestable obligation to pay the claim.

  Although you may on occasion receive a Remittance Advice along with a check, routinely these two documents are sent separately.

If a payment or denial is not received by your office within the time allotted per applicable state and/or federal law, we strongly encourage you to contact us immediately so that we may assist you and resolve the issue.

Claims for emergency services: It is Concordia Behavioral Health'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.

Concordia uses and applies the definition of **"emergency medical condition"** provided by the Balanced Budget Act (BBA, 1997) as: *"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."

Concordia considers care **"urgent"** when the application of the time periods for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life, health or safety of the member or others due to the member's psychological state, ***or***
- If in the opinion of a practitioner with knowledge of the member's medical or behavioral healthcare condition, a delay in treatment would subject the member to adverse health consequences

When Concordia identifies a claim as one for emergency services/urgent care, the claim will be processed within CMS guidelines. If the service was provided by an out-of-network provider, upon receipt, the claim will be placed on hold or 'suspended' to allow us time to review it and, if needed, negotiate rates/charges with the non-contracted providers. If there is a negotiation, the claim will be paid according to the negotiated rates, if not the claim will be paid according to Medicare guidelines and approved rates (Medicare allowable rate). The maximum hold time Concordia will hold a claim during this review and negotiation process will never exceed **seventy-two (72) hours**, by which time the hold on the claim will be released (unsuspended) and adjudicated.

BILLING MEMBERS AND CLAIMS INQUIRIES

The contracted rates listed in the schedule on your Concordia contract include any applicable co-payment. Concordia will reimburse you at your contracted rate minus the member's co-payment amount and/or deductible. You may collect applicable co-payments and/or deductibles directly from our Member but never engage in the following billing practices that are strictly prohibited by Concordia:

- *Balance billing our members:* Under no circumstance does Concordia allow its Network Providers to 'balance bill' our members and considers this practice grounds for terminating our contract. Balance-billing is defined as the practice of a clinician or facility in which payment is requested from a member for the difference between Concordia's contracted rate and the clinician's or facility's usual charge for that service. Our members must never be charged amounts in excess of our rate schedule.
- *Charging our members for missed appointments:* Members may be billed if a written statement explaining your billing policy for missed or cancelled appointments is signed by the member during the initial evaluation. You may bill the Member no more than your Concordia contracted rate. **Note that some plans and government-funded programs prohibit billing for no-shows or cancellations with less than 24-hours notice under any circumstances.**
- *Billing our Member for a service that was NOT pre-authorized:* Under no circumstances is a Concordia Member to be charged for failure to have a service pre-authorized.

CLAIMS MONITORING

When a client organization delegates claims processing to Concordia, it is Concordia's responsibility to comply with *fraud and abuse prevention* processes as noted. Upon receipt of a claim, the Claims Processor shall identify practitioners and/or providers who:

- Have on more than **two (2) occasions** demonstrated a pattern of filing claims encounter data that did not occur
- Have on more than **two (2) occasions** demonstrated a pattern of overstated claims reports or up-coded levels of service
- Network Practitioners and Providers who have on more than **one occasion** charged beneficiaries for covered services

The Claims Processor shall notify the Claims Manager the same day of discovery of any of the above. The Claims Manager shall conduct an investigation of the claims data, within **one (1) working day** of notification, to confirm the identification of the alleged fraudulent claims submission.

Upon confirmation of potentially fraudulent claims submission, the Claims Manager shall notify the Director of Operations within **one (1) working day** of confirmation and they will coordinate further appropriate actions.

VI. QUALITY IMPROVEMENT PROGRAM

A full description of Concordia Behavioral Health (Concordia) Quality Improvement Program (QIP) and a progress report in meeting our goals are available to you upon request. We always welcome your comments, suggestions and ideas on how we can improve care and services. You may contact us using the following methods:

Quality Improvement: Local (Miami-Dade): 305-514-5350 Toll Free: 855-541-5300 ext. 5350

TYY: 305-514-5399

Fax Numbers: Local (Miami-Dade): 305-514-5351

Mailing address:
Concordia Behavioral Health
Attn: Quality Improvement Department
7190 SW 87th Avenue
Suite 204
Miami, FL 33173

OVERVIEW

Concordia aims at exceeding customer expectations in delivering safe, responsive and high quality cost effective clinical care. We see our Network Providers as essential partners in helping us realize this goal. Through our Quality Improvement Program (QIP), we engage in continuous quality improvement processes that enhance positive outcomes in the services and care delivered to our Members. We are certain of fulfilling our commitment to excellence with your cooperation. In this Manual, we highlight some of our QIP main focus areas.

The Quality Improvement Program (QIP) objectively and systematically monitors, reviews and evaluates different aspects of our managed behavioral healthcare delivery systems and identifies targeted key areas for improvement. Some of these areas are:

- Accessibility statistics on how quickly members receive assistance when calling Concordia by telephone and the abandonment rate of calls
- Accessibility: the time for members to be offered appointments for routine care, urgent care, emergency and non-life-threatening emergency care, psychiatric medication evaluations, psychiatric consults and psychological testing
- Availability: the time it takes members to reach practitioners and facilities, and the number of practitioners and facilities required per 1500 members
- Adherence to clinical practice guidelines and recovery and resiliency oriented treatment
- Continuity and coordination of care within the behavioral health continuum and between behavioral health and medical delivery systems and practitioners
- Specific clinical quality improvement processes
- Monitoring and improving the number of members who complete an initial outpatient appointment within **seven (7) days** of discharge from inpatient care for a behavioral health condition
- Member satisfaction processes that include annual surveys and analysis of complaints and appeals
- Increasing access to community services for individuals with severe mental illnesses

As a Concordia Network Provider, you have agreed to collaborate with Concordia on Quality Improvement (QI) processes that include, but are not limited to:

- Participating and cooperating with all relevant aspects of our Quality Improvement Program (QIP) adhering to clinical practice guidelines, all applicable laws, regulations and accreditation care standards
- Protecting our Member's privacy and their Protected Health Information (PHI) by maintaining their records confidential and appropriately using and disclosing Member information according to federal and state regulations
- Helping identify early on in treatment, at-risk Members, complex cases as well as collaborating with Concordia's Care Advocates and Utilization Management staff in planning safe and effective levels of care
- Providing our Members with prompt appointments for care and rapid follow-up upon discharge from inpatient care
- Promoting continuity and coordination of our Members' care, with their written consent, by communicating and collaborating with Members' Primary Care Physicians (PCP), as well as other treating clinicians and/or facilities
- Cooperating with our on-site audits and requests for Member treatment records
- Cooperating with Concordia in addressing Member complaints, as necessary

The Quality Improvement Committee (QIC) is chaired by our Medical Director and includes varied professional disciplines in its membership. The Committee meets regularly to oversee the implementation of the QIP and monitor Concordia's compliance with standards set forth by accreditation bodies and regulatory agencies, including but not limited to, the Center for Medicare and Medicaid Services (CMS) and the Agency for Health Care Administration (AHCA). The QIC sets standards and goals for measurement processes, collects data to measure performance against standards and goals, analyzes data, determines actions to improve performance, oversees their implementation and schedules re-measurement to evaluate their effectiveness. An evaluation of the QIP is conducted annually and a report is prepared for the Board of Directors. The results are also delivered via our website and/or a Provider Newsletter to our Network Providers and Members.

ACCESSIBILITY

Concordia ensures that Medicare, Medicaid and Commercial members have clinically appropriate and timely access to outpatient emergency, urgent and routine care within the access standards specified by CMS, state regulatory agencies and accrediting bodies, as noted below:

- *Routine care* – within **seven (7) business days** for Medicare and Medicaid members and within **ten** (**10) business days** for Commercial health plan members
- *Urgent care* – within twenty-four (**24) hours** for Medicare and Medicaid members and within **forty-eight** (**48) hours** for Commercial health plan members
- *Non-life threatening emergency* - within **six (6) hours**
- *Life threatening emergency care* – **should be responded to immediately and receive care within 2 hours** of the initial call. Care should never be delayed due to lack of authorization.
- *Psychiatric consults* within **six (6) hours** for emergency consults and within **twenty-four (24) hours** for routine consults
- *Medication evaluations* by psychiatrists within **ten (10) business days** for Commercial members and within **seven (7) business days** for Medicare/Medicaid members
- *Psychological testing* within **thirty (30) days** for Commercial/Medicare/Medicaid members

Annually, Concordia will distribute to our Providers and Practitioners a survey inquiring about outpatient appointment accessibility based on the urgency of care. The survey's information and member complaints about inability to access a timely outpatient appointment are analyzed collectively and findings incorporated into a report that is presented to the Utilization Management Committee, the Credentialing Committee and the Quality Improvement Committee. Based on the report's findings, the committees identify and prioritize opportunities for improving access to care and will implement action(s) that are likely to have a positive impact on access performance.

When an individual practitioner is out of compliance with any of the access standards based on the results of the annual survey and/or when a member complaint is reported, an improvement

action plan shall be requested. The practitioner shall forward their improvement action plan within **thirty (30) days** of the request. The corrective actions are reviewed and approved by the Utilization Management and Credentialing Committees.

In addition to monitoring and improving access to care based on urgency of need, Concordia also assesses its Network of Providers and Practitioners annually, for other factors that contribute to care access. We make continuous efforts to ensure that our Network has:

1) A sufficient number of behavioral health care practitioners and providers so that Members seeking care and/or services can do so in a timely manner
2) An adequate geographic distribution of practice and service locations to provide members 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 our Member's continuum of behavioral care needs, and
4) An adequate mix of expressed ethnicity, cultures and languages in our Network to meet the related needs and preferences of Members and promote culturally sensitive and competent behavioral health care

CONTINUITY AND COORDINATION OF CARE

Concordia has many processes that promote Member safety and an integrated approach to quality care. A central component of this effort involves a focus on improving the continuity and coordination of our Member's care through the exchange of pertinent clinical information between behavioral health and medical service providers, especially the members Primary Care Physician (PCP). We encourage our Network Providers to educate our Members on the importance of this communication and ask that early in treatment, the Member's sign a consent to allow for this essential communication during their treatment period.

Coordination of care between behavioral health clinicians and PCPs improves the quality of member care by:

- Minimizing potential adverse medication interactions
- Promoting early detection of medical conditions that might be contributing to or causing psychiatric symptoms
- Providing more efficient and effective treatment
- Reducing the risk of relapse for patients with substance abuse disorders
- Promoting early identification of non-compliance with treatment

The high-risk communication criteria identified below are some particular circumstances in which communication between behavioral health practitioners and medical specialists should occur to promote optimal, safe and effective behavioral health care:

- Members who are prescribed medications by their PCP and their Psychiatrist
- Members who are prescribed psychotropic medications by their PCPs
- Members with behavioral symptoms that may be a side-effect of prescribed medication(s) or whose symptoms may be masking an underlying metabolic disease,

neurological disorder or other medical condition that needs to be ruled out and treated, if present

- Members who have a pre-existing medical condition and are being prescribed psychotropic medication by their psychiatrist
- Members who fail to improve or show sufficient response to behavioral treatment
- Members whose mental status suddenly changes

Concordia will continue to educate its Provider Network, as well as its Members, on the importance of coordination of care through our website.

QUALITY PATIENT CARE AND MEMBER SAFETY

Concordia has adopted the Mihalik Medical Necessity Manual for Behavioral Health Care and treatment guidelines for acute and chronic behavioral health and substance abuse conditions adapted from evidence-based guidelines by nationally recognized sources. The QIC is responsible for the development, review and revision of these tools. The guideline selection process includes the identification of annual high risk / high volume Member demographic data obtained from claims.

At least every two (2) years, Concordia reviews the level of care criteria manual and treatment guidelines. When applicable, changes and updates are reviewed and 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 makes revisions when indicated.

PEER REVIEW PROCESS

Peer review will be utilized in order to establish evaluation mechanisms for clinical care and service delivery that identify opportunities for improving care. Concordia utilizes independently licensed behavioral health clinicians with expertise in the services being reviewed to collect peer review data. Peer reviewers include:

- Concordia Medical Director (chair)
- Concordia Director of Clinical Operations
- Concordia Care Advocate(s)
- A network psychiatrist
- A network psychologist
- A network licensed practitioner of the healing arts

Concordia's peer review process adheres to the following best practices guidelines, it:

1) Establishes consistent standards for review
2) Establishes goals for the peer review committee, including their roles and responsibilities
3) Establishes reasonable timeline for completion of reviews
4) Creates a sense of urgency for peer review, as issues that are detected and taken care

of quickly can prevent situations from becoming worse

5) Utilizes the results to improve the quality of care by providing guidance and suggestions for improvement and allowing the provider under review to improve
6) Conducts regular auditing to make improvements to peer review policy and allow reviewers to provide feedback on how to improve auditing process
7) Addresses critical incidents immediately, specifically any incident which puts a member at risk
8) Utilizes the peer review as an educational tool to train providers when applicable
9) Reviews randomly selected cases
10) Refers cases to an external reviewer when indicated
11) Analyzes data trends

Concordia's peer review process monitors compliance with standards set forth by accreditation bodies and regulatory agencies, including, but not limited to, the National Committee for Quality Assurance (NCQA), URAC, the Center for Medicare and Medicaid Services (CMS) and the Agency for Health Care Administration (AHCA) for the following:

- Adequacy and completeness of treatment record documentation according to Concordia's Treatment Record Standards and Guidelines
- Adequacy and appropriateness of assessment, diagnosis, treatment, collaboration and coordination of care with PCP and ancillary providers
- Provider grievances for patterns that might signal an opportunity for improvement
- Treatment record review results for the purpose of identifying opportunities for improvement

MEMBER SATISFACTION

Member satisfaction is very important to Concordia. A member satisfaction survey is conducted annually for all Members. Concordia considers complaints carefully. Complaints are reviewed individually as soon as they are received and a thorough investigation of the issues surrounding the complaint is conducted. Although the time standard for resolving complaints is **thirty (30) days** from receipt, Concordia strives to resolve all complaints promptly. The member is notified of the resolution of the complaint and of the right to appeal the decision, if appropriate. Appeals of the proposed resolution of complaints are also carefully considered. Opportunities for improvement are identified from the satisfaction surveys and from annual member complaint and grievance analyses.

PROVIDER SATISFACTION

Concordia is committed to achieving a high level of satisfaction among their contracted providers. We value provider feedback and always welcome your suggestions.

On an annual basis, we send out our confidential Provider Satisfaction Survey to our Network practitioners to gather data about our strengths and opportunities for improvement. Concordia then uses these survey results to evaluate operations and to identify opportunities for

improvement. A summary of the results and of improvement actions will be available to you via our Provider Newsletter and/or the Concordia website.

TREATMENT RECORD STANDARDS AND GUIDELINES

Concordia expects practitioners to maintain an organized treatment record-keeping system according to established professional standards and Concordia guidelines. Well-documented treatment records facilitate communication, coordination and continuity of care, as well as promote efficiency and effective treatment. Treatment records are the primary vehicle for the maintenance and communication of a patient's Personal Health Information (PHI). Consistent and complete treatment records are an essential component of quality patient care. Concordia's guidelines for treatment record documentation, standards for availability of treatment records and performance goals define its expectations for practitioners. Concordia assesses treatment records to ensure that practitioners in its network comply with these guidelines and standards.

Treatment record criteria are based on the Medicaid HMO Contract, Section 13.0, *Medical Records Requirements*.

Privacy and Security: The reviewer will confirm that Protected Health Information (PHI) is maintained per the following:

- The Health Insurance Portability and Accountability Act (HIPAA)
- The Standards for Privacy of Individually Identifiable Health Information (Privacy Rule)
- Federal regulation "Confidentiality of Alcohol and Drug Abuse Records", Code 42, Chapter 1, Subchapter A, Part 2
- The Florida Mental Health Act, Chapter 394.4615, "Clinical Records; Confidentiality"

General Record Filing and Documentation:

- Records are kept in a secure and locked location with limited access to ensure confidentiality
- There is a practice-site specific process for assuring treatment record availability (at practice–site, itself, or centralized location)
- There is an organized filing system (i.e., alphabetical or numbering order)
- The system includes a consistent format within the record where similar type documents are filed together
- The record includes the Member's date of birth, gender, address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms, and guardianship information, if relevant
- The primary language spoken by the Member is noted; if member requires translation, the documentation reflects measures taken to address the need adequately and any other communication barrier, or need for assistance, has been, identified, considered and adequately addressed
- All pages in the treatment record contains the Member's name or identification number (front and back of pages, if applicable)

- All clinical entries include the name of the responsible clinician's name, their signature, their professional degree and if applicable, their relevant identification number
- The record contains the Member 's signed consent/authorization for treatment
- The Member has signed consents for releases of information; (per Concordia's contractual agreement with Network Providers, they are required to obtain Member's written consent for the release of information to Concordia. The release is for case management, utilization management and quality improvement processes.)
- The record contains documentation of emergency care and hospital discharge summaries
- The record is maintained accurate and up-to-date; all entries are completed as soon as possible after the encounter, dated, signed and maintained in chronological order
- All entries are legible and their content and format uniform (to facilitate effective internal and external peer review, medical audit and adequate follow-up treatment)
- Entry errors in documentation are corrected by drawing a line through the error, dating and initialing them only – correction fluid is never used
- Abbreviations, when used, are standard and readily identifiable to others
- (For MD's Only) There is documentation that the Member was given written information concerning the Member's rights regarding Advanced Directives (written instructions for living will or power of attorney), and whether or not the member has executed an Advance Directive (the provider shall not, as a condition of treatment, require the member to execute or waive an Advance Directive in accordance with section 765.110, F.S. The plan must comply with the requirements of 42 CFR 422.128 for maintaining written policies and procedures for Advance Directives)

Initial Assessments:

- Presenting problems are documented and relevant biopsychosocial conditions affecting the patient's medical and psychiatric status are included
- Special status situations, such as imminent risk of harm, suicidal ideation or development problems are prominently noted, actions documented, reviewed, revised and updated accordingly
- A behavioral health substance use and/or abuse history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests and consultation reports
- The record notes what medications have been prescribed, the dosage of each and the dates of initial prescription and refills, as well as the name of the prescribing physician
- A medical history is documented, which may include previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant medical conditions are listed, prominently identified and revised
- Allergies and adverse reactions are clearly documented; unknown allergies and sensitivities to pharmaceuticals and other substances are prominently noted
- A mental status evaluation documents the patient's affect, speech, mood, thought,

content, judgment, insight, attention or concentration, memory and impulse control

- A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data and is reviewed and/or revised, as needed
- For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic), are documented
- For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs

Treatment Plans:

- Treatment plans are consistent with diagnoses, include objective measurable goals and target dates for goal attainment or problem resolution and the plan is reviewed at regular intervals
- The focus of treatment interventions is consistent with the treatment plan goals and objectives
- The patient's understanding of the treatment plan and informed consent for medication is documented

Progress Notes:

- Progress notes reflect the Member's response to treatment interventions, provide a running record of their response and describe their strengths and limitations in achieving treatment plan goals and objectives
- Progress notes include a record of significant telephonic conversations in which significant advice, recommendations or advice given over the phone

Care Coordination and Continuity:

- Documentation reflects that Members who become homicidal, suicidal, or unable to conduct activities of daily living, are promptly referred to the appropriate level of care
- Documentation reflects continuity and coordination of care between Member's Primary Care Physician (PCP), consultants, ancillary providers, health care institutions and Member's support system
- Documentation includes dates of follow-up appointments
- Missed appointments are documented and entries reflect efforts to contact Member to reschedule the missed appointment and Member's response is noted
- A discharge plan is documented
- Consideration and/or use of preventive services and measures are documented,(e.g., relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources)

FRAUD, WASTE AND ABUSE PREVENTION

Protecting and maintaining the integrity of behavioral healthcare services is important to us. Concordia monitors compliance with functions and processes governing program integrity in order to reduce the incidence of fraud, waste and abuse by contracted Network Practitioners and Providers, vendors and other business entities and its Members. Fraud, waste and abuse are defined as follows:

Fraud: An intentional deception or misrepresentation made by a person with the knowledge the deception or misrepresentation could result in an unauthorized benefit to him/herself or another individual.

Waste: To neglectfully use health care benefits and/or health care dollars without actual justification.

Abuse: To engage in practices inconsistent with sound fiscal and/or medical practices resulting in unnecessary costs and/or requests for reimbursement of services that were not medically necessary or failed to meet professionally recognized standards of health care.

Concordia complies with all applicable federal and state laws related to fraud, waste, and abuse. In order to monitor the services rendered to our members, Concordia has a comprehensive compliance program and actively pursues all suspected cases of fraud, waste, and abuse. In addition, Concordia complies with all applicable state and federal billing and requirements for all government sponsored and commercial plans, 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. Our Fraud, Waste and Abuse Policy can be downloaded from our website.