carelon℠

Carelon Behavioral Health

Provider Handbook

www.carelonbehavioralhealth.com/providers

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1. INTRODUCTION

1.01 Overview

Welcome to the Carelon Behavioral Health[1,2] (Carelon) network of participating providers. This handbook is an extension of the provider agreement and includes requirements for doing business with Carelon and its affiliates and subsidiaries, including policies and procedures for individual providers, affiliates, group practices, programs, and facilities. Requirements for doing business with Anthem, Inc. health plans can be found at www.anthem.com/provider/policies.

Together, the provider agreement, addenda, and this handbook outline the requirements and procedures applicable to participating providers in the Carelon network(s).

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

Important Notice: Except to the extent a given section or provision in this handbook is included to address a regulatory, accreditation, or government program requirement or specific benefit plan requirement, in the event of a conflict between a member's benefit plan, the provider agreement, and this handbook, such conflict will be resolved by giving precedence in the following order:

1. The member's benefit plan
2. The provider agreement
3. This handbook

This provider handbook replaces and supersedes all previous versions.

This handbook may be updated at any time and is subject to change. If there is a material change to this handbook, then Carelon will make reasonable efforts to notify Providers and Facilities in advance of such change through web-posted newsletters, letters or email communications. In such cases, the most recently published information will supersede all previous information and be considered the current directive. This handbook is not intended to be a complete catalog of all Carelon policies and procedures. Other policies and procedures not included in this handbook may be posted on the Carelon website or published in specially targeted communications, including but not limited to bulletins and newsletters.

Links to the website, other information, and forms referenced throughout this handbook are included for convenience purposes only and such information and/or forms are subject to change without notice. Participating providers should access and download the most up-to-date information and/or forms from the provider website at the time needed.

Questions, comments, and suggestions regarding this handbook should be directed to:

Carelon Behavioral Health
National Provider Service Line
800-397-1630
Mon. through Fri., 8 a.m. to 8 p.m. ET

[1] Any use of or reference to "Carelon Behavioral Health" or to "Carelon" in any communication, publication, notice, disclosure, mailing or other document, whether written or electronic, requires the prior written authorization of Carelon Behavioral Health.

[2] This handbook applies to participating providers in provider network(s) maintained by Carelon Behavioral Health, Inc. and the following subsidiaries: Carelon Behavioral Health of California, Inc.; and CHCS IPA, Inc. CHCS IPA, Inc. is an independent practice association operating only in New York and is a wholly owned subsidiary of Carelon Behavioral Health, Inc.

1.02 About Carelon Behavioral Health

While Carelon Behavioral Health, Inc. is licensed in numerous states as a third-party administrator and/or utilization review agent of behavioral health services, some of Carelon's affiliates and subsidiaries are licensed as full service or limited service health plans operating in a designated state. Carelon Behavioral Health of California, Inc., CHCS IPA, Inc., are all subsidiaries of Carelon, Inc. For purposes of this handbook, references to "Carelon" shall mean, individually or collectively, as applicable, the Carelon legal entity with whom the provider has contracted to provide services with respect to a member.

Carelon, through contracts with clients, manages and/or administers behavioral health and wellness benefits and services, including employee assistance programs (EAP), work/life services, wellness programs, and mental health and substance use disorder benefits and services in a wide array of settings. Today, clients include employer groups, commercial/exchange health plans, Medicare Advantage and managed Medicaid health plans, and state and local government programs and agencies. Additional information about Carelon is available on the Carelon website at www.carelonbehavioralhealth.com.

Carelon manages mental health and substance use disorder services of benefit plans sponsored and/or administered, in whole or in part, by companies and organizations contracted with Carelon in compliance with applicable laws, rules, and regulations, including without limitation the Federal Mental Health Parity and Addictions Equity Act, Affordable Care Act, state parity laws, and regulations. Subject to benefit plan requirements, inpatient covered services and other higher levels of care generally require prior authorization/certification or notification of the admission. Outpatient covered services are reviewed for medical necessity when clinical factors indicate possible non-evidenced based practice or the need for additional interventions. Certain high-risk or complex cases may require prior review and/or more intensive review and/or case management. Details of individual benefit plan requirements and procedures are available through Carelon's secure, HIPAA-compliant provider portals- **ProviderConnect** and **eServices**. Hereinafter, referred to as provider portal.

Carelon's mission is to help people live their lives to the fullest potential. Our values guide the way we treat our members, providers, clients, and each other. They are the heart of all we do. A number of Carelon's regions or Engagement Centers sponsor consumer self-help groups, educational programs, drop-in centers, advocacy programs, and other consumer-led activities that help people become actively involved in achieving their highest possible level of functioning in their communities.

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

Carelon does not specifically offer rewards or incentives, financial or otherwise, to its utilization management staff, contractors, participating providers, Clinical Care Managers (CCMs), Peer Advisors, or any other individuals or entities involved in making medical necessity determinations for issuing denials of coverage or service or that are intended to encourage determinations that result in underutilization. Utilization management decisions are based solely on appropriateness of care and service, existence of coverage and utilizing the medical necessity criteria approved for use by Carelon.

Information specific to participating providers in EAP networks is located in **Appendix 5** on our website.

Contact information for Carelon is located in this handbook. Additional information about the locations, email addresses, and toll-free numbers of Carelon's offices throughout the country are conveniently located on our website.

1.03 Contact Information

Administrative Appeal	To request an administrative appeal, call the toll-free number included in the administrative denial letter received.
Potential Quality of Care (PQOC) Concerns	Report all Potential Quality of Care Concerns (PQOC) to Carelon within 24 hours using the clinical form available on Carelon's website at www.carelonbehavioralhealth.com/providers/forms-and-guides or follow local notification processes when applicable.
Changing your Provider Profile (e.g., name, address)	To change or update your Provider Profile (e.g., address, phone, etc) use one of the following methods: • CAQH (*Carelon's preferred method*) o Participating CAQH providers: Log in to your CAQH ProView o New users: Register for CAQH Proview • The Carelon Provider Portal o Log in to the Carelon Provider Portal o Select "Update Demographic Information" • National Provider Service Line o Call the Carelon National Provider Service Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET. **Note:** Updating a Tax ID requires an accompanying W-9 form. The W-9 can be submitted via the provider portal as an attachment. Providers without access to the provider portal can contact the National Provider Service Line for assistance in submitting a W-9.
Claims	For general claim inquiries, call 800-888-3944. For technical questions related to direct claim submission via ProviderConnect, please contact the E-support service team at: ▪ **Telephone:** 888-247-9311 from 8 a.m. - 6 p.m. ET ▪ **Fax:** 866-698-6032 For EDI claims use Carelon's payer ID: BHOVO for submission through our clearinghouse partner, Availity. For support with EDI Claims, please contact Availity's Customer Service line at 800-282-4548. *For providers who are unable to submit a claim electronically, paper claims should be sent to the address referenced on the member's benefit plan, as addresses may vary.*
Claim Appeals	To request a claim appeal, write to the address on your provider summary voucher.

Clinical Appeals	To request a clinical appeal on a member's behalf, call the toll-free number included in the adverse determination letter received.
Complaints/Grievances	To file a complaint/grievance, call the toll-free number on the member's identification card to speak to customer service.
Credentialing	To obtain information pertaining to network participation status, contact Carelon's National Provider Service Line at 800-397-1630 Mon. through Fri., 8 a.m. to 8 p.m. ET. To send supporting documentation such as malpractice or insurance cover sheets, please fax to 866-612-7795.
Fraud and Abuse	To report compliance, ethics or fraud waste and abuse concerns, contact Carelon's Ethics and Compliance hotline at 888-293-3027. You may also email us at SIU@Carelon.com.
Member Benefits, Eligibility, and Authorizations	For questions about member eligibility or benefits, providers can submit an inquiry via ProviderConnect by selecting "Eligibility and Benefits." For questions about authorization status, providers can select the "Review an Authorization" option via ProviderConnect. *For additional questions about authorizations or benefits, call the toll-free number on the back of the member's identification card.*
Member Customer Service	To reach member customer service, call the toll-free number on the back of the member's identification card.

2. ELECTRONIC RESOURCES

2.01 CAQH

All participating providers are encouraged to register and participate with CAQH®, including attesting on a regular basis, to reduce the credentialing timeline and improve directory accuracy. CAQH is an industry standard solution to capture and share health care self-reported information that 1.4 million health care providers use today—more than 90 percent of Carelon's practitioners participate in CAQH. Carelon accesses information from CAQH as updates are made to provider data. Be sure to add Carelon as one of the organizations authorized to access your CAQH information.

2.02 Provider Portals

Our Carelon Provider Portals, ProviderConnect and eServices, provide you with the information, tools and resources you need to support the day-to-day needs of your patients and office.

ProviderConnect

ProviderConnect is a secure, password-protected portal where participating providers conduct certain online activities with Carelon directly 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues). Online activities include, but are not limited to:

- Authorization or certification requests for all levels of care
- Concurrent review requests and discharge reporting
- Claim status review for both paper and electronic claims submitted to Carelon
- Verification of eligibility status
- Submission of inquiries to Carelon's provider customer service
- Updates to practice profiles/records
- Electronic access to authorization/certification letters from Carelon
- Provider summary vouchers (PSVs)

eServices

eServices is a secure, password-protected portal used by certain health plans contracted with Carelon. Participating providers using this portal can conduct certain online activities with Carelon directly 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues). Currently, participating providers are provided with access to the following online activities:

- Check real-time claim status
- Print explanation of benefit (EOB) information
- Check member eligibility
- Check initial encounters used
- Request authorizations
- Check the status of authorizations, including units used
- Update practice and clinician information
- View or print provider documents such as manuals, forms, or bulletins
- Generate and print reports

eServices transactions take less time to complete than paper submissions, enabling providers to improve productivity. Fax transmission problems, mail delays, and most errors are eliminated by using eServices, thereby reducing provider administrative staff burden.

Links to information and documents important to providers are located on the eServices page of our website.

2.03 Achieve Solutions (Member Educational Behavioral Health and Wellness Resources)

Achieve Solutions is Carelon's educational behavioral health and wellness information website. As this website is educational in nature, it is not intended as a resource for emergency crisis situations or as a replacement for medical care or counseling. The website includes self-management tools and other resources that can support members.

When members can self-identify risk factors or health issues early on, they can proactively take steps to improve their health and reduce potential risk factors. Offering self-management tools encourages members to monitor, track, and take charge of their own behavioral and/or physical health conditions.

Carelon offers member-specific self-management tools and educational content on its **Achieve Solutions platform**, which you can find on the Carelon website at www.carelonbehavioralhealth.com/providers/resources/achieve-solutions

Topics include (but are not limited to):

- Adult BMI Calculator
- Reducing High-Risk Drinking
- Increasing Physical Activity
- Integrated Care: Taking Charge of Your Health
- Do You Have a Nicotine Addiction?
- Are Your Weight Management Habits Healthy?
- Managing Stress in Your Life
- Identifying Common Emotional Concerns
- How Well Do You Bounce Back from Life's Challenges?

We encourage you to promote the use of this award-winning website with the individuals you serve.

3. PARTICIPATING PROVIDERS

Participating providers are independent contractors of Carelon. This means that participating providers practice and operate independently, are not employees of Carelon, and are not partners with or involved in a joint venture or similar arrangement with Carelon. Carelon does not direct, control, or endorse health care or treatment rendered or to be rendered by providers or participating providers.

Carelon does not refuse to contract or terminate existing contractual relationships with providers because a provider:

- Advocates on behalf of a member
- Files a complaint with or against Carelon
- Appeals a decision or determination made by Carelon

Carelon encourages participating providers/providers to communicate with members to discuss available treatment options, including medications and available options, regardless of coverage determinations made to or to be made by Carelon or a designee of Carelon. Treating providers, in conjunction with the member (or the member's legal representative), make decisions regarding what services and treatment are rendered. Any preauthorization, certification, or medical necessity determinations by Carelon relate solely to payment. Participating providers/providers should direct members to Carelon or their respective benefit plan representatives for questions regarding coverage or limitations of coverage under their benefit plan prior to rendering non-emergency services.

3.01 Carelon Provider Identification Numbers

The Carelon provider number is a provider's/participating provider's unique number assigned by Carelon. Some contracts will assign a provider number specific to that contract that includes an alpha prefix. The provider number identifies a provider in the Carelon system and is used for giving access to Carelon's provider portal. The provider number is on file with Carelon. Providers/participating providers should contact the Carelon National Provider Services Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET for questions regarding Provider Identification Numbers and/or for assistance in obtaining a Provider Identification Number.

The provider's service location vendor number is a number that identifies where services are or were rendered. A participating provider may have multiple vendor locations and each vendor location is given a five-digit number preceded by a letter (e.g., A23456, D45678).

The pay-to vendor number is a vendor number issued by Carelon and indicates the mailing address for all payments and also when using our electronic payments service through PaySpan. A provider can have more than one pay-to vendor number and each number needs to be registered with PaySpan.

The National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI is different from a Carelon-assigned provider number. The NPI is a provider identifier that replaces the different identifiers used in standard electronic transactions. HHS adopted the NPI as a provision of HIPAA. This number is also contained in the Carelon system and can be used to locate a provider record for claims, referrals, and authorization purposes.

3.02 Changes to Carelon Provider Records

Information about participating providers' physical addresses and locations, billing addresses, hours of operation, clinical specialties, and licensure or certification status are used in credentialing and re-credentialing activities as well as in provider directories and listings made available to clients and members. Participating providers must notify Carelon in advance of changes or updates to information provided to Carelon.

Changes and updates to participating provider information and records may be submitted in one of the following methods:

- CAQH (*Carelon's preferred method*)
    - Participating CAQH providers: Log in to your CAQH ProView
    - New users: Register for CAQH Proview
- The Carelon Provider Portal
    - Log in to the Carelon Provider Portal
- National Provider Service Line
    - Call the Carelon National Provider Service Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET.

If changes to a Tax ID are necessary, an accompanying W-9 form is required. The W-9 can be submitted via the provider portal as an attachment. Providers without access to the provider portal can contact the National Provider Service Line for assistance in submitting a W-9.

At the time of recredentialing, participating providers should make changes to information previously submitted to Carelon and contained in their Carelon Provider Record through one of the three methods mentioned above.

Failure to report changes in a timely manner can adversely affect participation in the network and may result in delayed claims payments.

3.03 Policies and Procedures

Pursuant to the terms of the provider agreement, participating providers must comply with Carelon's policies and procedures and as outlined in this handbook. Certain policies and procedures may apply only to a designated line of business or type of benefit plan or government sponsored health benefit program; a list of these is located in **Appendix 3**.

The CMS requires Medicare Advantage plans to include certain terms and provisions in provider agreements and in policies and procedures. **Appendix 4** includes references to specific regulatory requirements and guidelines about participation in networks available to Medicare Advantage plans.

As more specifically detailed in other parts of this handbook, Carelon maintains continuous quality improvement and utilization management programs that include policies and procedures and measures designed to provide for ongoing monitoring and evaluation of services rendered to members (e.g., clinical review criteria, member and participating provider surveys, evaluations, and audits). Participating provider involvement is an integral part of these programs. Participating providers must cooperate with and participate in Carelon's quality improvement and utilization management programs and activities. Refusal to cooperate with Carelon's quality improvement and/or utilization management activities may adversely affect continued network participation status or result in sanctions up to and including termination of network participation status.

In addition, some Carelon clients establish procedures and requirements unique to benefit plans offered or administered by that client or to a specific government health benefit program. Therefore, in addition to careful review of the information provided in this handbook, it is very important to review any client and/or network specific requirements located in the 'Carelon Providers' section of the website.

Detailed information about a specific member's benefit plan requirements can be obtained by viewing a member's benefits on the 'Benefit' tab in provider portal.

4. CREDENTIALING AND RE-CREDENTIALING

Carelon's credentialing processes for new providers seeking to contract with Carelon and re-credentialing processes for participating providers currently contracted with Carelon are designed to comply with national accreditation standards to which Carelon is or may be subject, as well as applicable state and/or federal laws, rules, and regulations. Credentialing and re-credentialing is required for all providers and participating providers, respectively, including without limitation individual practitioners and organizations (clinics, facilities, or programs). All provider/participating provider office or facility locations where services are rendered and that share the same federal tax identification number that are identified in credentialing/ re-credentialing applications will be considered for participation status under that application.

Providers and participating providers are credentialed and re-credentialed, respectively, for participation status for designated services, level(s) of services and practice sites. Should participating providers have other or additional services, levels of services or practice sites available, additional credentialing and/or re-credentialing may be necessary prior to designation as a 'participating provider' for such additional services, levels of services or practice sites. Services, levels of services or practice sites for which a participating provider is not credentialed for are subject to all applicable out-of-network authorization, certification, and any benefit or coverage limitations under the member's benefit plan.

As provided for in Carelon's policies and procedures, decisions to approve or decline initial credentialing applications, to approve re-credentialing applications, and/or to submit a given credentialing or re- credentialing application for further review are made by the Carelon National Credentialing Committee (NCC), or where applicable by a local Carelon established credentialing committee.

Participating providers have the right to:

- Request review of information submitted in support of credentialing or re-credentialing applications
- Correct erroneous information collected during the credentialing or re-credentialing processes
- Request information about the status of credentialing or re-credentialing applications

All requests to review information must be submitted in writing. Verbal requests for the status of a credentialing or re-credentialing application can be made by calling the Carelon National Provider Services Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET. Regardless of the above, Carelon will not release information obtained through the primary source verification process where prohibited by applicable state and/or federal laws, rules, and/or regulations.

4.01 Credentialing

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

Practitioners

Council for Affordable Quality Healthcare (CAQH) Participating Providers:

To eliminate the need for practitioners to submit multiple credentialing applications, Carelon participates in the CAQH.

- If you are registered with CAQH, please add Carelon as one of the health plans authorized to access your information and ensure a current attestation.
- If you are not registered with CAQH, visit CAQH.com to set up an account and complete an application. Please add Carelon as one of the health plans authorized to access your information.

Call the CAQH Help Desk at 888-599-1771 for answers to your questions related to the CAQH application or website.

Non-CAQH Participating Providers:

- Contact the Carelon National Provider Services Line at 800-397-1630 for further instruction.

Facility

This includes without limitation attestation as to:

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

Failure to submit a complete and signed credentialing application and all required supporting documentation timely, may result in rejection of request for participation status with Carelon.

Once the participating provider has been approved for credentialing and contracted with Carelon as an individual practitioner, group member, or facility, Carelon will advise of the effective date for specified lines of business.

Once the facility has been approved for credentialing and contracted with Carelon, all licensed or certified behavioral health professionals listed may treat members for applicable services and lines of business. The credentialed facility is responsible for credentialing and overseeing its clinical staff as Carelon does not individually credential facility-based staff.

Contact the Carelon National Provider Services Line at 800-397-1630 for further instruction.

4.02 Re-Credentialing

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

Practitioners

CAQH Participating Providers:

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

Non-CAQH Participating Providers:

- Contact the Carelon National Provider Services Line at 800-397-1630 for further instruction.

Facility

- You will receive re-credentialing application via email or fax
- The facility re-credentialing application can also be found on the Provider Forms page at: www.carelonbehavioralhealth.com/providers/forms-and-guides
- If you have questions, contact the Carelon National Provider Services Line at 800-397-1630

Required documentation includes without limitation attestation as to:

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

Non-response or failure to submit a complete and re-signed credentialing application and all required supporting documentation timely, may result in rejection or voluntary termination of participation, unless otherwise determined by the NCC. Such providers may be required to go through the initial credentialing process.

4.03 Standards

Standards applicable to providers in the initial credentialing process and to participating providers in the re-credentialing process include, but are not limited to the following:

- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements), and valid license to practice as an independent provider at the highest level certified or approved by the state or states in which services are performed for the provider's/participating provider's specialty (individual practitioners)
- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements), and valid license to practice and/or operate independently at the highest level certified or approved by the state or states in which services are performed for the provider's/participating provider's facility/program status (organizations)
- Accreditation currently accepted by Carelon for organizations* (currently TJC, CARF, COA, HFAP, AAAHC, NIAHO, CHAP, and AOA)
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the ability to independently practice in his/her specialty (individual practitioners)
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, or licensure (individual practitioners)
- Current specialty board certification, if indicated on the application (individual practitioners)
- A copy of a current Drug Enforcement Agency (DEA) certificate and/or Controlled Dangerous Substance (CDS) Certificate where applicable (individual practitioners)

- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the provider/participating provider which disclose an instance of, or pattern of, behavior which may endanger members
- Good standing with state and federal authorities and programs (organizations)
- No exclusion or sanctions from government-sponsored health benefit programs (e.g., Medicare/Medicaid) (individual practitioners and organizations)
- Current specialized training as required for certain levels or areas of specialty care (individual practitioners)
- Malpractice and/or professional liability coverage in amounts consistent with Carelon's policies and procedures (individual practitioners and organizations)
- An appropriate work history for the provider's/participating provider's specialty (individual practitioners)

***** Structured site visits are required for all unaccredited organizations.

Changes or updates to any of the above noted information is subject to re-verification from primary sources during the re-credentialing process, or at the time of notice of such a change or update from the participating provider. Additionally, providers/participating providers must have:

- No adverse record of failure to follow Carelon's policies and procedures or quality management activities
- No adverse record of provider actions that violate the terms of the provider agreement
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating potential or actual member endangerment
- No criminal charges filed relating to the participating provider's ability to render services to
  - members
- No action or inaction taken by participating provider that, in the sole discretion of Carelon, results or may result in a threat to the health or well-being of a member or is not in the member's best interest

4.04 Site Visits

In addition, and as part of credentialing or re-credentialing, Carelon uses an external vendor to conduct a structured site visit of provider's/participating provider's offices/locations. Site visits include, but may not be limited to, an evaluation using the Carelon site and operations standards and an evaluation of clinical recordkeeping practices against Carelon's standards.

While Carelon, at its discretion, may require a site visit in the course of credentialing and/or re-credentialing processes based on information submitted and/or obtained in the process, site visits will be conducted for providers/participating providers in the following categories:

- Unaccredited organizations
- Site visits required by a Carelon client as part of credentialing/re-credentialing activities delegated to Carelon
- Providers/participating providers with two or more documented member complaints in a six-month time frame relating to physical accessibility, physical appearance, adequacy of waiting/examining room space, or alleged quality of care issues

Site visits are arranged in advance. Following the site visit, a written report detailing the findings is provided. Report may include required monitoring where applicable and/or requirements for the participating provider to submit an action plan.

4.05 Updates to Credentialing and Re-credentialing Information

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

- Any action against licenses, certifications, registrations, and/or accreditation status*
- Any legal or government action initiated that could materially affect the rendering of services to members
- Any legal action commenced by or on behalf of a member
- Any initiation of bankruptcy or insolvency proceedings, whether voluntary or involuntary
- Any other occurrence that could materially affect the rendering of services to members
- Discovery that a claim, suit or criminal or administrative proceeding is being brought against the provider/participating provider relating to the provider's delivery of care (i.e., a malpractice suit), compliance with community standards and/or to applicable laws, including but not limited to any action by licensing or accreditation entities and/or exclusions from a government-sponsored health benefit program (e.g., Medicare/Medicaid)

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

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

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

Any changes in demographic or contact information or changes in practice patterns, such as change of services and/or billing address, name change, coverage arrangements, tax identification number, hours of operation, and/or changes in ownership, must be provided to Carelon in advance of such changes. Carelon must receive 60 days' advance notice of any new programs or services offered by a facility provider in order to allow for completion of the credentialing process prior to provision of services to members.

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

4.06 Delegation

Should Carelon, in its sole discretion, elect to delegate any credentialing and/or re-credentialing activities to a participating provider, such delegation is subject to all applicable policies and procedures, state and federal laws, rules and/or regulations, accreditation standards to which Carelon is or may be subject, and any client and/or government program specific requirements. Reference to possible delegation herein in no way obligates or requires Carelon to consider delegation of any credentialing and/or re-credentialing activities.

4.07 Sanctions

While efforts are made to resolve provider/participating provider credentialing/re-credentialing issues and/or quality issues through consultation and education, occasionally further action is necessary to provide for quality service delivery and protection of members. Sanctions may be imposed for issues related to member complaints/grievances, credentialing/re-credentialing issues, professional competency and/or conduct issues, quality of care concerns/issues, and/or violations of state and/or federal laws, rules and/or regulations. Carelon's processes comply with all applicable local, state and/or federal reporting requirements regarding professional competence and/or conduct. The provider agrees to screen any employee, temporary employee, volunteer, consultants, governing body member, vendors prior to hire or contract, and monthly thereafter against U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities & Most Wanted Fugitives, the System for Award Management, and any other list of individuals excluded from participation in any Federal or State health care program and disclose to Carelon all exclusions and events that would make them ineligible to perform work related, directly or indirectly, to federal health care programs.

4.08 Appeals of National Credentialing Committee/Provider Appeals Committee Decisions

The NCC and Carelon's local credentialing committees will give providers/participating providers written notice of the committee's decision regarding credentialing or re-credentialing applications submitted.

The NCC and Carelon's local credentialing committees will also give providers written notice of the committee's decision regarding any denials or disenrollment decisions, sanctions imposed or recommended, the reason for the decision, and of the provider's/participating provider's right to appeal adverse decisions along with an explanation of the applicable appeals procedure(s). Unless otherwise identified in such written notice, providers/participating providers have 30 calendar days from the date of the committee's notice of an adverse decision to file a written request for an appeal.

Provider/participating provider appeals of adverse credentialing/re-credentialing decisions of a Carelon local credentialing committee may be appealed to the NCC.

The NCC:

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

Provider/participating provider appeals of adverse credentialing/re-credentialing decisions of the NCC may be appealed to the Carelon Provider Appeals Committee (PAC). The PAC is comprised of representatives of major clinical disciplines, participating providers, and clinical representatives from corporate departments within Carelon, none of whom have participated in the original NCC adverse decision under review.

Requests for appeals of adverse credentialing/re-credentialing decisions of the NCC should include an explanation of the reasons the provider/participating provider believes the NCC reached a decision to be in error and include supporting documentation. The PAC will review the explanation provided, the information previously reviewed by the NCC, and any additional information determined to be relevant. The PAC may request additional information from the provider/participating provider in order to make a determination or decision. The PAC will support, modify, or overturn the decision of the NCC. Written notification of the PAC's decision, an explanation of the decision, and any appeal and/or fair hearing rights available for adverse decisions, will be sent to the provider/participating provider within 14 business days after the PAC's record is complete.

4.09 Professional Review Activities/Fair Hearing Process

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

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

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

Carelon will identify peer reviewers who will participate as the fair hearing panel. Every effort will be made to include a representative of the discipline of the provider/participating provider requesting the fair hearing on the panel. Members of the fair hearing panel will not have participated in the prior adverse decisions of the PAC or NCC, and will be asked to represent that they do not have an economic interest adverse to the provider/participating provider. One member of the fair hearing panel will be selected to act as the hearing officer and will preside over the fair hearing.

Carelon and the provider/participating provider each have the right to legal representation if the provider/participating provider is eligible for a fair hearing. The provider/participating provider will receive the written recommendation from the panel within 15 business days after the fair hearing. The fair hearing process as set forth above is subject to applicable state and/or federal laws and/or regulations.

5. OFFICE PROCEDURES

5.01 Confidentiality, Privacy, and Security of Identifiable Health Information

Providers/participating providers are:

- Expected to comply with applicable federal and state privacy, confidentiality, and security laws, rules, and/or regulations, including without limitation the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 C.F.R. Part 2, Health Information Technology for Economic and Clinical Health Act (HITECH Act), and the rules and regulations promulgated thereunder.

- Responsible for meeting their obligations under these laws, rules, and regulations, by implementing such activities as monitoring changes in the laws, implementing appropriate mitigation and corrective actions, and timely distribution of notices to patients (members), government agencies and the media when applicable.

Providers are also responsible for obtaining written release of authorizations from members to share Substance Use Disorder PHI for treatment, payment, or healthcare operations purposes with Carelon. The written release should be retained on file.

With the enactment of the federal HIPAA and HITECH Act, members or their legal guardian give consent for the release of information regarding treatment, payment, and health care operations at the signup for health insurance. Treatment, payment, and health care operations involve many different activities, including but not limited to:

- Submission and payment of claims
- Seeking authorization for extended treatment
- Quality Improvement initiatives, including information regarding the diagnosis, treatment, and condition of members to ensure compliance with contractual obligations
- Member information reviews in the context of management audits, financial audits, or program evaluations
- Chart reviews to monitor the provision of clinical services and ensure that authorization criteria are applied appropriately

In the event that Carelon receives a complaint or becomes aware of a potential violation or breach of an obligation to secure or protect member information, Carelon will notify the provider/participating provider utilizing the general complaint process, and request that the provider/participating provider respond to the allegation and implement corrective action when appropriate. Participating providers must respond to such requests and implement corrective action as indicated in communications from Carelon.

Providers/participating providers and their business associates interacting with Carelon staff should make every effort to keep protected health information (PHI) and personally identifiable information (PII) secure. If provider/participating provider does not use email encryption, Carelon recommends sending protected health information to Carelon through an inquiry in the Carelon provider portal or by secure fax.

5.02 Appointment and Availability Standards

Participating providers are expected to maintain established office/service hours and access to appointments with standards established by Carelon and/or as may be required by a given client of Carelon and/or specific government sponsored health benefit program. Carelon's provider contract requires that the hours of operation of all of our network providers are convenient to the population served and do not discriminate against members (e.g., hours of operation may be no less than those for commercially-insured or public fee-for-service-insured individuals), and that services are available twenty- four hours a day, seven days a week, when medically necessary.

Except as otherwise required by a specific client and/or government sponsored health benefit program for providers participating in networks available to their respective members and/or as delineated in the provider agreement, the following are standards of availability for appointments which participating providers are required to maintain:

Emergency:	In an emergency situation, the member should be seen in person immediately or referred to appropriate emergency service providers. Participating providers who do not maintain 24-hour coverage must maintain a system for referring members to a source of emergency assistance during non-business hours. The preferred methods are through a live answering service or an on-call pager system. However, participating providers may elect to maintain a reliable recorded answering machine system through which members experiencing an emergency are given clear instructions about how to access immediate assistance after hours.
Emergent:	In an emergent situation, the member should be seen within six (6) hours of the request for an appointment or referred to appropriate emergency service providers.
Urgent:	In an urgent situation, the member must be offered the opportunity to be seen within 48 hours of a request for an appointment.
Routine:	In a routine situation, a member must be offered the opportunity to be seen within 10 business days of a request for an appointment.
Routine Follow- Up Office-Visit (non-prescriber)	In a routine follow-up situation, a member should be seen within 30 business days of initial visit.
Routine Follow- Up Office-Visit (prescriber)	In a routine follow-up situation, a member should be seen within 90 business days of initial visit.

5.03 Requests for Additional Information

To maintain in-network status, participating providers must furnish Carelon with any requested documentation or information promptly. Failure to do so may result in the participating provider's status being changed from active to inactive. Inactive providers are ineligible to receive referrals or reimbursement as participating providers for services rendered to members of Carelon's clients and/or payors.

6. SERVICES TO MEMBERS

Pursuant to the terms of the provider agreement, participating providers are contracted and credentialed to provide identified covered services to members. Covered services should be rendered in:

- The same manner as services rendered to other patients
- Accordance with accepted medical standards and all applicable state and/or federal laws, rules, and/or regulations
- A quality and cost-effective manner

Participating providers should note that coverage for behavioral health services and any limitations and/or exclusions as well any pre-authorization and/or certification requirements for non-emergency services vary by benefit plan.

Participating providers must:

- Verify member eligibility and benefits using Carelon's provider portal prior to rendering non-emergency services as possession of a member identification card does not guarantee that the member is eligible for benefits.

  Note: Member eligibility information on Carelon's provider portal is updated every night. Eligibility information obtained by phone is accurate as of the day and time it is provided by Carelon. Carelon cannot anticipate and is not responsible for retroactive changes or disenrollments reported at a later date. Carelon recommends that providers check eligibility frequently.
- Document other or third party health benefit coverage for members (claims must be submitted to the primary initially)
- Preauthorize or certify care where required in Carelon's policies and procedures or the applicable member benefit plan, prior to rendering non-emergency services using Carelon's provider portal
- Collect member expenses from the member prior to, at the time of, or subsequent to services being rendered
- Provide continuous care for members or arrange for on-call coverage by other Carelon participating providers and communicate with members accordingly
- Adhere to the accessibility and availability standards established by Carelon
- Provide equal treatment to patients in a non-discriminatory manner, regardless of source of payment or coverage type or product
- Update demographic, office, and/or participating provider profile information promptly and in advance of changes using Carelon's provider portal
- Notify Carelon of potential inpatient discharge problems
- Advise members in writing of financial responsibility regarding services that are not covered, prior to rendering such service
- Cooperate with Carelon in coordinating continued care through alternative agencies, other vendors, or community resources when benefits end
- Notify Carelon of members who may be candidates for potential Care Management

- Coordinate care with a member's other health/medical care provider(s), either behavioral and/or medical providers who are treating the same or related (co-morbid) conditions
- Screen, evaluate, and treat (as medically appropriate), any behavioral health problem.
- Refer members to other participating providers when alternative or different mental health or substance use services are required
- Submit claims on behalf of members
- Upon written request by Carelon or third party payors, submit copies of member treatment records without charge (unless otherwise expressly provided for in the provider agreement)
- Make resources available to members who require culturally, linguistically, and/or disability competent care, such as, but not limited to, disability and language lines

6.01 Emergency Services

In the event of an emergency admission, participating providers should notify Carelon of the date of admission as soon as reasonably practical and in any event within 48 hours or within such alternative period of time specified in the provider agreement and/or state regulations. Retrospective review of such admissions and associated services is subject to the terms of the member's benefit plan.

Emergency services that are necessary to screen and stabilize a member are authorized without prior approval when:

- A prudent layperson, acting reasonably, believes that an emergency behavioral health condition exists
- An authorized representative, acting on behalf of Carelon, has authorized the provision of emergency services
- As otherwise required under applicable law

Carelon shall at all times authorize an emergency psychiatric evaluation as per the member's benefit plan.

6.02 Referrals

Participating providers may receive referrals from several sources, including but not limited to:

- Providers and/or other participating providers
- Self-referral of members;
- From Carelon
- Through an EAP

Participating providers needing to refer a member for other or additional services should contact Carelon to identify what are covered services under the member's benefit plan and any limitations, exclusions and/or notice, pre-authorization, or certification or notification requirements under their benefit plan. When possible, Carelon will seek to refer members to participating providers in the Carelon network.

6.03 EAP Transition to Health Plan Benefits

For those members participating in an EAP administered by Carelon and who may schedule and/or be referred for appointments for behavioral health services by network providers under their benefit plan, participating providers must be sure to obtain pre-authorization or certification as may be required under the member's benefit plan. Questions regarding what are covered services under the member's benefit plan and associated member expenses for covered services should be directed to Carelon by viewing a member's benefits on the 'Benefit' tab in Carelon's provider portal.

6.04 Coordination with Primary Care/Treating Providers

As part of care coordination activities, participating providers should identify all providers/participating providers involved in the medical and/or behavioral health care and treatment of a member. Subject to any required consent or authorization from the member, participating providers should coordinate the delivery of care to the member with these providers/participating providers. All coordination, including PCP coordination, should be documented accordingly in the member treatment record. Carelon consent forms are available through the website.

Tips to Improve Coordination of Care:

1. Request a release of information from the member to coordinate with his/her medical providers or behavioral health providers. Use motivational interviewing techniques to encourage information sharing across providers.
    - Educate the member that care coordination improves patient safety and can lead to improved treatment outcomes. Explain in detail what will be shared and why.
    - Discuss any concerns about care coordination with the member. Encourage questions and provide adequate time for discussion.
2. Use a standard form to share information. You can use your own or one of the two versions available for free on Carelon's website: www.carelonbehavioralhealth.com/providers/forms-and-resources/.

    For coordination with a primary care provider:

    - Authorization for Behavioral Health Provider and Primary Care Provider to Share Confidential Information Form
    - Primary Care Provider Behavioral Health Communication Form

    For coordination with other provider types, such as another behavioral health provider:

    - Authorization For Carelon To Release Confidential Information (Also Available in Spanish)
3. Follow a standard process for sharing and requesting information with the member's medical or behavioral health provider(s).
    - Call the provider's office and ask the office manager or receptionist how best to communicate and share information. Discuss a protocol for any urgent medical or behavioral health needs.
    - Routinely communicate with any other treatment provider at specific points in treatment, such as when treatment begins, when there are changes in the member's status, or upon discharge.
4. Ensure that this coordination of care is documented in the member's medical record. Audit your own records for compliance with your policies and procedures.
5. Ensure that your intake paperwork/process includes medical history.
6. Keep the member in the communication loop, as clinically appropriate. Provide ongoing updates on communication between you and other providers.

6.05 Continuation following Provider Agreement Expiration or Termination

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

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

Participating providers are required to continue providing services to any enrollee receiving active treatment at the time of disenrollment until either the course of treatment has been completed or until Carelon makes arrangements to have another provider render services, per terms of the provider agreement.

Payment for such covered services rendered to members following non-renewal or termination will be at the rates in the provider agreement.

Commercial (MH/SUD) providers may be required to continue providing covered services, under the rates and terms set out in their Provider Agreement, for Commercial (MH/SUD) members currently in their care for up to 97 days from your disenrollment date.

6.06 Certain Regulatory Requirements

Provider agreements include provisions requiring participating providers to comply with all applicable state and/or federal laws, rules and/or regulations, including without limitation those related to the provision of mental health and/or substance use disorder services (e.g., required licensure/certification, workplace standards, non-discrimination, etc.); child or elder abuse; and duty-to-warn or obligation to report certain types of disclosures by patients; and those related to fraud, waste, and abuse. It is the responsibility of providers and participating providers to understand and comply with the professional and legal requirements within the state(s) in which providers/participating providers practice and/or render services.

By way of example, the Americans with Disabilities Act of 1990, as amended (ADA) contains provisions regarding services to certain individuals identified as covered under the ADA. Participating providers are encouraged to adapt services and their offices/locations to meet the special needs of members.

6.07 Fraud, Waste, and Abuse

We are committed to protecting the integrity of our health care programs and the effectiveness of operations by preventing, detecting and investigating fraud, waste and abuse (FWA). Combating FWA begins with knowledge and awareness.

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. The attempt itself is fraud, regardless of whether or not it is successful
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** When health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud.

Reporting Fraud, Waste and Abuse

If someone suspects any Member or Provider (a person who receives benefits) has committed fraud, waste or abuse, they have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

Report concerns by:

- Calling Provider Services at 800-397-1630
- Calling the Carelon Ethics and Compliance hotline at 888-293-3027

Any incident of fraud, waste or abuse may be reported to Carelon anonymously; however, Carelon's ability to investigate an anonymously reported matter may be limited if Carelon doesn't have enough information. Carelon encourages Providers and Facilities to give as much information as possible. Carelon appreciates referrals for suspected fraud, but be advised that Carelon does not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Member Fraud, Waste and Abuse:

- Forging, altering or selling prescriptions
- Letting someone else use the Member's ID (Identification) card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service Plan area
- Using someone else's ID card

When reporting concerns involving a Member include:

- The Member's name
- The Member's date of birth, Member ID or case number if available
- The city where the Member resides
- Specific details describing the fraud, waste or abuse

Examples of Provider Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if available
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Investigation Process

The Special Investigations Unit ("SIU") investigates suspected incidents of FWA for all types of services. Carelon may take corrective action with a Provider or Facility, which may include, but is not limited to:

- Written warning and/or education: Carelon sends letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or requests for repayment, or may advise of further action.
- Medical record review: Carelon reviews medical records to investigate allegations or validate the appropriateness of Claims submissions.
- Edits: A certified professional coder or investigator evaluates Claims and places payment or system edits in Carelon's Claims processing system. This type of review prevents automatic Claims payments in specific situations.
- Recoveries: Carelon recovers overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from our network, or legal action.

Prepayment Review

One method Carelon uses to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to Carelon's attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider or Facility is an outlier compared to his/her/its peers.

Once a Claim, or a Provider or Facility, is identified as an outlier or has otherwise come to Carelon's attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination that the Provider's or Facility's actions may involve FWA, unless exigent circumstances exist, the Provider or Facility is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider or Facility is on prepayment review, the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Carelon can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Carelon in accordance with this requirement will result in a denial of the Claim under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, Carelon may review coding, documentation, and other billing issues. In addition, Carelon may use one or more clinical utilization management guidelines in the review of Claims submitted by the Provider or Facility, even if those guidelines are not used for all Providers or Facilities delivering services to Plan Members.

The Provider or Facility will remain subject to the prepayment review process until Carelon is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our network.

Finally, Providers and Facilities are prohibited from billing a Member for services Carelon has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers or Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider and Facility Agreement, proper billing procedures and state law. Providers or Facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

In addition to the previously mentioned actions, Carelon may refer suspected criminal activity committed by a Member, Provider or Facility to the appropriate regulatory and/or law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse the provider:

- Will be referred to the Special Investigations Unit
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily dis-enrolled from our health care plan, with state approval.

Recoupment/Offset/Adjustment for Overpayments

Carelon shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Carelon to Provider or Facility ("Overpayment Amount") against any payments due and payable by Carelon or any Affiliate to Provider or Facility with respect to any Health Benefit Plan under this Agreement or under any Agreement between Provider and an Affiliate regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Carelon that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount to Carelon within thirty (30) calendar days of the date of the overpayment refund notice from Carelon to the Provider or Facility. If the Overpayment Amount is not received by Carelon within the thirty (30) calendar days following the date of such notice letter, Carelon shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Carelon or an Affiliate to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider or Facility agrees that all future Claim payments, including Affiliate Claim payments, applied to satisfy Provider's or Facility's repayment obligation shall be deemed to have been legally paid to Provider or Facility in full for all purposes, including Affiliates and/or Regulatory Requirements as defined by the Provider or Facility Agreement. Should Provider or Facility disagree with any determination by Carelon or a Plan that Provider or Facility has received an overpayment or improper payment, Provider or Facility shall have the right to appeal such determination under Carelon's procedures set forth in the Provider Manual, provided that such appeal shall not suspend Carelon's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Carelon reserves the right to employ a third party collection agency in the event of non-payment.

Relevant Legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains Qui Tam or "whistleblower" provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

Employee Education about the False Claims Act

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least 5 million dollars (cumulative from all sources), must comply with the following:

Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).

Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, abuse and waste. Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse and waste.

7. MEMBER RIGHTS AND RESPONSIBILITIES

7.01 Member Rights and Responsibilities

The following is the list of Carelon's Member Rights & Responsibilities.

Carelon members have the right to:

- Be treated with respect and dignity.
- Have your personal information be private based on our policies and U.S. law.
- Get information that is easy to understand and in a language you know.
- Know about the way your health benefits work.
- Know about our company, services, and provider network.
- Know about your rights and responsibilities.
- Tell us what you think your rights and responsibilities should be.
- Get care when you need it.
- Talk with your provider about your treatment options - regardless of cost or benefit coverage.
- Decide with your provider what is the best plan for your care.
- Refuse treatment if you want, as allowed by the law.
- Get care without fear of any unnecessary restraint or seclusion.

- Decide who will make medical decisions for you if you cannot make them.
- Have someone speak for you when you talk with Carelon.
- See or change your medical record, as allowed by our policy and the law.
- Understand your bill.
- Expect reasonable adjustments for disabilities as allowed by law.
- Request a second opinion.
- Tell us your complaints.
- Appeal if you disagree with a decision made by Carelon about your care.
- Be treated fairly - even if you tell us your thoughts or appeal.

Carelon members have the role to:

- Give us and your providers the information needed to help you get the best possible care.
- Follow the health care plan that you agreed on with your health care provider.
- Talk to your provider before changing your treatment plan.
- Understand your health problems as well as you can. Work with your health care providers to make a treatment plan that you all agree on.
- Read all information about your health benefits and ask for help if you have questions.
- Follow all health plan rules and policies.
- Choose an In-Network primary care physician, also called a PCP, if your health plan requires it.
- Tell your health plan or Carelon of any changes to your name, address or insurance.
- Contact your provider when needed, or call 911 if you have any emergency.

Carelon's Member Rights and Responsibilities Statement is available as a one -page pdf in English and Spanish for download from the website. Providers and practitioners are encouraged to ensure your practice supports the Rights and Responsibilities of our Members.

8. PARTICIPATING PROVIDER COMPLAINTS, AND GRIEVANCES

The Carelon complaint, grievance, and appeal processes provide an effective method and dependable problem resolution procedure for the informal resolution of participating provider complaints, issues, concerns, or disputes that may arise related to the credentialing/re-credentialing process, medical necessity adverse determinations, administrative denials, claims processing, and payment or denial of claims, and otherwise related to the provider agreement.

Information about the process for appeals related to credentialing and/or re-credentialing decisions is set out in the appeals section of this handbook.

Information about the process for appeals of adverse determinations is set out in the appeals section of this handbook.

8.01 Complaints Regarding the Provider Agreement

Initial participating provider complaints regarding the terms of the provider agreement and/or performance by Carelon or the participating provider under the provider agreement should be submitted in writing to the local Carelon Engagement Center or to Carelon's Provider Relations Department at the address referenced in the Contacts section of this handbook within ten business days of the event that gave rise to the complaint or within ten business days from the time the participating provider should have reasonably first become aware of the event.

Correspondence should include all documentation in support of the complaint and should provide, at a minimum:

- Reference to the specific term or provision in the provider agreement in dispute (It is helpful if the participating provider attaches a copy of the page or pages with the specific term or provision in dispute.)
- A detailed description of the nature of the complaint and what action or inaction allegedly is not consistent with or contrary to provision in the provider agreement
- The specific remedy requested for resolution.

Carelon will review the documentation, investigate the concern, and respond in writing to the participating provider within 30 business days of receipt of the complaint and requested documentation.

If the participating provider is not satisfied with the response from Carelon to the participating provider's initial complaint regarding the terms of the provider agreement and/or performance by Carelon or the participating provider under the provider agreement, the participating provider may be file a second level complaint within 10 business days of receipt of Carelon's response to the participating provider's initial complaint, or in the absence of a response to the participating provider's initial complaint, within 35 business days of submission of the initial complaint, to the local Carelon Engagement Center or Carelon Provider Relations Department at the address referenced in the Contacts section of this handbook. The written second level complaint must contain, at a minimum, the same information required in the initial complaint as well as any additional information pertinent to the complaint. Carelon will review the documentation, investigate the concern, and provide a final written response to the participating provider within 30 business days of receipt of the second level complaint and requested documentation.

8.02 General Complaints and Grievances

Participating provider complaints regarding issues other than those related to the terms of the provider agreement and/or performance under the provider agreement (e.g., service complaints, complaints about Carelon's policies and procedures or the policies and procedures applicable to a specific client benefit plan or government-sponsored health benefit program[3]) should be directed to the Carelon National Provider Services Line at 800-397-1630, Mon. through Fri., between 8 a.m. and 8 p.m. ET or in writing to:

Carelon Behavioral Health, Inc.
Attn: Provider Complaint Department
P.O. Box 989
Latham, NY 12110

Carelon will acknowledge receipt of participating provider complaints verbally or in writing, and thereafter will investigate and attempt to reach a satisfactory resolution of the complaint within 30 calendar days of receipt of the complaint. A one-time extension of 15 calendar days can be taken by Carelon when a resolution cannot be reached within the above noted 30 calendar day timeframe and the extension is solely for the benefit of a member. Carelon will notify the participating provider verbally or in writing of the resolution to the complaint.

[3] Questions about the policies or procedures applicable to a specific client benefit plan or government sponsored health benefit program should be directed to the Carelon Customer Service Department by calling the number on the member's identification card.

9. CLAIMS PROCEDURES

Carelon maintains claims processing procedures designed to comply with the requirements of client plans, government-sponsored health benefit programs, and applicable state and/or laws, rules, and/or regulations.

Providers in the Carelon network are strongly recommended to electronically submit all claims.

To electronically submit claims, Carelon participating providers are strongly encouraged to use one of the electronic claims resources detailed further in the section titled "Electronic Resources." These resources will expedite claims processing and assist participating providers to conduct certain claim submission and other routine transactions. Electronic claim submission is also accepted through clearinghouses. When using the services of a clearinghouse, providers must reference Carelon's Payer ID, BHOVO, to ensure Carelon receives those claims. Each clearinghouse may have a payer list that provides an alternative value specific to Carelon, the value published on their website can also be used.

9.01 Member Expenses

Member expenses due from the member for covered services are determined by the member's benefit plan. Detailed information about most of the amounts of member expenses due for inpatient, outpatient or emergency covered services can be obtained by viewing a member's benefits within our provider portal. Participating providers are encouraged to contact Carelon's Customer Service at the member's toll-free number for questions regarding member expenses.

It is the responsibility of the participating provider to collect member expenses due to the participating provider for covered services rendered.

9.02 Preauthorization, Certification, or Notification

Preauthorization, certification, or notification requirements vary from plan to plan. Participating providers must determine if such requirements exist prior to the provision of non-emergency services to members. Information regarding Carelon's policies and procedures on authorization, certification or notification is located in the utilization management/review section of this handbook. Participating providers may not bill, charge or seek reimbursement or a deposit from members for services determined not to be medically necessary.

Providers/participating providers may verify member eligibility, submit and review authorization/ certification requests, and view authorizations/certifications through the provider portal on the website.

9.03 No Balance Billing

Participating providers may not balance bill members for covered services rendered. This means that the participating provider may not bill, charge or seek reimbursement or a deposit, from the member for covered services except for applicable member expenses, and non-covered services. Participating providers are required to comply with provisions of Carelon's code of conduct where applicable, including, without limitation, cooperation with claims and billing procedures and participation in training and education. Balance billing education is provided by Carelon as included in quarterly Fraud, Waste, and Abuse provider training. It is the provider's responsibility to check benefits prior to beginning treatment of the member, to obtain appropriate authorization to provide services, if applicable, and to follow the procedures set forth in this Handbook.

9.04 Claim Submission Guidelines

Unless otherwise identified in the provider agreement, participating providers must file or submit claims within 90 calendar days from the date of service or the date of discharge for inpatient admission, or where applicable from date of determination by the primary payer. Claims after the above noted 90-day time period after the date of service may be denied due to lack of timely filing. Claims must match the authorization or certification or notification applicable to covered services for which the claim applies to avoid potential delays in processing.

Participating providers should not submit claims in their name for services that were provided by a physician's assistant, nurse practitioner, psychological assistant, intern or another clinician. In facility or program settings, supervising clinicians should not submit claims in their name for services that were provided by a resident, intern or psychological assistant.

Separate claim forms must be submitted for each member for whom the participating provider bills and it must contain all of the required data elements. Each billing line should be limited to one date of service and one procedure code.

When billing for CPT codes that include timed services in the code description (e.g., 90832, 90833, 90834, 90836, 90837, 90838, 90839, and appropriate Evaluation and Management codes, the actual time spent must clearly be documented within the member's treatment record. This time should be documented indicating a session's start and stop times (e.g., 9:00-9:50).

Participating providers should submit claims consistent with national and industry standards. To ensure adherence to these standards, Carelon relies on claims edits and investigative analysis processes to identify claims that are not in accordance with national and industry standards and therefore were paid in error. The claims edits and investigative analysis processes include CMS's National Correct Coding Initiative (NCCI), which consists of:

- Procedure-to-Procedure edits that define pairs of HCPCS/CPT codes that should not be reported together.
- Medically Unlikely Edits (MUE) or units-of-service edits. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct and therefore needs to be supported by medical records.
- Other Edits for Improperly Coded Claims – regulatory or level of care requirements for correct coding.

Examples of claims edits can include but are not limited to the following:

- Invalid procedure and/or diagnosis codes
- Invalid code for place of service
- Invalid or inappropriate modifier for a code
- State-specific edits to support Medicaid requirements
- Diagnosis codes that do not support the procedure
- Add-on codes reported without a primary procedure code
- Charges not supported by documentation based on review of medical records
- Claims from suspected fraudulent activities of providers and members that warrant additional review and consideration

- Services provided by a sanctioned provider or provider whose license has been revoked or restricted
- Incorrect fee schedule applied
- Duplicate claims paid in error
- No authorization on file for a service that requires prior authorization

Claims for covered services rendered to members should be submitted electronically using one of the electronic claims resources detailed further in the section titled "Electronic Resources."

Note: If a participating provider uses a clearinghouse to electronically submit claims, please provide the clearinghouse with Carelon's payer id, **BHOVO**.

All billings by the participating provider are considered final unless adjustments or a request for review is received by Carelon within the time period identified in the provider agreement, or if no time period is identified in the provider agreement within 60 calendar days from the date indicated on the Explanation of Benefits (EOB). Payment for covered services is based upon authorization, certification, or notification (as applicable), coverage under the member's benefit plan and the member's eligibility at the time of service.

Note: Client plan or government sponsored health benefit program specific claim submission requirements are located in the 'Carelon Providers' section of the website under 'Network- Specific.'

The individual provider is ultimately responsible for the accuracy and valid reporting of all claims submitted for payment. A provider using the services of a billing agency must ensure through legal contract (a copy of which must be made available to Carelon upon request) the responsibility of a billing service to report claim information as directed by the provider in compliance with all policies stated by Carelon. It is also the provider's responsibility to submit claims timely in accordance with the terms in the Provider Agreement.

9.05 Required Claim Elements

Claims for covered services rendered to members should be submitted using UB-04 or CMS-1500 forms, or their respective electronic equivalent or successor forms, with all applicable fields completed and all elements/information required by Carelon included. Tip sheets containing Carelon's required claim fields to make a clean claim for the UB04 and CMS-1500 are located on the handbook page of the website.

**All data elements noted as required must be provided, but they must also be current and match what the subscriber's employer has on file. If the member's ID on the claim is illegible, or does not match what the subscriber's employer has provided, we may not be able to determine the claimant. We strongly recommend that you obtain a copy of the member's ID card, and validate that it is current at the time of each visit.

**There are times when supporting information is required to approve payment; if supporting documentation is not included, the claim may not be considered clean.

**Claims that are not submitted on a CMS 1500 2012-02 or a UB04 often will not contain the information we need to consider the claim clean and will cause the claim to reject or take a longer processing time. Claims submitted on old claim forms may be returned.

**Electronically submitted claims must also be in a HIPAA 5010 compliant format and conform to the Carelon companion guide to be considered clean.

In addition, the claim should be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the participating provider will forward information reasonably requested for the purpose of consideration and in obtaining necessary information relating to coordination of benefits, subrogation, and verification of coverage, and health status.

Claims submission guidance, including required claim fields to make a clean claim, is available on the 'Carelon Providers' section of the website.

For paper claims, the use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. The following elements are required to take advantage of this automated process. If the participating provider does not follow these guidelines, claims may be returned from the scanning vendor:

- Use machine print
- Use original red claim forms
- Use black ink
- Print claim data within the defined boxes on the claim form
- Use all capital letters
- Use a laser printer for best results
- Use correction tape for corrections
- Submit any notes on 8 ½" x 11" paper
- Use an eight-digit date format (e.g., 10212012)
- Use a fixed width font (Courier, for example)

9.06 Requests for Additional Information

To maintain in-network status and upon request by Carelon, or its authorized designee, participating providers must promptly furnish requested documentation or information related to and/or in support of claims submitted. Failure to do so may result in a change in network participation status from active to inactive. Inactive providers are ineligible to receive referrals or payment as a participating provider for covered services rendered to members.

9.07 Claims Processing

Carelon, or its designee, will process complete and accurate claims submitted by providers/participating providers for covered services rendered to members in accordance with normal claims processing policies and procedures, the payment terms included in the provider agreement, and applicable state and/or federal laws, rules and/or regulations with respect to timeliness of claims processing.

Normal claims processing procedures may include, without limitation, the use of automated systems which compare claims submitted with diagnosis codes and/or procedure codes and associated billing or revenue codes. Automated systems may include edits that result in an adjustment of the payment to the provider/participating provider for covered services or in a request for submission of treatment records.

Participating provider agrees that no payment is due for covered services or claims submitted unless the covered services are clearly and accurately documented in the treatment record prior to submission of the claim.

Reimbursement for covered services provided in an inpatient facility, inpatient rehabilitation or residential setting/level of care will be at the contracted reimbursement rate in effect on the date of admission.

Payment for services rendered to members is impacted by the terms in the provider agreement, the member's eligibility at the time of the service, whether the services were covered services, if the services were medically necessary, compliance with any preauthorization/certification/notification requirements, member expenses, timely submission of the claim, claims processing procedures, overpayment recovery, and/or coordination of benefits activities.

Note: Regardless of any provision to the contrary, participating providers acknowledge and agree that the payment rates in the provider agreement extend and apply to covered services rendered to members of benefit plans administered in whole or in part by Carelon.

9.08 Provider Summary Vouchers

PSVs or remittance advices are the documents that identify the amount(s) paid and member expenses due from the member. Providers/participating providers should access PSVs through the Carelon provider portal or request copies of PSVs via facsimile through Carelon's automated PSV faxback service at 866-409-5958. Additionally, Provider Summary Vouchers may be obtained through Payspan Health, our vendor responsible for distribution of claim payment. Accessing PSVs electronically is a transaction subject to the e-commerce initiative. Additional information regarding access to PSVs is available at the 'Provider' section on the website.

9.09 Coordination of Benefits

Some members may have health benefits coverage from more than one source. In these instances, benefit coverage is coordinated between primary and secondary payers.

Participating providers should obtain information from members as to whether the member has health benefits coverage from more than one source, and if so provide this information to Carelon.

Coordination of benefits amongst different sources of coverage (payers) is governed by the terms of the member's benefit plan and applicable state and/or federal laws, rules and/or regulations. To the extent not otherwise required by applicable laws or regulations, participating providers agree that in no event will payment from primary and secondary payers for covered services rendered to members exceed the rate specified in the provider agreement.

Participating providers must submit a copy of the EOB with their claim submission. If submitting the claim electronically, through our direct submission model using ProviderConnect or Availity, the EOB can be uploaded. When submitting a claim using electronic data interchange or via mail, the EOB must also be sent via mail and includes the primary payer's determination. The services included in the claim submitted to Carelon should match the services included in the primary payer EOB.

Authorization, certification or notification requirements under the member's benefit plan still apply in coordination of benefits situations.

Note: Some benefit plans require that the member update at designated time periods (e.g., annually) other health benefit coverage information. Claims may be denied in the event the member fails to provide the required other coverage updates.

9.10 Claim Appeals

A participating provider who disagrees with Carelon's denial or reimbursement rate for a claim may request a claim appeal, unless government program requirements provide a different resolution mechanism for the disputed claim. Claim appeal requests may be submitted in writing to the address given in the PSV. A complete appeal request must be received within 60 calendar days from date of the payment determination being appealed, unless the provider agreement or applicable laws or regulations establish a longer filing period.

A claim appeal request is not considered complete until all necessary information has been received. At a minimum, it must include the patient's name and identifying information, the participating provider's name and contact information, the billed service and dates of service, and the reason the participating provider believes Carelon's determination is incorrect. The participating provider may submit any additional information for Carelon to consider in our decision. If Carelon finds that additional information is necessary to make a decision, Carelon will notify the participating provider of the information needed and the timeframe to submit the information.

Carelon issues an appeal decision within 30 calendar days from receipt of a complete appeal request, and sends the participating provider a written decision letter. If the appealed determination is upheld, the decision letter will explain the reason it was upheld. If the determination is overturned, the claim will be reprocessed in accordance with the decision within 30 calendar days from the date of the appeal decision.

When a member assigns appeal rights in writing to a provider, the provider may request a member claim appeal on behalf of the member. Member appeal rights are limited to those available under the member's benefit plan. Requests for a member claim appeal must be received in the manner and timeframe stated on the member's Explanation of Benefits, subject to the terms of the member's benefit plan and applicable laws and regulations.

Participating providers must exhaust all administrative processes concerning unresolved claims disputes pursuant to the terms of the provider agreement, and more specifically any dispute resolution provisions, prior to pursuing any legal or equitable action.

9.11 Overpayment Recovery

All providers should routinely review claims and payments in an effort to assure that they code correctly and have not received any overpayments. Carelon will notify providers and participating providers of overpayments identified by Carelon, clients and/or government agencies, and/or their respective designees. Overpayments include, but are not limited to:

- Claims paid in error
- Claims allowed/paid greater than billed
- Inpatient claim charges equal to the allowed amounts
- Duplicate payments
- Payments made for individuals whose benefit coverage is or was terminated
- Payments made for services in excess of applicable benefit limitations
- Payments made in excess of amounts due in instances of third party liability and/or coordination of benefits
- Claims submitted contrary to national and industry standards such as the CMS National Correct Coding Initiative (NCCI) and medically unlikely edits (MUE) described in the Claims Submission Guidelines

Subject to the terms of the provider agreement and applicable state and/or federal laws and/or regulations, Carelon or its designee will pursue recovery of overpayments through:

- Adjustment of the claim or claims in question creating a negative balance reflected on the PSV (claims remittance)
- Written notice of the overpayment and request for repayment of the claims identified as overpaid

Failure to respond to any written notice of and/or request for repayment of identified overpayments in the time period identified in the notice/request is deemed approval and agreement with the overpayment; thereafter, Carelon will adjust the claim or claims in question creating a negative balance. Any negative balance created will be offset against future claims payments until the negative balance is zeroed out and the full amount of the overpayment is recovered. Carelon may use automated processes for claims adjustments in the overpayment recovery process.

If the provider/participating provider disagrees with an overpayment recovery and/or request for re-payment of an overpayment, the provider/participating provider may request review to Carelon in writing such that the written request for review is received by Carelon on or before the date identified in the notice of overpayment recovery or request for re-payment of an overpayment. Please attach a copy of your written demand or request letter to your request for review and include the following information; provider/participating provider's name, identification number and contact information, member name, and number, a clear identification of the disputed items to include the date of service and the reason the disputed overpayments are being contested.

In those instances in which there is an outstanding negative balance as a result of claims adjustments for overpayments for more than 90 calendar days, Carelon reserves the right to issue a demand for re-payment. Should a provider/participating provider fail to respond and/or provide amounts demanded within the 30 calendar days of the date of the demand letter, Carelon may pursue all available legal and equitable remedies, including without limitation placing the outstanding overpayment amount (negative balance) into collections. No additional request for review, other than the one described in the paragraph above this, is allowed.

9.12 Electronic Claim Submission and Clearinghouses

Carelon has contracted with Availity Essentials ("Availity") as our primary clearinghouse. All providers and facilities that generate HIPAA compliance 837 files will need to register with Availity and submit their files through Availity's web portal. The Availity portal also offers direct data entry of claim records using both professional and institutional claim formats.

Providers and facilities that are submitting through a clearinghouse other than Availity (i.e. Change Healthcare, Office Ally) can continue to do so as all existing clearinghouse trading partners will be routing claims through Availity to Carelon.

For information about testing and setup for EDI, review Carelon's 837 companion guide available on Carelon's website. Carelon accepts standard HIPAA 837 professional and institutional health care claim transactions and provides 999 and 277CA response.

9.13 PaySpan

Carelon providers/participating providers must use Payspan for electronic fund transfer. Payspan enables providers to receive payments automatically in their bank account of choice, receive email notifications immediately upon payment, view remittance advices online, and download an 835 file to use for autoposting purposes.

10. UTILIZATION MANAGEMENT

The Carelon utilization management program encompasses management of care from the point of entry through discharge using objective, standardized, and widely-distributed clinical protocols and enhanced outpatient care management interventions. Specific utilization management activities may apply for high- cost, highly restrictive levels of care and cases that represent clinical complexity and risk. Participating providers are required to comply with utilization management policies and procedures and associated review processes.

Examples of review activities included in Carelon's utilization management program are determinations of medical necessity, preauthorization, certification, notification, concurrent review, retrospective review, care/case management, discharge planning, and coordination of care.

The Carelon utilization management program includes processes to address:

- Easy and early access to appropriate treatment
- Working collaboratively with participating providers in promoting delivery of quality care according to accepted best-practice standards
- Addressing the needs of special populations, such as children and the elderly
- Identification of common illnesses or trends of illness
- Identification of high-risk cases for intensive care management
- Screening, education and outreach

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

All utilization management decisions are based on the approved medical necessity criteria. Additionally, criteria is applied with consideration to the individual needs of the member and an assessment of the local delivery system.

1. Individual needs and characteristics of the member include: age, linguistic, or ethnic factors, co-morbidities and complications, progress of treatment, psychosocial situation, and home environment.
2. Characteristics of the local delivery system available to the member include aspects such as availability of alternative levels of care, benefit coverage for the available alternatives, and ability of local providers to provide all recommended services within the estimated length of stay.

Prior to beginning a course of outpatient treatment and/or a non-emergency admission, providers/participating providers must verify member eligibility and obtain authorization or certification (where applicable). Providers/participating providers are strongly encouraged to verify eligibility and benefits and submit authorization requests (where applicable) via the provider portal.

In order to verify member eligibility, the provider/participating provider will need to have the following information available:

- Patient's name, date of birth, and *member* identification number
- Insured or covered employee's name, date of birth, and *member* identification number
- Information about other or additional insurance or health benefit coverage

Based on the most recent data provided by employer/benefit plan sponsor, benefit plan administrator, and/or where applicable the sponsoring government agency, Carelon will:

- Verify member eligibility
- Identify benefits and associated member expenses under the member's benefit plan
- Identify the authorization or certification procedures and requirements under the member's benefit plan

Note: Verification of eligibility and/or identification of benefits and member expenses are not authorization or certification or a guarantee of payment.

10.01 New and Emerging Technologies

Carelon recognizes the need for knowledge of emerging technologies to provide access to optimum care for members. Carelon evaluates these technologies in terms of their overall potential benefits to members and in some instances recommends these technologies to clients for inclusion in their respective benefit packages. Examples of new technologies are psychotropic medications or new, approved uses of current medications, innovative community service programs and new approaches to provision of psychotherapy and treatment. Carelon has established committees that conduct formal reviews of potential new technologies. The effectiveness of new service technologies will be considered in medical necessity decisions.

10.02 Treatment Planning

Providers/participating providers must develop individualized treatment plans that utilize assessment data, address the member's current problems related to the behavioral health diagnosis, and actively include the member and significant others, as appropriate, in the treatment planning process. CCMs review the treatment plans with the providers/participating providers to ensure that they include all elements required by the provider agreement, applicable government program, and at a minimum:

- Specific measurable goals and objectives
- Reflect the use of relevant therapies
- Show appropriate involvement of pertinent community agencies
- Demonstrate discharge planning from the time of admission
- Reflect active involvement of the member and significant others as appropriate

Providers/participating providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.

10.03 Clinical Review Process

Provider/participating provider cooperation in efforts to review care prospectively is an integral part of care coordination activities. Subject to the terms of the member's benefit plan and applicable state and/or federal laws and/or regulations, providers/participating providers must notify Carelon prior to admitting a member to any non-emergency level of care. The Mental Health Parity & Addiction Equity Act of 2008 requires that mental health and substance use disorder benefits, provided by group health plans with more than 50 employees, must be available on an equivalent or better basis to any medical or surgical benefits. Some benefit plans, but not all, may fall under this guideline and do not require notification or authorization for standard outpatient services. Others may allow for a designated number of outpatient sessions without prior-authorization, certification, or notification. Carelon may request clinical information at various points in treatment to ensure the ongoing need for care and treatment that is appropriate and effective in improving health outcomes for members.

In all cases, providers/participating providers are encouraged to contact Carelon prior to initiating any non-emergency treatment to verify member eligibility and to clarify what the authorization or certification requirements are, if any, for the proposed treatment.

Coverage and payment for services proposed for and/or provided to members for the identification or treatment of a member's condition or illness is conditioned upon member eligibility, the benefits covered under the member's benefit plan at the time of service, and on the determination of medical necessity of such services and/or treatment. Overpayments made as a result of a change in eligibility of a member are subject to recovery (see Overpayment Recovery section).

Subject to verification of eligibility under the member's benefit plan, upon request for authorization or certification of services, the CCM gathers the required clinical information from the provider/participating provider, references the appropriate medical necessity criteria for the services and/or level of care, and determines whether the services and treatment meets criteria for medical necessity. The CCM may authorize or certify levels of care and treatment services that are specified as under the member's benefit plan (e.g., acute inpatient, residential, partial hospitalization, intensive outpatient, or outpatient).

Authorizations or certifications are for a specific number of services/units of services/days and for a specific time period based on the member's clinical needs and provider characteristics. Carelon reserves the right to reject or return authorization requests that are incomplete, lacking in specificity, or incorrectly filled out. Carelon will provide an explanation of action(s) which must be taken by the provider to resubmit the request.

Carelon is required by the state, federal government, NCQA and the Utilization Review Accreditation Commission (URAC) to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. Carelon has adopted the strictest timeframe for all UM decisions to comply with the various requirements.

Carelon's internal timeframes for rendering a UM determination and notifying members of such determination begin at the time of Carelon's receipt of the request. Note, the maximum timeframes may vary on a case-by-case basis in accordance with state, federal government, NCQA or URAC requirements. Refer to the provider portal and network specific sites for specific plan requirements.

Prior to initial determinations of medical necessity, the member's eligibility status and coverage under a benefit plan administered by Carelon should be confirmed. If eligibility information is not available in non- emergency situations, a CCM may complete a screening assessment and pend the authorization/certification awaiting eligibility verification. CCMs will work with members and providers/participating providers in situations of emergency, regardless of eligibility status.

If a member's benefits have been exhausted or the member's benefit plan does not include coverage for behavioral health services and there's no alternative coverage, the CCM, in coordination with the provider/participating provider as appropriate, will provide the member with information about available community support services and programs, such as local or state-funded agencies or facilities, that might provide sliding scale discounts for continuation in outpatient therapy, or where available under the member's benefit plan, explore benefit exchanges with the client plan.

10.04 Retrospective Review

When a provider/participating provider requests a retrospective review for services previously rendered, Carelon will first determine whether such a retrospective review is available under the member's benefit plan and request the reason for the retrospective review (e.g., emergency admission, no presentation of a Carelon member identification card, etc.). In cases where a retrospective review is available, services will be reviewed as provided for in this handbook. In cases where a retrospective review is not available under the member's benefit plan and/or and where the provider/participating provider fails to follow administrative process and requirements for authorization, certification, and/or notification, the request for retrospective review may be administratively denied. Subject to any client, government-sponsored health benefit program, and/or benefit plan specific requirements, the chart below references the standard timeframes applicable to the type of review request:

STANDARD DETERMINATION TIME FRAMES		
REQUEST TYPE	**TIMING**	**DETERMINATION**
Prospective *Urgent*	Prior to treatment	Within 72 hours
Prospective Non-Urgent	Prior to treatment	Within 15 calendar days (14 for contracts governed by *CMS*)
Concurrent *Urgent*	>24 hours of *authorization* expiration	Within 24 hours
Concurrent *Urgent*	<24 hours from *authorization* expiration	Within 72 hours
Concurrent Non-Urgent	Prior to *authorization* term	*Reverts to Prospective*, so within 72 hours/15 calendar days (14 for contracts governed by *CMS*)
Retrospective	After services	Within 30 calendar days

Carelon's procedures for authorization, certification and/or notification apply to services and treatment proposed and/or previously rendered in instances where the member benefit plan administered by Carelon is primary and instances where the member benefit plan administered by Carelon is secondary.

Carelon, at times, may administer both primary and secondary benefit plans of a given member. To avoid possible duplication of the review process in these cases, providers/participating providers should notify Carelon of all pertinent employer and other insurance information for the member being treated.

Note: Failure to follow authorization, certification, and/or notification requirements, as applicable, may result in administrative denial/non-certification and require that the member be held harmless from any financial responsibility for the provider's/participating provider's charges.

10.05 Definition of Medical Necessity

Unless otherwise defined in the provider agreement and/or the applicable member benefit plan and/or the applicable government sponsored health benefit program, Carelon's reviewers, CCMs, Peer Advisors, and other individuals involved in Carelon's utilization management processes use the following definition of medical necessity or medically necessary treatment in making authorization and/or certification determinations as may be amended from time to time:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (current ICD or DSM) that threatens life, causes pain or suffering, or results in illness or infirmity
- Expected to improve an individual's condition or level of functioning
- Individualized, specific and consistent with symptoms and diagnosis, and not in excess of patient's needs
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications
- Reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment is available
- Not primarily intended for the convenience of the recipient, caretaker or provider/participating provider
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency
- Not a substitute for non-treatment services addressing environmental factors

10.06 Medical Necessity Criteria

Carelon's Medical Necessity Criteria (MNC), also known as clinical criteria, are reviewed and updated at least annually to ensure that they reflect the latest developments in serving individuals with behavioral health diagnoses. Carelon's Corporate Medical Management Committee (CMMC) adopts, reviews, revises and approves Medical Necessity Criteria per client and regulatory requirements.

Medical Necessity Criteria varies according to state and/or contractual requirements and member benefit coverage. To determine the proper Medical Necessity Criteria, use the following as a guide:

1. For all Medicare members, first identify relevant Centers for Medicare and Medicaid (CMS) National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.
2. If no CMS criteria exists for Medicare members and for all non-Medicare members, identify relevant custom Medical Necessity Criteria.
3. If no custom criteria exists for the applicable level of care and the treatment is substance use related, the American Society of Addiction Medicine (ASAM) criteria would be appropriate.
   * Exception: Substance Use Lab Testing Criteria is in InterQual® Behavioral Health Criteria.
4. If the level of care is not substance use related, Change Healthcare's InterQual® Behavioral Health Criteria would be appropriate.
5. If 1-4 above are not met, Carelon's National Medical Necessity Criteria would be appropriate.

Carelon has five (5) types of MNC, depending on client or state contractual requirements and lines of business:

A. Centers for Medicare and Medicaid (CMS) Criteria – National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) contained in the Medicare Coverage Database (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

B. Change Healthcare's InterQual Behavioral Health Criteria

C. American Society of Addiction Medicine (ASAM) Criteria

D. Custom criteria, including state or client specific levels of care

E. Carelon's National Medical Necessity Criteria

Network providers are given an opportunity to comment or give advice on development or adoption of medical necessity criteria and on instructions for applying the criteria. These comments and opinions are solicited through practitioner participation on committees and through provider requests for review.

Medical Necessity Criteria is available on Carelon's website via hyperlinks whenever possible and is available upon request. To order a copy of the ASAM criteria, please go to the following website: www.asam.org/asam-criteria. In addition, Carelon disseminates criteria sets via the website, provider handbook, provider forums, newsletters, and individual training sessions.

10.07 Clinical Practice Guidelines

Carelon reviews and endorses clinical practice guidelines on a regular basis to support providers in making evidence-based care treatment decisions on a variety of topics. The most up-to-date, *endorsed, clinical practice guidelines (CPGs) are posted on the Carelon website*. Included are those that have been developed or updated within the past two years and represent the best clinical information we have at this time. Others clinical practice resources, while not considered current, still contain information that continues to be clinically relevant. For example, some of the guidelines may recommend specific treatment interventions without adequately addressing the sufficiency of the evidence to support the recommendation. Continued use of the guidelines is warranted because resultant positive clinical contribution outweighs the fact that the summaries of the supporting research may have lacked adequate transparency related to the process of ranking the studies necessary to meet today's standards of guideline development.

CPGs are used in collaboration with providers to help guide appropriate and clinically effective care for a variety of complex psychiatric conditions. They may also may be referred to by CCMs and Peer Advisors during reviews.

The Carelon Scientific Review Committee (SRC) reviews and/or updates each guideline at least every two years. In addition, if the original source of the guideline publishes an update or makes a change, the SRC will initiate additional review of the guideline prior to the two-year review cycle. Updates/changes are then presented to Carelon's Corporate Medical Management Committee (MMC) for final approval.

As Carelon providers, you are expected to ensure your standards of practice align with the endorsed clinical practice guidelines.

10.08 Clinical Care Manager Reviews

Carelon's CCMs base reviews on established criteria adopted by Carelon and/or criteria developed by Carelon. CCMs are trained to match the needs of members to appropriate services, levels of care, treatment and length of stay, and community supports. This requires careful consideration of the intensity and severity of clinical data presented, with the goal of quality treatment in the least restrictive environment. The clinical integrity of the utilization management program seeks to provide that members who present for care are appropriately monitored and that comprehensive reviews of all levels of care are provided. Those cases that appear to be outside of best practice guidelines or appear to have extraordinary treatment needs are referred for specialized reviews. These may include evaluation for intensive care management, clinical rounds, peer advisor review or more frequent CCM review.

CCMs obtain clinical data from the provider/participating provider or designee relating to the need for care and treatment planning. The CCM evaluates this information and references applicable medical necessity criteria to determine medical necessity of the requested level of care or service. Where appropriate, care is pre-certified for a specific number of services/days for a specific time period at a specific level of care, based on the needs of the member.

Except where disclosure of certain information is expressly prohibited by or contrary to applicable state or federal laws or regulations, participating providers must be prepared to provide Carelon with the following information at the time of the review, as necessary and appropriate:

- Demographics
- Diagnosis (current DSM or ICD)
- Reason for admission/precipitant
- Suicidal/homicidal risk, including:
    - Ideation
    - Plan
    - Intent
    - Psychotic/Non-Psychotic (e.g., command hallucinations, paranoid delusions)
- Substance use disorder history
    - Type
    - Amount
    - Withdrawal symptoms
    - Vital signs
    - Date(s) of initial use and last use
    - Date(s) of periods of sobriety
- Other presenting problem/symptomatology description, if applicable
- Progress since admission (if concurrent review)
- Medical problems
    - Medical history
    - Organic cause of psychiatric symptoms/behaviors
    - Medical problems which exacerbate psychiatric or substance use disorder symptoms/behaviors

- Current medications
  - Type(s)
  - Dosage(s)
  - Date(s)
  - Duration
  - Response
  - Provider(s)
- Primary care physician (PCP) interface, if applicable
- Other behavioral health care provider interface, if applicable
- General level of functioning
  - Sleep, appetite
  - Mental status
  - ADLs (Activities of Daily Living)
- Psychological stressors and supports
  - Socioeconomic
  - Family
  - Legal
  - Social
  - Abuse, neglect, domestic violence (as appropriate)
- Response to previous treatment
  - Previous treatment history, most recent treatment, past treatment failures
  - Relapse/recidivism, motivation for treatment
  - Indications of compliance with treatment recommendations
- Treatment plan
  - Estimated length of stay
  - Treatment goals
  - Specific planned interventions
  - Family involvement
  - Precautions for specific risk behaviors
  - Educational component for regulatory compliance and substance use disorder situations
- Discharge plan
  - Aftercare required upon discharge
  - Barriers to discharge

10.09 Inpatient / Higher Levels of Care

All inpatient and alternative level of care programs (this does not include outpatient therapy rendered in a provider's/participating provider's office or outpatient therapy in a clinic or hospital setting) will be subject to the review requirements described in this section. Prior to non-emergency admission and/or beginning treatment, the provider/participating provider must contact Carelon:

- For notification
- To confirm benefits and verify member eligibility
- To provide clinical information regarding the member's condition and proposed treatment
- For authorizations or certifications, where required under the member's benefit plan and in compliance with state regulations

It is preferred that providers use the Carelon provider portal, available 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues), to confirm benefits and provide notification and clinical information as appropriate. Providers/participating providers can secure copies of the authorization/certification requests at time of submission for their records.

CCMs and/or referral line clinicians are available 24 hours a day, seven days a week, 365 days a year and can provide assessments, referrals, and conduct authorization or certification reviews if such processes are unavailable through the provider portal.

Where authorization, certification, or notification is required by the member's benefit plan and unless otherwise indicated in the provider agreement, providers/participating providers should contact Carelon within 48 hours of any emergency admission for notification and/or to obtain any required authorization or certification for continued stay.

If prior to the end of the initial or any subsequent authorization or certification, the provider/participating provider proposes to continue treatment, the provider/participating provider must contact Carelon for a review and recertification of medical necessity. It is important that this review process be completed 24 hours prior to the end of the current authorization or certification period.

Continued stay reviews:

- Focus on continued severity of symptoms, appropriateness, and intensity of treatment plan, member progress, and discharge planning
- Involve review of treatment records and discussions with the provider/participating provider or appropriate facility staff, EAP staff, or other behavioral health providers and reference to the applicable medical necessity criteria

In instances where the continued stay review by a CCM does not meet medical necessity criteria and/or where questions arise as to elements of a treatment plan or discharge plan, the CCM will forward the case file to a Peer Advisor for review.

Note: Submission requirements may vary depending on benefit plan; therefore, it is recommended that the provider/participating provider contact customer service by dialing the toll-free number on the member's insurance card to obtain the correct procedure.

10.10 Discharge Planning

Discharge planning is an integral part of treatment and begins with the initial review. As a member is transitioned from inpatient and/or higher levels of care, the CCM will review/discuss with the provider/participating provider the discharge plan for the member. The following information may be requested and must be documented:

- Discharge date
- Aftercare date
    - Date of first post-discharge appointment (must occur within seven days of discharge)
    - With whom (name, credentials)
    - Where (level of care, program/facility name)
- Other treatment resources to be utilized:
    - Types
    - Frequency
- Medications
    - Patient/family education regarding purpose and possible side effects
    - Medication plan including responsible parties
- Support systems
    - Familial, occupational and social support systems available to the patient. If key supports are absent or problematic, how has this been addressed
    - Community resources/self-help groups recommended (note purpose)
- EAP linkage
    - If indicated (e.g., for substance use aftercare, workplace issues, such as Return-to-Work Conference, enhanced wraparound services) indicate how this will occur
- Medical aftercare (if indicated, note plan, including responsible parties)
- Family/work community preparation
    - Family illness education, work or school coordination, (e.g., EAP and Return-to-Work Conference) or other preparation done to support successful community reintegration. Note specific plan, including responsible parties and their understanding of the plan.

10.11 Case Management Services (For select patients who meet high-risk criteria)

As part of the case management program at Carelon, we offer assistance with:

- Discharge planning
- Assessment and integration of service for ongoing needs
- Coordination with behavioral health services
- Collaboration with healthcare providers and caregivers
- Providing information about what benefits might be available
- Medication education and monitoring

Hospitals may be asked for assistance in enrolling patients in case management during inpatient admissions.

If a call is received from a member requesting a referral and/or information about participating providers in the member's location, a care manager may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to participating providers, taking into account member preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the participating provider holds and gender. Additionally, the member may require a clinician with a specialty, such as treatment of eating disorders. In all cases, where available, the care manager will assist in arranging care for the member. The name, location, and phone number of at least three participating providers will be given to the member.

10.12 Adverse Clinical Determination/Peer Review

If a case does not appear to meet medical necessity criteria at the requested level of care, the CCM attempts to discuss the member's needs with the provider/participating provider and to work collaboratively with the provider/participating provider to find an appropriate alternative level of care. If no alternative is agreed upon, the CCM cannot deny a request for services. Requests that do not appear to meet medical necessity criteria or present quality of care issues are referred to a peer reviewer for second level review. It is important to note that only a Psychiatrist and for some levels of care, a doctoral level clinical psychologist peer reviewer can clinically deny a request for services.

The peer reviewer considers the available information and may elect to conduct a Peer-to-Peer Review, which involves a direct telephone conversation with the attending or primary participating provider to discuss the case. Through this communication, the peer reviewer may obtain clinical data that were not available to the CCM at the time of the review. This collegial clinical discussion allows the peer reviewer the opportunity to explore alternative treatment plans with the provider/participating provider and to gain insight into the attending provider's anticipated goals, interventions and timeframes. The peer reviewer may request more information from the provider/participating provider to support specific treatment protocols and ask about treatment alternatives.

When an adverse determination is made, the treating provider (and hospital, if applicable) is notified of the decision. In urgent care cases, notification will be given telephonically at the time of the determination. Written notification of an adverse determination is issued to the member, member representative, practitioner, and facility within decision timeframes.

If an adverse decision is rendered, the provider/participating provider has the right to speak with the peer reviewer who made the adverse determination by calling Carelon at the toll-free phone number of the member's plan. For substance use treatment, and treatment of minors, Carelon follows federal and state guidelines regarding release of information in determining the distribution of adverse determination letters.

All written or electronic adverse determination notices include:

a. The specific reason(s) for the determination not to certify

b. A statement that the clinical rationale, criteria, (or copy of the relevant medical necessity criteria), guidelines, or protocols used to make the decision will be provided, in writing, upon request

c. The right of the provider/participating provider to request a reconsideration within three business days of receipt of the notice when a medical necessity denial is issued without a peer-to-peer conversation having taken place, or when an administrative denial is issued because of the failure of a provider/participating provider to respond to a request for peer-to- peer conversation within a specified timeframe

d. Rights to and instructions for initiating an appeal, including the opportunity to request an expedited appeal if applicable for first level appeals, and information about the appeal process

e. The right to request an appeal verbally, in writing, or via fax transmission

f. The timeframe for requesting an appeal

g. The opportunity for the member, provider/participating provider to submit, for consideration as part of the appeals process, written comments, documents, records, and other information relating to the case

h. Information regarding the appeals process for urgent care including that expedited external review may occur concurrently

i. The member's right to bring a civil action under the Employer Retirement Income Security Act of 1974 (ERISA), when applicable

10.13 Telehealth

Carelon has adopted several guidelines with recommendations when telehealth is used:

- American Psychological Association (APA) Guidelines for the Practice of Telepsychology
- American Psychiatric Association (APA) and American Telemedicine Association (ATA) Best Practice in Videoconferencing-Based Telemental Health
- American Academy of Child & Adolescent Psychiatry (AACAP) Telepsychiatry Toolkit
- National Association of Social Workers (NASW), Association of Social Work Boards (ASWB), Council on Social Work Education (CSWE) and Clinical Social Work Association (CSWA) Standards for Technology in Social Work Practice

Providers/participating providers can reference the Telemental Health Guidelines for decision-making on the appropriateness of telehealth located on under 'Clinical Practice Guidelines' on the website. Participating providers should contact Carelon for benefit coverage prior to providing this service.

10.14 Outpatient Services

Prior to beginning a course of outpatient treatment, providers/participating providers must verify member eligibility and obtain authorization or certification (where applicable).

For some Plans, members are allowed a specific set of initial therapy sessions without prior authorization. These sessions, called initial encounters (IEs), must be provided by contracted in-network providers and are subject to meeting medical necessity criteria.

Carelon's model is to count the initial IEs to the provider, not member. This means that if the member changes providers, the count of initial encounters restarts with the new provider. Initial encounters may also be refreshed when a member has a break in treatment of more than six months. These IEs are not renewed annually, rather are applied towards each member's episode of care with a provider. An episode of care is defined as continuous treatment with no gap greater than six months. A member is considered new to outpatient treatment if the member has not been in outpatient treatment within the previous six- month period as a member. Each IE is counted as one regardless of session duration and the total can be reviewed through our provider portal

Refer to your provider agreement for specific information about procedure and revenue codes that can be used for billing. Providers will be asked a series of clinical questions to support medical necessity for the service requested. If sufficient information is provided to support the request, the service will be authorized. If additional information is needed, the provider will be prompted to contact Carelon via phone to continue the request for authorization. While Carelon prefers providers to make requests electronically, Carelon will work with providers who have technical or staffing barriers to requesting authorizations in this way.

Providers should request authorization or certification for outpatient services electronically through our provider portal if authorization is needed. If the electronic method is not available, providers/participating providers should submit a Carelon Outpatient Review or other state-required or approved outpatient review form (where applicable), or use the toll-free number for a telephonic review where applicable. In instances where a review does not meet medical necessity criteria and/or where questions arise as to elements of a treatment plan, the case file may be forwarded to a Peer Advisor for review.

10.15 Appeal of Adverse Determinations

When a member assigns appeal rights in writing to a participating provider, the participating provider may appeal on behalf of the member adverse determinations (denials) made by Carelon. Participating providers must inform the member of adverse determinations and any appeal rights of which the participating provider is made aware.

Member appeal rights are limited to those available under the member's benefit plan, and may involve one or more levels of appeal.

While the number of appeals available is determined by the member's benefit plan, the type of appeal, 'administrative' or 'clinical', is based on the nature of the adverse determination. The member's care circumstances at the time of the request for appeal determine the category of appeal as urgent, non- urgent, or retrospective. The member benefit plan and applicable state and/or federal laws and regulations determine the timing of the appeal as expedited, standard, or retrospective. For example, if a provider/participating provider files a Level I appeal on behalf of a member in urgent care, the appeal is processed as an expedited appeal, even if the member is discharged prior to the resolution of the appeal.

Unless otherwise provided for in the member benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, the provider/participating provider and/or the member (or the member's authorized representative), has the right to file or request:

- An initial (Level I) appeal of an adverse determination for up to 180 calendar days from receipt of notice of the adverse determination. Initial (Level I) appeals may be made verbally, in writing, or via fax transmission.
- A second level (Level II) appeal of an adverse determination for up to 90 calendar days from receipt of notice of the Level I appeal determination, in those instances where a second level or Level II appeal is available to the member. Unless otherwise provided for or restricted under the member benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, second level (Level II) appeals may be made verbally, in writing, or via fax transmission.

Unless otherwise provided for or restricted under the member benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, second level (Level II) appeals may be made verbally, in writing, or via fax transmission.

The member, member's authorized representative, and/or the provider/participating provider may submit any information they feel is pertinent to the appeal request and all such information is considered in the appeals review, whether or not it was available to Carelon's reviewers during the initial determination.

The date of the request for a Level I or Level II appeal of the adverse determination is considered the date and time the appeal request is received by Carelon.

When a provider/participating provider, member (or the member's authorized representative) requests an appeal of an adverse determination, the provider/participating provider may not bill or charge the member until all appeals available to the member have been exhausted by the member, and the member agrees in writing to pay for non-certified services.

Written notice of determinations for all Level I and Level II appeals of adverse determinations will be made to the member and the provider/participating provider where required by the member benefit plan, government sponsored health benefit program, and/or applicable state or federal laws or regulations.

Unless otherwise provided for in the member benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, the chart below sets out the turn-around-times for completion of adverse determination appeals conducted by Carelon.

Unless otherwise provided for in the member benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, no adverse determination may be appealed to court, arbitration or otherwise unless and until all available Carelon administrative appeals have been utilized and exhausted. Failure to timely request any available Carelon administrative appeal shall preclude a provider from challenging an adverse determination in court, arbitration or otherwise.

Standard Turnaround Times for Appeal Completion and Notice by Type of Care Request[5]

APPEAL TYPE (INCLUDES CLINICAL AND ADMINISTRATIVE)

TYPE OF CARE REQUEST AT TIME APPEAL IS FILED	EXPEDITED APPEAL (LEVEL I ONLY)	STANDARD APPEAL (LEVEL I OR II)	RETROSPECTIVE APPEAL (ONE LEVEL ONLY)
Urgent	Within 72 hours of receipt of the appeal request **Notification**: Verbal notice to *provider* within one calendar day of decision; written notice to the *provider* and the *member* within the decision timeframes	Not Applicable	Not Applicable
Non-Urgent (Standard)	Not Applicable. If provider indicates that delay would impact the life or health of member, process as Urgent (above)	Within 15 calendar days of the receipt of the *appeal* request **Notification:** Written notice to the *provider* and the *member* within the decision timeframe	Not Applicable
Retrospective	Not Applicable	Not Applicable	30 calendar days from receipt of request for *appeal* **Notification:** Written notice to *provider* and *member* within decision timeframe

[5] LACK OF INFORMATION – No extensions are allowed for lack of information or for "reasons beyond the control of Carelon". If information submitted is incomplete, Carelon has the option of requesting the necessary information; however, the decision must still be made within the timeframe for making the appeal decision, or making the decision based on information on hand.

10.16 Clinical Appeals

Clinical appeal reviews of adverse medical necessity determinations administered by Carelon are conducted by an Appeal Reviewer in the same profession and/or in a similar specialty as typically manages the behavioral health condition, procedure or treatment, as deemed appropriate, or a committee of practitioners having similar qualifications of an appeal reviewer. Clinical appeal reviewers are neither the individual who made the original adverse medical necessity determination, nor the subordinate of such an individual.

Written notice of Level I and Level II clinical appeal determinations upholding the original adverse determination (or Level I appeal where applicable), in whole or in part, will include:

1. The principal reason or reasons for the determination
2. Reference to the medical necessity criteria and/or guidelines used to be made available upon request
3. The procedures for initiating the next step in the appeal process, if any
4. The right of the member and/or the provider/participating provider to submit additional information in support of the next level of appeal, if any
5. Where applicable information related to the member's right to file suit and/or to pursue other voluntary dispute options as required by ERISA, or provisions as may be required by applicable laws, regulations or government-sponsored health benefits programs (e.g., Medicare Advantage or Managed Medicaid)

APPEAL PROCESS BY LEVEL OF APPEAL

TYPE OF APPEAL	PROCESS
Level I Standard	Upon being assigned a case for review of an adverse determination clinical appeal, an Appeal Reviewer will investigate the substance of the appeal, including aspects of the clinical care involved, and review of documents, records, or other information submitted with the request for the Level I appeal, regardless of whether such information was also submitted or considered in the original adverse determination and the applicable medical necessity criteria. The Appeal Reviewer will attempt to contact the provider/participating provider (or the clinical representative of facility or program providers/participating providers) directly to conduct a telephonic review as appropriate. Based on consideration of all pertinent information, including relevant medical necessity criteria and guidelines, the Appeal Reviewer will make a determination to reverse (i.e., overturn) the original adverse determination in whole or part, or to uphold the original adverse determination. When an adverse determination clinical appeal review is conducted and completed telephonically, the Appeal Reviewer will verbally inform the provider/participating provider of the determination. If the determination is to reverse the original adverse determination, the Appeal Reviewer will identify the length of stay, level of care and/or number of service units or sessions determined to be medically necessary. If the determination is to uphold the adverse determination, the Appeal Reviewer includes any recommendations for treatment for which medical necessity could be confirmed and the procedure for following the next step in the appeals process, if any. *(Continues on following page)*

Expedited Appeal (Level I only)	An expedited appeal is a request to review an adverse determination concerning admission, continued stay, or other behavioral health care services for a member who has received urgent services but has not been discharged from a facility, or when a delay in decision making might seriously jeopardize the life or health of the member. Only a Level I appeal can be processed as an expedited appeal. Carelon follows the same determination procedures outlined above for standard appeals, but issues the decision and notification for all expedited appeals within 72 hours of the appeal request. Expedited appeals are conducted by an Appeal Reviewer not involved in the original adverse determination. Determinations are communicated by telephone on the same day as the determination, with written notification sent within the 72-hour timeframe. Continued coverage is provided for concurrent (expedited) appeals for inpatient substance use disorder treatment that is provided by an in-network OASAS-certified facility while the appeal is pending.
Level II	Upon being assigned a case for review of an adverse determination clinical appeal, an Appeal Reviewer will investigate the substance of the appeal, including aspects of the clinical care involved, and review of documents, records, or other information submitted with the request for the Level II appeal, regardless of whether such information was also submitted or considered in the original adverse determination or the Level I appeal and the applicable medical necessity criteria. The Appeal Reviewer will attempt to contact the provider/participating provider (or the clinical representative of facility or program providers/participating providers) directly to conduct a telephonic review as appropriate. Based on consideration of all pertinent information, including relevant medical necessity criteria and guidelines, the Appeal Reviewer will make a determination to reverse (i.e., overturn) the Level I appeal determination in whole or part, or to uphold the original adverse determination and Level I appeal determination. This level of clinical appeal involves a review of all pertinent clinical information by another Peer Reviewer who has not been previously involved with the adverse determination, or a Level II Appeal Committee, depending on the member's benefit plan and what administrative activities have been delegated to Carelon by the client plan. When a Level II clinical appeal is conducted by a Level II Appeal Committee, in some circumstances and only where indicated in the notice of Level I appeal determination the member may have the right to appear before the Level II Appeal Committee.
Retrospective	A retrospective clinical appeal is one requested after the member has been discharged from the level of care or treatment service under consideration. Retrospective clinical appeals of adverse determinations require that the provider/participating provider send in specific sections of the treatment record for review. Retrospective clinical appeal determination notices are issued within the decision timeframe and contain the required information outlined above under 'Standard Appeals.' There is only one level of retrospective appeal.

10.17 Administrative Appeals

Administrative appeal reviews of adverse determinations (not based on medical necessity) are conducted by the applicable Carelon Region or Engagement Center Vice President or their designee, or by a Carelon committee. Administrative appeal reviewers are neither the individual who made the original adverse determination, nor the subordinate of such an individual.

The types and levels of appeal, as well as decision and notification requirements mirror those described above for clinical appeals. However, if an administrative denial is in place, it must be resolved before the clinical request can be processed. The result of this process can include three scenarios:

1. The administrative denial is upheld and the clinical request is never processed
2. The administrative denial is overturned; however, a clinical review is not necessary (e.g., timely filing waiver approved, corrected claim submitted, etc.)
3. The administrative denial is overturned, the clinical requested is processed, and a clinical determination is made

10.18 Final Appeal Level

For those benefit plans that provide for a final stage of appeal (clinical or administrative) for the member, Carelon will cooperate with the requirements of such final stage of appeal and where agreed upon with the client plan coordinate such final stage of appeal. Final stages of appeal may include reviews by an arbitration board, benefits committee, external review entities, state agency sponsored external review processes, and government sponsored health benefits program medical directors, or other review entities and/or processes. Information about and procedures for such final appeal level, if any, will be included in notice of appeal determination for the last level of appeal available before final appeals.

11. QUALITY MANAGEMENT/QUALITY IMPROVEMENT

Carelon utilizes a Continuous Quality Improvement (CQI) philosophy through which Carelon directly or through its authorized designees, monitors and evaluates appropriateness of care and service, identifies opportunities for improving quality and access, establishes quality improvement initiatives, and monitors resolution of identified problem areas. This includes monitoring and evaluation of services performed by Carelon or its designees, as well as behavioral health services rendered by providers and participating providers.

Carelon's comprehensive Quality Management Program (QMP) includes Quality Management (QM) policies and procedures applicable to all participating providers, strategies and major activities performed to provide for consistency and excellence in the delivery of services, includes a program description, an annual work plan that includes goals and objectives and specific QM related activities for the upcoming year and evaluation of the effectiveness of those activities. Participating providers are responsible for adhering to the QMP and are encouraged to provide comments to Carelon regarding ongoing QMP activities through direct telephone communications and/or via the Provider website. Carelon requires each provider to also have its own internal QM and I Program to continually assess quality of care, access to care, and compliance with medical necessity criteria.

11.01 Quality Management Committees

The Carelon Enterprise Clinical and Quality Oversight Committee (BECQOC) has ultimate accountability for the oversight and effectiveness of the QMP. The Corporate Quality and Medical Management Committee (CQMMC) is delegated authority by the Carelon Enterprise Clinical and Quality Oversight Committee (BECQOC) for development and execution of the Quality and Clinical Management programs including the Annual Program Description, Work Plan and evaluation, approval of quality and clinical initiatives, and establishment of program priorities. Resource allocation to accomplish the goals of the QM and Clinical Program and major policy decisions are recommended by the CQMMC to Executive Leadership and the BECQOC for final approval.

The CQMMC is the body responsible for coordinating all corporate level quality management and clinical activities and providing oversight, direction, and consultation to the Region or Engagement Center as well as specific quality management programs. Carelon Region or Engagement Centers are responsible for oversight of the day-to-day operations of their specific QM/Clinical programs that includes reporting and communication of their activities and findings to the CQMMC as well as incorporating activities in their Region or Engagement Center as part of oversight monitoring responsibilities.

The CQMMC reviews reports, minutes, and other documents of the activities of all its subcommittees. These documents allow the CQMMC to monitor key components of company performance to ensure that activities to achieve quality improvement are ongoing, effective, and consistent throughout the company and take into consideration their impact on all functional areas of the company. The CQMMC assures that company standards and practices put in place to assure high levels of performance continue to be meaningful and appropriate and that the standards are applied consistently, to the extent possible, across the organization.

Certain functional areas within Carelon (e.g., claims) maintain quality management programs specific to the activities and services performed. Quality programs within functional areas are responsible for coordinating their quality management programs with the overarching QMP by communicating their findings and activities to the CQMMC and incorporating activities into their respective QMP.

The CQMMC reviews and approves the Corporate Quality Management and Clinical Management Program Descriptions, Program Evaluations, and integrated Work plans at least annually and at the time of any revision. The CQMMC receives a quarterly summary of all QM activities included in the work plan.

11.02 Quality Management Program Overview

The Carelon Corporate Quality Management Program (QMP) monitors and evaluates quality across the entire range of services provided by the company. Along with the trending of quality issues at the Region or Service Center level, the corporate QMP is intended to ensure that structure and processes are in place to lead to desired outcomes for members, clients, providers/participating practitioners, and internal clients.

The scope of the Corporate QMP includes:

a. Clinical Service Activities
b. Supporting improvement of continuity and coordination of care
c. Case Management/Intensive Case Management/Targeted Case Management
d. Quality Improvement Activities (QIAs)/Projects (QIPs)
e. Outcome Measurement and data analysis
f. Network Management/Provider Relations Activities
g. Member Experience Survey
h. Clinical Treatment Record Evaluation
i. Service Availability and Access to Care
j. Practitioner and Provider Quality Performance
k. Annually evaluating member Complaints and Grievances (Appeals) using valid methodology
l. Member Rights and Responsibilities
m. Patient Safety Activities (including identification of safety issues during prospective reviews)
n. Performance Indicator development and monitoring activities
o. Health Literacy and Cultural Competency assurance
p. Compliance with Section 1557, nondiscrimination law in the Affordable Care Act (ACA)
q. Promotion of the use of member self-management tools
r. Screening Programs
s. Complaints and Grievances

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

11.03 Role of Participating Providers

Participating practitioners/providers are informed about the QMP via the Carelon Provider Handbook, provider newsletters, website information, direct mailings, email provider alerts, seminars and training programs. Many of these media venues provide network practitioners/providers with the opportunity to be involved and provide input into the QM and Clinical Programs. Additional opportunities to be involved include representation on the National Credentialing and Provider Appeals Sub-Committees as well as on various committees and sub-committees and/or workgroups at the Regional or Engagement Center level (e.g., Credentialing Committee and Clinical Advisory Committees).

Involvement includes, but is not limited to:

- Providing input into the Carelon medical necessity criteria
- Providing peer review and feedback on proposed practice guidelines, screening programs, clinical quality monitors and indicators, new technology and any critical issues regarding policies and procedures of Carelon
- Reviewing QI activities and making recommendations to improve quality of clinical care and services
- Reviewing, evaluating, and making recommendations for the credentialing and re-credentialing of participating practitioners and organizational providers
- Reviewing, evaluating and making recommendations regarding sanctions that result from participating practitioner and organizational provider performance issues

As part of the QMP, Carelon incorporates principles designed to encourage the provision of care and treatment in a culturally competent and sensitive manner. As such, Carelon has developed a Cultural and Linguistic Program, the purpose of which is to assess and improve healthcare quality and equity by reducing health care disparity and to deliver culturally and linguistic appropriate health care services to its member population. Carelon assesses the race/ethnicity and language needs of its membership in addition to the provider and practitioner network to ensure the network is able to meet the membership's cultural needs and preferences. Key principles of the program include:

- Emphasis on the importance of culture and diversity
- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Consideration of sex and gender identity
- Adaptation of services to meet the specific cultural and linguistic needs of *members*.
- Making resources available to members who require culturally, linguistically, and/or disability competent care such as disability and language lines
- Offering interpretation services and written materials in alternative languages and format for our membership

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

11.04 Quality Performance Indicator Development and Monitoring Activities

A major component of the quality management process is the identification and monitoring of meaningful companywide Key Performance Indicators (KPI) that are established, collected, and reported for a small but critical number of performance measures across Regions or Engagement Centers and all functional areas of the company. These core performance indicators are selected by functional area leads along with associated goals or benchmarks and are approved by senior management. KPIs are reported to the Executive Leadership Team (ELT) and Corporate Quality and Medical Management Committee (CQMMC) at least annually.

All functional areas are responsible for prioritizing their resources to meet or exceed performance goals or benchmarks established for each indicator. When performance is identified below established goals and/or trends, a corrective action plan is established to improve performance.

Carelon Regions or Engagement Centers are expected to identify, track, and trend local core performance indicators relevant to the populations they serve. Client performance reporting requirements may also be required. In any case, behavioral health care access and service performance is monitored regularly, including, but not limited to:

- Access and availability to behavioral health services
- Telephone service factors
- Utilization decision timeliness, adherence to medical necessity, and regulatory requirements
- Member and provider complaints and grievances
- Member and provider experience with program services
- Nationally recognized or locally prescribed care outcome indicators such as HEDIS measures whenever possible
- Potential member safety concerns, which are addressed in the Member Safety Program section of this handbook, include
    - Serious reportable events (SREs) as defined by the National Quality Forum (NQF) and Carelon
    - Trending Events (TEs)

11.05 Service Availability and Access to Care

Carelon uses a variety of mechanisms to measure member's access to care with participating practitioners. Unless other appointment availability standards are required by a specific client or government-sponsored health benefit program, service availability is assessed based on the following standards for participating practitioners:

- An individual with life-threatening emergency needs is seen immediately
- An individual with non-life-threatening emergency needs is seen within six (6) hours
- An individual with urgent needs is seen within 48 hours
- Routine office visits are available within 10 business days
- Routine follow-up office visits for non-prescribers are available within 30 business days of initial visit
- Routine follow-up office visits for prescribers are available within 90 business days of initial visit

The following methods may be used to monitor participating provider behavioral health service availability and member access to care:

- Analysis of member complaints and grievances related to availability and access to care
- Member experience surveys specific to their experience in accessing care and routine appointment availability
- Open shopper staff surveys for appointment availability—an approach to measuring timeliness of appointment access in which a surveyor contacts participating provider's offices to inquire about appointment availability and identifies from the outset of the call that he or she is calling on behalf of Carelon
- Referral line calls are monitored for timeliness of referral appointments given to members
- Analysis and trending of claims data to measure member's access and availability of care for routine follow-up office visits for prescribers and non-prescribers
- Analysis and trending of information on appointment availability obtained during site visits
- Analysis of call statistics (e.g., average speed of answer, abandonment rate over five seconds)
- Annual Geo-Access and network density analysis (see Network policies and procedures)

In addition to these monitoring activities, participating providers are required by contract to report to network management when they are at capacity. This assists customer service in selecting appropriate, available participating practitioners for member referral.

11.06 Healthcare Effectiveness Data and Information Set (HEDIS®[6])

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

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

While the HEDIS measures are population-based measures of our partner health plan performance and major contributors to health plan accreditation status, our partner health plans rely on us to ensure behavioral health measure performance reflects best practice. Our providers are the key to guiding their patient to keep an appointment after leaving an inpatient psychiatric facility; taking their antidepressant medication or antipsychotic medication as ordered; ensuring a child has follow up visits after being prescribed an ADHD medication; and ensuring an individual with schizophrenia or bipolar disorder has annual screening for diabetes and coronary heart disease.

[6] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

There are six domains of care and service within the HEDIS library of measures:

1. Effectiveness of Care
2. Access and Availability
3. Utilization and Relative Resource Use
4. Measures Collected Using Electronic Clinical Data Systems (ECDS)
5. Experience of Care
6. Health Plan Descriptive Information A brief description of these measures:

1. **Effectiveness of Care**: These measures are known to improve how effective care is delivered. One very important measure in this domain is Follow-up after Mental Health Hospitalization (Aftercare). In effect, this means how long someone waits to get mental health care after they are discharged from an inpatient mental health hospital. To prevent readmission and help people get back into the community successfully, best practice is from seven to thirty days after discharge.
2. **Access/Availability**: Measures in this domain focus on how quickly and frequently members receive care and service within a specific time. For example, the Initiation and Engagement of Substance Use Disorder. Treatment measure relies on frequency and timeliness of treatment to measure treatment initiation and treatment engagement. Studies show that an individual who engages in the treatment process have better outcome and success in recovery and sobriety.
3. **Utilization and Relative Resource Use**: This domain includes evidence related to the management of health plan resources and identifies the percentage of members using a service. For example, Carelon measures Mental Health Utilization and Plan All Cause Readmissions.
4. **Measures Collected Using Electronic Clinical Data Systems (ECDS)**: This is the newest domain, and it requires calculation of outcomes by accessing data through the electronic submission of a member's electronic health record (EHR). An example of an ECDS measure is the Utilization of the PHQ-9. This demonstrates whether a PHQ-9 was administered to a patient with depression four months after initiation of treatment to measure response to treatment.
5. **Experience of Care**: This domain is specific to health plans.
6. **Health Plan Descriptive Information**: We supply Board Certification of physicians and psychologists to the plan; all other information is specific to the health plan.

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

1. **Follow-up after Hospitalization for Mental Illness**

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

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

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

   The critical pieces of this measure for providers/participating providers are:

   - **Inpatient facilities** need to:
     - Use accurate diagnoses when submitting claims for inpatient treatment. If the diagnosis on admission is a mental health diagnosis but subsequent evaluation during the stay confirms that the primary diagnosis is substance use, please use the substance use diagnosis on the claim submitted at discharge.
     - Ensure that discharge planners educate patients about the importance of aftercare for successful transition back to their communities.
     - Ensure that follow-up visits are within seven calendar days of discharge. **Note:** It is important to notify the provider/participating providers that the appointment is post hospital discharge and that an appointment is needed in seven calendar days.
     - Ensure that the appointment was made with input from the patient. If the member has a pre-existing provider and is agreeable to going back to that provider schedule the appointment with that provider. If not, the location of the outpatient provider or PHP,
       IOP or other alternative level of care, must be approved by the member and be realistic and feasible for the member to keep that appointment.
   - **Outpatient providers/participating providers** need to make every attempt to schedule appointments within seven calendar days for members being discharged from inpatient care. Providers/participating providers are encouraged to contact those members who are "no show" and reschedule another appointment.

2. **Initiation and Engagement of Substance Use Disorder Treatment**

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

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

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

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

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

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

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

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

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

- **Continuation and Maintenance (C&M) Phase**: For children who remain on the medication for at least 7 of the 10 months after receiving the initial medication, at least two additional follow-up visits with a practitioner in the nine months after the initial prescribing event are required for best practice.

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

For members with Schizophrenia or Bipolar diagnosis who are treated with an antipsychotic medication, this measure looks at the rate at which members are screened for Type 2 Diabetes with an HbA1C test or glucose test.

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

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

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

   For members with Schizophrenia or Bipolar diagnosis who also have cardiovascular disease, this measure looks at the rate at which members have an LDL-C test during the measurement year.

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

   This measure is described as the percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

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

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

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

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

    First line treatment is associated with improved outcomes and adherence.

11. **Utilization of the PHQ-9 to Monitor Depression for Adolescents and Adults (DMS)**

    For members diagnosed with depression treated in outpatient settings the PHQ-9 or PHQ-9: Modified for Teens must be administered by the outpatient provider at least once during a four-month treatment period.

12. **Depression Remission or Response for Adolescents and Adults (DRR)**

    The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within four to eight months of the elevated score. Three rates are reported:

    - **Follow-Up PHQ-9**. The percentage of members who have a follow-up PHQ-9 score documented within the four to eight months after the initial elevated PHQ-9 score.
    - **Depression Remission**. The percentage of members who achieved remission within four to eight months after the initial elevated PHQ-9 score.
    - **Depression Response**. The percentage of members who showed response within four to eight months after the initial elevated PHQ-9 score.

    Note: These measures are collected utilizing Electronic Clinical Data Sets (ECDS) as found in the provider's Electronic Medical Record. While NCQA/HEDIS is looking to expand the options for collecting this data, Carelon has yet to begin discussing this requirement with providers.

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

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

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

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

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), who had a follow up visit for SUD. Two rates are reported:

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

Here is the complete list of HEDIS Behavioral Health measures:

Effectiveness of Care:

- **AMM:** Antidepressant Medication Management
- **ADD:** Follow-Up Care for Children Prescribed ADHD Medication
- **FUH:** Follow-Up After Hospitalization for Mental Illness
- **SSD:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- **SMD:** Diabetes Monitoring for People with Diabetes and Schizophrenia
- **SMC:** Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
- **SAA:** Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- **APC:** Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- **APM:** Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **FUM:** Follow-up After Emergency Department Visit for Mental Illness
- **FUA:** Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence

Access and Availability

- **IET:** Initiation and Engagement of Substance Use Disorder Treatment
- **APP:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Utilization/Relative Resource Use - Utilization

- **PCR:** Plan All-Cause Readmissions

Electronic Clinical Data Systems

- **DMS:** Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
- **DRR:** Depression Remission or Response for Adolescents and Adults

11.07 Continuity and Coordination of Care

Carelon monitors continuity and coordination of care throughout its continuum of behavioral health services. Monitoring may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient providers/participating providers, and monitoring provider/participating provider performance on pre-determined coordination of care indicators. Processes are established seeking to avoid disruption of care for the member when there is a change in their treating provider/participating provider. Such changes may include, but are not limited to:

- A member requires a change in level of care, necessitating a new participating provider
- There are multiple providers/participating providers involved in treatment simultaneously (psychiatrist for medication management, therapist for on-going treatment)
- A change in health plans or benefit plans
- Termination of a participating provider
- A member is being treated for several (co-morbid) conditions simultaneously with multiple providers/participating providers (both behavioral health specialists, primary care, medical specialists, or providers specializing in developmental disabilities)

11.08 Screening Programs

Carelon supports the early detection and treatment of depressive and comorbid disorders to promote optimal health for members 13 years and older.

A few helpful reminders:

- Carelon offers many screening tools and programs available at no cost:
  - PCP/ Provider Toolkit
  - Depression Screening Program
  - Comorbid Mental Health and Substance Use Disorder Screening Program
- Use screening tools at the first visit and repeat at regular intervals as clinically indicated to identify potential symptoms that may need further evaluation.
- Depression
  - Patient Health Questionnaire 9 (PHQ-9) is a brief, multi-purpose tool for assessing depression, and is available in English, Spanish, and a variety of other languages in Carelon's PCP/ Provider Toolkit.
  - When assessing for depression, remember to rule out bipolar disorders; you may choose to use the Mood Disorder Questionnaire (MDQ).
- Suicide
  - Carelon endorses the National Action Alliance for Suicide Prevention's Recommended Standard Care for People with Suicide Risk, which screens individuals for suicide and includes a list of screening tools in the Appendix.
- Comorbid issues
  - Remember to screen for possible mental health disorders when a diagnosis of a substance use disorder is present and conversely to screen for a potential substance use disorder when a mental health disorder is present.

The CRAFFT Screening Interview (PDF) assesses for substance use risk specific to adolescents.

Learn more about Carelon's Depression Screening Program and Comorbid Screening Program at the attached links.

11.09 Treatment Record Standards and Guidelines

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

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

Progress notes should include what psychotherapy techniques were used, and how they benefited the member in reaching his/her treatment goals. Progress notes do not have to include intimate details of the member's problems but should contain sufficient documentation of the services, care, and treatment to support medical necessity of same. Intimate details documenting or analyzing the content of conversations during a private counseling session or a group, joint, or family counseling session should be maintained within the psychotherapy notes and kept separate from the member's treatment record made available for review and audit.

Member treatment record reviews and audits are based on the record keeping standards set out below:

- Each page (electronic or paper) contains the member's name or identification number.
- Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- All entries in the treatment record are dated and include the responsible clinician's name, professional degree, and relevant identification number (if applicable), and modality of treatment (office-based or telehealth (if telehealth video, phone or other modality). The length of the visit/session is recorded, including visit/session start and stop times.
- Reviews may include comparing specific entries to billing claims as part of the record review.
- The record, when paper based is legible to someone other than the writer.
- Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the member has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
- Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status and the results of a mental status exam, are documented.

- Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented, and revised in compliance with written protocols.
- Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data, and relevant family information.
- For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events (when available), along with a developmental history (physical, psychological, social, intellectual and academic).
- For members 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.
- A DSM (or the most current version of the DSM) diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.
- Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.
- Treatment plans are updated as needed to reflect changes/progress of the member.
- Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers, and health care institutions are documented as appropriate.
- Informed consent for medication and the member's understanding of the treatment plan are documented.
- Additional consents are included when applicable (e.g., alcohol and drug information releases).
- Progress notes describe the member's strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives.
- Documented interventions include continuity and coordination of care activities, as appropriate.
- Dates of follow-up appointments or, as applicable, discharge plans are noted.

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

11.10 Treatment Record Reviews

Participating providers are required to cooperate with treatment record reviews and audits conducted by Carelon and associated requests for copies of member records. For the purpose of conducting retrospective case reviews, treatment records for Carelon members should be maintained for the time period(s) required by applicable state and/or federal laws and/or regulations, and as detailed in the provider agreement.

Carelon may conduct treatment record reviews and/or audits:

- On an unplanned basis as part of continuous quality improvement and/or monitoring activities
- As part of routine quality and/or billing audits
- As may be required by clients of Carelon
- In the course of performance under a given client contract
- As may be required by a given government or regulatory agency
- As part of periodic reviews conducted pursuant to accreditation requirements to which Carelon is or may be subject
- In response to an identified or alleged specific quality of care, professional competency or professional conduct issue or concern
- As may be required by state and/or federal laws, rules, and/or regulations
- In the course of claims reviews and/or audits
- As may be necessary to verify compliance with the provider agreement
- Carelon treatment record standards and guidelines for member treatment record reviews conducted as part of quality management activities are set out in the quality management section of this handbook.

Treatment record reviews and/or audits may be conducted through on-site reviews in the participating provider's office or facility location, and/or through review of electronic or hard copy of documents and records supplied by the participating provider. Unless otherwise specifically provided for in the provider agreement and/or other sections of this handbook with respect to a particular type of record review or audit, participating providers must supply copies of requested records to Carelon within five business days of the request.

Carelon will use and maintain treatment records supplied by participating providers for review and/or audit in a confidential manner and in accordance with applicable laws and regulations regarding the privacy or confidentiality of protected health information and/or patient identifying information. Never send original records as they will not be returned at the completion of the review or audit. Only send those sections of the record that are requested. Unless otherwise specifically provided in the provider agreement, access to and any copies of member treatment records requested by Carelon or designees of Carelon shall be at no cost. Records are reviewed by licensed clinicians. Treatment records reviews and/or audits conducted as part of Quality Management activities include application of an objective instrument(s). The instrument(s) are reviewed at least annually; Carelon reserves the right to alter/update, discontinue and/or replace such instruments in its discretion and without notice.

Following completion of treatment record reviews and/or audits, Carelon will give the participating provider a written report that details the findings. If necessary, the findings report will include a corrective action plan with specific recommendations that will enable the participating provider to more fully comply with Carelon standards for treatment records.

Participating providers will grant access for members to the member's treatment records upon written request and with appropriate identification. Participating providers should review member treatment records prior to granting access to members to ensure that confidential information about other family members and/or significant others that may be referenced and/or included therein is redacted.

11.11 Member Safety Program

Carelon has a defined procedure for the identification, reporting, investigation, resolution and monitoring of Potential Quality of Care (PQOC) concerns. PQOC concerns are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. These types of issues may be identified from a variety of sources, including without limitation member and provider/participating provider complaints, internal reviews, clients, government agencies and others.

These concerns are resolved and monitored at both the region and network-wide level. Regional teams have a designated committee, in which the local medical director participates, that oversee the investigation and resolution of these issues through to completion.

Carelon's member safety program includes the following components: prospective identification and reporting and investigation of potential Serious Reportable Events (internal and external events), trend analysis of member and provider and client complaints, annual evaluation and updating of existing member safety policies, prevention activities and the promotion of evidenced-based practice by our network credentialed providers and Carelon employed clinicians.

Effective 6/1/2020, Carelon's Member Safety Program utilizes a model of Potential Quality of Care (PQOC) Concerns including Serious Reportable Events (SREs) and Trending Events (TE). Carelon adopted the National Quality Forum's (NQF) Serious Reportable Event classification system as a base for its Member Safety Program. This allows the use of a standard taxonomy across a wide variety of settings and supports standard definitions across our diverse organization. For some contracts the term adverse incident, sentinel event or major incident may be used interchangeably or may have a specific definition based on state requirements.

Serious Reportable Events (SRE) include, but are not limited to:

- Surgical or Invasive Procedures (i.e., wrong site, wrong patient, wrong procedure, foreign object, and death of ASA class 1 patient)
- Product or Device Events (i.e., contamination, device malfunction, and embolism)
- Patient Protection Events (i.e. discharge of someone unable to make decisions, elopement, completed suicide, attempted suicide, and self-injurious behaviors)
- Care Management Events (i.e., medication error, fall)
- Environmental Events (i.e., electric shock, gas, burn, restraint, seclusion, restrictive interventions)
- Potential Criminal Events (i.e., impersonation, abduction, physical assault, and sexual behavior)
- Carelon Specific (such as disaster management, accidents, staff misconduct, standards of care, and natural death)

Trending Events (TE) include, but are not limited to the following categories/sub-categories:

- Provider inappropriate/unprofessional behavior
  - Inappropriate boundaries/relationship with member
  - Practitioner not qualified to perform services
  - Aggressive behavior
  - Displays signs of cognitive, mental health, or substance use concerns impacting the care being provided
- Clinical practice-related issues
  - Abandoned member or inadequate discharge planning
  - Timeliness, accuracy, or adequacy of diagnosis, assessment, or referral
  - Delay in treatment
  - Effectiveness of treatment
  - Failure to coordinate care or follow clinical practice guidelines
  - Failure to involve family in treatment when appropriate
  - Medication error or reaction
  - Treatment setting not safe
- Access to care-related issues
  - Failure to provide appropriate appointment access
  - Lack of timely response to telephone calls
  - Prolonged in-office wait time or failure to keep appointment
  - Provider non-compliant with American Disabilities Act (ADA) requirements
  - Services not available or session too short
- Attitude and service-related issues
  - Failure to allow site visit
  - Failure to maintain confidentiality
  - Failure to release medical records
  - Fraud and abuse
  - Lack of caring/concern or poor communication skills
  - Poor or lack of documentation
  - Provider/staff rude or inappropriate attitude
- Other monitored events
  - Adverse reaction to treatment
  - Failure to have or follow communicable disease protocols
  - Human rights violations
  - Ingestion of an unauthorized substance in a treatment setting
  - Non-serious injuries (including falls)
  - Property damage and/or fire setting
  - Sexual behavior

Participating providers are required to report to Carelon within 24 hours all Potential Quality of Care (PQOC) concerns involving members. Carelon investigates Potential Quality of Care Concerns (PQOC) and uses the data generated to identify opportunities for improvement in the clinical care and service members receive. Carelon tracks and trends PQOC concerns and when necessary, investigates patterns or prevalence of incidents and uses the data generated to identify opportunities for quality improvement.

Based on the circumstances of each incident, or any identified trends, Carelon may undertake an investigation designed to provide for member safety. As a result, participating providers may be asked to furnish records and/or engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. Participating providers may also be subject to disciplinary action through the NCC based on the findings of an investigation or any failure to cooperate with a request for information pursuant to an adverse incident investigation.

11.12 Professional Review/Fair Hearing Process

Individual providers/participating providers, where required by applicable law, may request a second level of appeal/a fair hearing when the PAC denies credentialing or re-credentialing, issues a sanction, or recommends termination of participation status of the provider from the Carelon provider network, where such denial, sanction, or recommendation is based on quality of care issues and/or issues related to professional competence or professional conduct. Information about the fair hearing process is located in the appeals section of this handbook.

11.13 Quality Improvement Activities/Projects

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

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

11.14 Experience Surveys

When delegated, Carelon, either directly or through authorized designees, conducts some form of experience survey to identify areas for improvement as a key component of the QMP. Experience survey participation may include members, participating providers, and/or clients.

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

Annual participating provider experience surveys measure opinions regarding clinical and administrative practices. The results of participating provider surveys are aggregated and used to identify potential improvement opportunities within Carelon and possible education or training needs for participating providers. Results are reviewed with the Executive Leadership Team (ELT), Corporate Quality and Medical Management Committee (CQMMC), Quality Leads, Provider Relations Leads, and Provider Quality Management. Where appropriate, corrective actions are implemented in the Carelon functional department or as applicable in the Region.

11.15 Member Complaints

All members and providers have a right to voice complaints about the care or service received. Carelon uses an information and technology system for complaint documentation and tracking. This system allows Carelon to create complaint records to document various types of contacts, including referrals, authorizations, reviews and claims questions.

Complaints are handled in accordance to Carelon policies that govern the complaint process. The complaint process may also be subject to state and federal regulations. Internal workflows are created to ensure complaints meet individual contractual client obligations.

The records of complaints are routed to the appropriate complaint work queue. When the record is sent to the queue, a Complaint Coordinator reviews the member complaint, categorizes it into at least one of the categories/sub-categories listed below, and routes it to the appropriate individual and/or department for investigation and resolution.

For the purpose of data management and evaluation, member complaints are categorized into the following:

- Access Issues
- Attitude and Service Issues
- Billing and Financial Issues
- Quality of Care Issues
- Quality of Practitioner Office Site

One method of identifying opportunities for improvement in processes at Carelon is to collect and analyze the content of member complaints. The complaints process has been developed to provide a structure for timely responses and to track and trend complaint and grievance data by type/category. Complaints data are compiled and reported to the local and national clinical quality committees at least semi-annually

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