



UBH Network Manual

TABLE OF CONTENTS

Introduction	1
UBH Resource Guide	3
Frequently Asked Questions	6
Glossary of Terms	15
UBH Network Requirements	22
Benefit Plans, Certification, EAP, and Access to Care	30
Treatment Philosophy	41
Treatment Record Documentation Requirements	46
Privacy Practices	50
Quality Improvement	52
Facility Quality Measure.....	57
Campaign for Excellence	59
Compensation and Claims Processing	61
Fraud, Waste and Abuse	66
Appeals and Provider Dispute Resolution	69
Manual Updates and Governing Law	72
Member Rights and Responsibilities	73

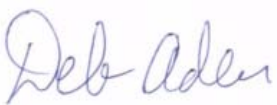
Introduction

Welcome! We are pleased to have you in the United Behavioral Health (UBH) network. We are focused on creating and maintaining a structure that helps people live their lives to the fullest. At a time of great need and change within the health care system, we are energized and prepared to meet and exceed the expectations of consumers, customers and partners like you.

Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. As we work together, you will find that we seek and pursue opportunities to collaborate with you to set the standard for industry innovation and performance.

We encourage you to make use of our industry-leading web site ubhonline.com where you can get news, access resources and conduct a variety of secure transactions at the time and pace you most prefer. We continuously expand our online functionality to better support your day-to-day operations. Visit us often!

Please take time to familiarize yourself with all aspects of the UBH Network Manual. We've included an easy reference Resource Guide and FAQs to get you started. There is much work to be done. We are interested in your contributions to constructive innovation. Let us hear from you!



Deb Adler
S.V.P. Behavioral Network Services
United Behavioral Health



About United Behavioral Health

United Behavioral Health (UBH) is the nation's largest accredited managed behavioral health care organization, providing services to one in six insured Americans. It is supported by the largest behavioral provider network in the United States - more than 84,000 practitioners. And we offer the industry's most comprehensive array of innovative and effective behavioral health care programs including integrated behavioral and medical programs, depression management, brain health, employee assistance, work/life management, disability support and pharmacy management programs.

UBH was officially formed on February 2, 1997, via the merger of U.S. Behavioral Health, Inc. (USBH) and United Behavioral Systems, Inc. (UBS). OptumHealth Behavioral SolutionsSM is a service mark of United Behavioral Health. Our company is a wholly owned subsidiary of UnitedHealth Group.

Today, our customers include small businesses, Fortune 100 companies, school districts, health plans, and disability carriers. At the time of this publication, UBH supports 43 million members nationwide.

Mission and Vision

Our Mission is to help people live their lives to the fullest. Our Vision is to be a constructive and transformational force in the health care system.

Core Values

Integrity

Honor commitments.
Never compromise ethics.

Compassion

Walk in the shoes of the people we serve and those with whom we work.

Relationships

Build trust through collaboration.

Innovation

Invent the future, learn from the past.

Performance

Demonstrate excellence in everything we do.

UBH RESOURCE GUIDE

Web Sites

www.ubhonline.com

Our industry-leading Provider web site includes both public and secure pages. Public pages include general updates and useful information. Secure pages are available only to network Providers and require registration. The password-protected secure “Transactions” give you access to Member and Provider specific information.

Secure Transactions:

- Check eligibility and authorization or notification of benefits requirements
- Obtain initial authorization or notification requests, if applicable
- Submit professional claims
- Register for Electronic Payments and Statements (EPS), including Electronic Funds Transfer (EFT)
- Update practice information
 - Add NPI
 - Add Taxonomy Code(s)
 - Update Languages Spoken
 - Update e-mail address
 - Update gender
 - Add Medicaid/Medicare Numbers
 - Update expertise
 - Update ethnicity
 - Request to add or remove Tax ID Number
 - Manage address locations, including practice, remit, credentialing and admitting privileges
 - Update phone and fax numbers
 - Availability status
 - Accessibility-practice hours, wheelchair accessibility, public transportation, etc.
- View Campaign for Excellence (CFE) and Facility Quality Measure (FQM) Scorecards
- Obtain pre-populated Wellness Assessments

To request a user id:

Select the “First-time User” link in the upper right hand corner of the home page
Click the ubhonline Support icon to access our Live Chat feature

Or

Call 1 (866) 209-9320
The ubhonline Support Center is available from 7 a.m. to 9 p.m. Central Time Monday through Friday, excluding holidays.

Public Pages:

The home page includes “Quick Links” to our most frequently accessed pages as well as recent news and updates.

- Access the latest information about **ALERT**[®]
- Obtain **CFE** and **FQM** program updates
- Download standard forms (see “Key Forms” section below)
- Find staff **contacts**
- Review **clinical guidelines**

- Locate current and archived issues of *Network Notes*, the UBH provider newsletter

www.liveandworkwell.com

Our primary Member web site makes it simple for Members to:

- Check benefits
- Request services
- Find articles on a variety of wellness and work topics
- Take self-assessments
- Locate community resources
- Identify UBH network clinicians and facilities

Members can explore the Mental Health Condition Centers for information related to symptoms, diagnoses, tests, treatment, and prevention on a list of conditions. The Life Stages Help Centers are designed to help Members manage and take control of life challenges.

Frequently Used Forms and What You Need to Know

You may obtain **Forms** by going to ubhonline or by calling the Forms Hotline at **(800) 888-2998** x 5759.

Employee Assistance Program (EAP) Services

- Benefit Transition Notification (BTN) – Upon completion of EAP services, submission of this form serves to generate an Open Certification for MH/SUD benefits for routine outpatient services
- Statement of Understanding – A mandatory form that describes the scope and limitations of EAP services, signed by both you and the member
- EAP Claim Submission through ubhonline secure “Transactions”

ALgorithms for Effective Reporting and Treatment (ALERT[®])

The one-page Wellness Assessment (WA) is a reliable, confidential, consumer-driven instrument used to help identify targeted risk factors in addition to establishing a baseline for tracking clinical change and outcomes. The WA is routinely administered at the beginning of the first session and then again at session three, four or five. The completed form is faxed to UBH. Detailed instructions and copies of the WA are available at ubhonline. Wellness Assessments are also available in Spanish.

- Adult Wellness Assessment — The adult Member seeking treatment completes this form
- Youth Wellness Assessment — The parent or guardian completes this form when the Member you are seeing is a minor

For questions and/or comments about ALERT feel free to e-mail the Clinical Network Services Team at ALERT_CNS_Ref@uhc.com.

Claims and Customer Service

Contact information for Claims and Customer Service issues can be found in the “[Contact Us](#)” section of ubhonline.

To ensure proper processing of claims, it is important to promptly contact Network Management if you change your Tax ID number. You may make changes to your practice address online. See secure “Transactions” above.

For Further Assistance

For general information and contractual questions, contact Network Management or your Facility Contract Manager. To locate your contact, go to ubhonline, follow the “[Contact Us](#)” link, then enter your state and select “Search for Network Management Staff.”

You may submit a credentialing status update request beginning 120 days after receiving an invitation to join the network. Submit your credentialing status inquiry to credentialing.status@optumhealth.com. Please include your full name with middle initial, license, full address and tax identification number(s) in your e-mail submission.

For credentialing or recredentialing questions, the following numbers are available to you: Clinicians **(800) 711-6089** and Facilities **(800) 333-8724**.

FREQUENTLY ASKED QUESTIONS

UBH Network Requirements

Who can I contact with specific questions or comments?

For general information and contractual questions, contact Network Management or your Facility Contract Manager. To identify the Network Management contact for your state, go to the “[Contact Us](#)” page and select “All Other Network Questions”.

What is a Payor?

Our Payor definition is the entity or person that has the financial responsibility for funding payment of covered services on behalf of a Member, and that is authorized to access MH/SUD services in accordance with the Agreement.

How do Network Lease Partnerships work?

Some patients may have access to the UBH network discounts through Network Lease Partners. A list of UBH Network Lease Partners can be found on [ubhonline](#). All claims for Members accessing your services through these arrangements are processed, paid by and the responsibility of the Network Lease Partners and not UBH. Please submit claims directly to these network lease partners for processing. Claims submission information is available on the back of the Member’s insurance card.

Do I have to notify anyone if I change my name, address, telephone number, or Tax Identification Number?

Yes. You are required to notify UBH within 10 calendar days, in writing, of any changes to your practice information. This is especially important for accurate claims processing. We encourage you to make such changes by going to [ubhonline](#) to update your practice demographics.

As a contracted facility, are we required to notify UBH in the event that we discontinue or change a program or service?

Yes. Contracted facilities are required to provide UBH with written notification of changes in the services they offer within 10 calendar days.

As a contracted facility, would the addition of programs, services or locations require review of our current contract with UBH?

Yes. Contact your Facility Contract Manager to initiate a review.

Can I be considered a participating clinician at one practice location and non-participating at another?

No. Your Agreement is between you and UBH. It is an agreement to see all Members eligible to access this Agreement, and is not specific to a location or Tax Identification Number. It is important to provide UBH with all practice locations and the Tax Identification Numbers under which you submit claims.

Since our facility or practice group has a UBH contract, does that mean all of our affiliated clinicians are considered participating network clinicians?

No. Generally, only clinicians credentialed with UBH are considered UBH network clinicians. The UBH network status of a facility or group does not guarantee that all clinicians in practice there are network clinicians. In situations where an Agency is credentialed by UBH, their affiliated clinicians are not credentialed, but are considered participating under the Agency's Agreement.

May I bill for Mental Health/Substance Abuse Disorder (MH/SUD) services that another practitioner, intern or assistant provides to UBH members in my office?

No. You can bill only for services which you personally provide. Please follow the UBH Operational Guide for Psychological and Neuropsychological Testing regarding the use of psychometrists. These are available on [ubhonline](#) under "Guidelines and Policies."

If my practice is filling up or if I am going to take a leave of absence from my practice, may I choose to be unavailable for new UBH referrals?

Yes. You may request to be listed in our database as unavailable at one or more of your practice locations for a period of up to six months. You are required to notify Network Management within 10 calendar days of your lack of availability for new referrals. Group practices and facilities/agencies that wish to be made unavailable should contact Network Management for their state.

Are there procedures to follow if I withdraw from the UBH network?

Yes. The terms and conditions for withdrawal from the network are outlined in your Agreement. For additional details, or to initiate the process, contact Network Management or your Facility Contract Manager. Please also see information about Continuation of Services after Termination in the "UBH Network Requirements" section of this manual.

Benefit Plans, Authorizations and Access to Care

Should I routinely contact UBH regarding eligibility and benefits?

Yes. You can inquire about eligibility and benefits at [ubhonline](#) or by calling the phone number on the back of the Member's insurance card. Services and/or conditions not covered under the Member's specific benefit plan are not eligible for payment. UBH complies with regulatory requirements related to coverage election periods and payment

grace periods. These requirements can lead to delays in UBH's knowledge of a Member's eligibility status. As a result, the Member is usually the best source for timely information about eligibility, coverage changes and services utilized to-date.

Can members initiate authorization of benefits for routine outpatient MH/SUD services?

Yes. The authorization for routine outpatient services, when required, is typically obtained through a telephone contact between the Member or family member and an Intake staff. It can also be initiated by the Member via the member web site. However, if a required authorization has not been issued at the time you inquire about eligibility, then you need to request it. You may do this through ubhonline or by calling the phone number on the back of the Member's insurance card.

Do all Members require prior authorization for outpatient treatment?

No. For UBH Members whose benefit plan does not require prior authorization, there is no need to obtain an authorization. To inquire about a Member's benefit plan requirements contact us through ubhonline or by calling the number on the back of the Member's insurance card.

Are all the services I provide covered under the MH/SUD Authorization?

No. Authorization that is issued to Members (when required) covers most common routine outpatient MH/SUD services you provide.

Please note that psychological testing, intensive outpatient care and other non-routine outpatient MH/SUD services still require clinician-specific or program-specific authorization of benefits prior to providing those services. To obtain those authorizations, please call the number on the back of the Member's insurance card.

Is the Wellness Assessment (WA) administered more than once?

Yes. The WA is administered at the first session or in the second session if the Member presents in crisis during the first session. It is administered again preferably at the third visit, but may be given at either the fourth or fifth visit. The exact timing is at the clinician's discretion.

Is there a way to ensure confidentiality with the WA for emancipated minors who are requesting services?

Yes. In these circumstances, you should only complete the demographic sections located at the top of the WA and return it to UBH. Fill in the bubble labeled "MRef" for Member refusal. A follow-up assessment will not be sent to the adolescent's home.

Where can I get more information about ALERT and Wellness Assessments?

Please refer to the “Benefits Plans, Authorization, EAP and Access to Care” section of this manual or the [ALERT](#) information on [ubhonline](#).

Is there a time limit in which an authorization of routine services is valid?

Yes. The authorization of routine services is valid for one year from the date of issue up to the benefit limit as long as the Member’s eligibility remains active.

Will I be notified when an authorization expires?

No. Please refer to the effective date on the most recent authorization letter. The authorization is valid for 12 months from the date of issue (up to the benefit limit as long as the Member’s eligibility remains active).

Can I make referrals directly to other UBH network clinicians without prior authorization of benefits?

Yes, in some cases. The authorization for routine services is open to any UBH network clinician and allows you to transfer a Member to another network clinician for routine outpatient MH/SUD services. Additionally, if you are referring a Member to a network clinician for routine medication evaluation and management, prior authorization is not required. However, a prior authorization is still required for services such as psychological testing, intensive outpatient services and other levels of care.

Is a consultation with a Care Advocate necessary to refer Members directly to inpatient, day treatment or intensive outpatient services?

Yes. Inpatient and subacute level of care admissions are pre-authorized by a Care Advocate. In the event of an emergency admission, facilities should immediately contact UBH.

Employee Assistance Program (EAP) Procedures

Do EAP services require prior authorization?

Yes. EAP benefits require specific authorization by calling. You will receive an EAP authorization letter.

Should EAP members be given the Wellness Assessment (WA) at their initial visit?

Yes. All UBH Members should be asked to complete the WA.

Do I need to obtain prior authorization for Members who transition from EAP to UBH MH/SUD benefits for routine psychotherapy services?

Some Members will have a managed behavioral health care benefit through UBH in addition to their EAP benefit. In some instances, an authorization or notification may be necessary for those Members who transition from EAP to MH/SUD benefits for routine psychotherapy services. To obtain an authorization or notification, use the “Auth Request” function through [ubhonline](#), or send the Benefit Transition Notification (BTN) form, enclosed with your EAP authorization to UBH. Upon completion of the [ubhonline](#) “Auth Request” or receipt of the BTN form UBH will generate an MH/SUD benefit authorization.

Am I required to ensure that an MH/SUD authorization is in place when a Member begins MH/SUD services with me after utilizing available EAP sessions with another clinician?

Yes. The EAP clinician should have requested MH/SUD authorization, if required. However, you need to verify that a required authorization has been obtained. If not, you should obtain the authorization.

Does use of EAP benefits change authorization or notification requirements for MH/SUD services?

No. You may inquire about benefit requirements through [ubhonline](#) or by calling the number on the back of the Member’s insurance card.

If a Member I am seeing through EAP benefits requires medication management services, is prior authorization of MH/SUD benefits required?

No. Medication management services under MH/SUD benefits do not require prior authorization.

Am I required to give a Wellness Assessment to a Member transitioning from EAP benefits?

Yes. All UBH Members should be offered the WA. If the Member reports having already completed a WA with the EAP clinician, it is not necessary to complete an initial session WA. However, you should administer the WA at either session three, four or five.

Do EAP benefits require a new authorization when a new benefit year begins?

Yes. You will need to obtain a new EAP authorization when a new benefit year begins.

Is there a time frame in which I may seek a retrospective review of services that were provided but not previously authorized?

Yes. On occasion, emergent or other unusual circumstances will interfere with the pre-authorization processes. In those cases, requests for a retrospective review of services must

be submitted within 180 calendar days of the date(s) of service unless otherwise mandated by state law.

Treatment Philosophy

Are UBH's Guidelines accessible online?

Yes. [Guidelines and Policies](#) are posted under "Quick Links" on the home page. You may also contact Network Management to have a paper copy of these documents mailed to you.

Am I expected to coordinate care with a Member's primary care physician or other health care professionals?

Yes. UBH requires network clinicians, both in and out of facilities, to pursue coordination of care with the Member's primary physician as well as other treating medical or behavioral health clinicians. A signed release of information should be maintained in the clinical record. In the event that a Member declines consent to the release of information, his or her refusal should be documented along with the reason for refusal. In either case, the education you provide regarding risks and benefits of coordinated care should be noted.

Compensation and Claims

Can Members be billed prior to claims submission?

No. Members are never to be charged in advance of the delivery of services. Members should be billed for deductibles after claims processing yields an Explanation of Benefits indicating Member responsibility.

Is there one format to be used for diagnosis on claims?

Yes. Submit your claims with standard DSM-IV or ICD-9-CM (their equivalent or successors) diagnostic codes, as appropriate.

Are there different methods or claim forms I should use when submitting claims to UBH?

Yes. See below.

Electronic Claims: UBH recommends electronic submission of claims for the most efficient claim processing. Network clinicians and group practices can submit MH/SUD and EAP claims electronically through ubhonline using the "claim entry" function. This and other secure transactions are accessed through a registered User ID. To obtain a user ID, go online to "chat" with a ubhonline representative or call toll-free (866) 209-9320. In addition, any clinician, group practice or facility provider can submit claims electronically through an EDI clearinghouse using Payer ID #87726.

Clinician Claim Forms: Paper claims for MH/SUD or EAP services should be submitted to UBH using the CMS-1500 Claims Form, or its successor form. All paper claims must be typewritten.

Facility Claim Forms: Paper claims should be submitted to UBH using the UB-04 billing format, or any successor forms as appropriate.

With all of the different products that UBH manages, is there some easy way for me to determine where to send my claim?

Yes. Claims submitted electronically through ubhonline are automatically routed to the appropriate claims office. You may also elect to submit electronically through an EDI vendor. EDI claims are also automatically routed correctly to UBH claims offices. UBH pays claims for its Members using a number of different claims systems. In order to assure prompt and accurate payment for claims submitted via the U.S. Postal Service, you should verify the mailing address for your claim. Often, the claims payment address for a medical claim is different than the address for a behavioral health claim.

Do I have to submit my claims within a certain time frame in order for them to be paid?

Yes. All information necessary to process claims must be received by UBH no more than 90 calendar days from the date of service, or as required by state or federal law or specific Member benefit plans.

Am I responsible for coordination of benefits?

Yes. You are responsible for determining if other insurance coverage is in effect and for billing the primary insurance carrier first, and notifying UBH of your findings. UBH is required to process claims using industry-wide Coordination of Benefits (COB) standards and in accordance with benefit contracts and applicable state laws.

Can I bill a Member when treatment is not authorized, as required, but the Member elects to receive services?

Yes. In the event that you seek prior authorization of benefits for behavioral health services or authorization for continued treatment when required, and UBH does not authorize the requested services, the Member may be billed under limited circumstances. For more detailed information, please review the billing for non-covered services in the "Compensation and Claims" section of this manual.

May I submit a claim to UBH for "no-shows"?

No. However, the Member may be billed if a written statement explaining your billing policy for appointments not kept or cancelled is signed by the member prior to such an occurrence. You may bill the Member no more than your UBH contracted rate. Note that some plans and government funded programs prohibit billing for no-shows under any circumstances.

May I submit a claim to UBH for telephone counseling or after-hours calls?

UBH covers telephone counseling in some situations when clinically necessary and appropriate and in accordance with the Member's benefit plan. Telephone counseling must be pre-authorized by UBH.

May I balance bill the Member above what UBH pays me?

No. You may not balance bill Members for services provided during eligible visits, which means you may not charge Members the difference between your billed usual and customary charges and the aggregate amount reimbursed by UBH and Member expenses.

Privacy Practices

Do HIPAA Regulations allow me to exchange Protected Health Information (PHI) with UBH?

Yes. The HIPAA Privacy Rule permits clinicians and UBH to exchange PHI, with certain protections and limits, for activities involving Treatment, Payment, and Operations (TPO).

Do I need a National Provider Identification to submit electronic claims?

Yes. HIPAA mandates that all health care Providers conducting standard electronic transactions (such as electronic claims submission) must obtain and use a unique identification number known as the National Provider Identifier (NPI). Some states presently require an NPI for paper claims as well.

Quality Improvement

Does UBH audit clinicians and facilities?

UBH representatives conduct site visits at clinician offices, agencies such as community mental health centers (CMHCs), facilities, and group provider locations. On-site audits are routinely completed with high-volume clinicians, clinicians who have a clinical office in their home or who offer services in the homes of Members, and CMHCs and facilities without national accreditation. In addition, audits are completed to address specific quality of care issues or in response to Member complaints about the quality of the office or facility environment. For additional information, please see the "Quality Improvement" section of this manual.

Appeals

Can I initiate the Appeals process if I disagree with UBH's decision not to authorize services I have requested?

Yes. You may initiate the Appeals process with UBH. Urgent appeals should be pursued as quickly as possible following an adverse determination. For non-urgent appeals, UBH has

established a 180-day time frame in which a clinician or Member can request the appeal. These time frames apply unless otherwise mandated by applicable law.

Are there different contacts for issues with claims processing or payment?

Yes. You may need to call different customer service numbers to request assistance for some Members.

UBH has several main customer service phone numbers (see the “UBH Resource Guide” or “Compensation and Claims” sections of this manual); however, it is best to call the phone number listed on the Provider Remittance Advice.

GLOSSARY OF TERMS

These definitions are general definitions applied for purposes of this manual. State law, certain Agreements and individual benefit plans define some of these terms differently. In such cases, the definitions contained in the applicable law or contract will supersede these definitions.

Abuse

Billing practices, which while not necessarily meeting the legal definition of “fraud,” run afoul of or take advantage of legally sanctioned standards or contract provisions.

Adverse Determination

A denial, reduction, or termination of coverage, or a failure to provide or make payment (in whole or in part) for a benefit, including, but not limited to, any such denial based on the eligibility of a Member or beneficiary to participate in a plan; and a denial resulting from utilization review, the experimental or investigational nature of the service, or the lack of medical necessity or appropriateness of treatment.

Agency

A non-facility based outpatient Provider meeting specific criteria. Examples include, Federally Qualified Health Centers (FQHC), Community Mental Health Centers (CMHC), State Licensed Outpatient Clinics, Community-based Service Agencies, and School Based Health Centers (SBHC). See definitions of these agency types within this Glossary.

Agreement

A contract describing the terms and conditions of the contractual relationship between UBH and a Provider under which mental health and/or substance use disorder services are provided to Members.

Algorithm

A set of decision rules UBH applies to Member-specific data to determine if there are any targeted clinical issues or risks. **AL**gorithms for **E**ffective **R**eporting and **T**reatment (ALERT[®]): An outcomes-based system using Member responses to a validated survey, in conjunction with claims data, for the identification of Members who are at moderate to high risk for poor clinical outcomes.

All-Payor Contract

An arrangement allowing for payment of health services delivered by a Provider regardless of product type (e.g., HMO, PPO, indemnity) or revenue source (e.g., fully funded or self-funded).

Appeal

A specific request to reverse an adverse determination or potential restriction of benefit reimbursement.

Authorization

The number of inpatient days or non-routine outpatient visits for which benefits have been applied as part of the Member benefit plan for payment (formerly known as a Certification). Authorizations are not a guarantee of payment. Final determinations will be made based on Member eligibility and the terms and conditions of the Member's benefit plan at the time the service is delivered

Balance Billing

The practice of a Provider requesting payment from a Member for the difference between the UBH contracted rate and the Provider's usual charge for that service.

Behavioral Health Care

Assessment and treatment of mental health and/or substance use disorders (MH/SUD).

Coverage Determination Guidelines

Guidelines intended to standardize the interpretation and application of terms of the Member's benefit plan including terms of coverage, benefit plan exclusions and limitations.

Benefit Plan

The specific plan of benefits for health care coverage, including MH/SUD Services, for a particular Member that is provided, sponsored or administered by UBH directly or through its Affiliate, or through a network rental arrangement UBH may have with a third party, and contains the terms and conditions of a Member's coverage for MH/SUD Services.

Benefit Transition Notification (BTN)

Submission of this form serves to generate an authorization when required, for MH/SUD benefits for routine outpatient services upon completion of EAP services.

Care Advocate

A UBH employee who is a licensed clinical professional (e.g., nurse, doctor, psychologist, social worker, or professional counselor) who works with Members, health care professionals, physicians, and insurers to maximize benefits available under a Member's benefit plan. EAP Care Advocates are referred to as EAP Specialists. Care Advocates were formerly referred to as Care Managers.

Clean Claim

A UB-04 or a CMS-1500 claim form, or its successor, submitted by a Provider for MH/SUD health services rendered to a Member which accurately contains all the following information: Member's identifying information (name, date of birth, subscriber ID); Provider information (name, address, tax ID); date(s) and place of service; valid DSM-IV diagnosis or ICD-9 code; procedure narrative; valid CPT-4 or revenue code; services and supplies provided; facility charges; and such other information or attachments that may be mutually agreed upon by the parties in writing.

The primary avenue for clinician claims submissions is electronically through [ubhonline[®]](https://www.ubhonline.com).

Clinician

A licensed professional that has contracted to deliver behavioral health care services to Members (also known as a network clinician).

Coinsurance

The portion of covered health care costs the Member is financially responsible for, usually according to a fixed percentage. Coinsurance often is applied after a deductible requirement is met.

Community-based Service Agency

Includes peer support group services and drop in centers (clubhouse model), and have business license but are not state licensed.

Community Mental Health Center (CMHC)

An entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located.

Co-payment

A cost-sharing arrangement in which a Member pays a specified charge for a specified service, such as \$20 for an office visit, for example. The Member usually is responsible for payment at the time the health care is rendered. Typical co-payments are fixed or variable flat amounts for clinician office visits, prescriptions or hospital services. Sometimes the term "co-payment" generically refers to both a flat dollar co-payment and coinsurance (see above).

Credentialing

The process by which a Provider is accepted into the UBH network and by which that association is maintained on a regular basis.

Deductible

The annual amount of charges for behavioral health care and MH/SUD services, as provided in the Member's benefit plan, which the Member is required to pay prior to receiving any benefit payment under the Member's plan.

EAP (Employee Assistance Program)

Services that are designed for brief intervention, assessment and referral.

EFT (Electronic Fund Transfer)/EPS (Electronic Payments and Statements)

A system which supports electronic claim payments and remittance advices. Claim payments are deposited directly into the designated bank account with access to all payment and remittance advice information via [ubhonline](http://ubhonline.com).

Emergency

A serious situation that arises suddenly and requires immediate care and treatment to avoid jeopardy to life or health. For appointment access standards see “Emergency - Life-threatening”, “Emergency — Non-life-threatening” and “Urgent”.

Emergency — Life-threatening

A situation requiring immediate appointment availability in which there is imminent risk of harm or death to self or others due to a medical or psychiatric condition.

Emergency — Non-life-threatening

A situation requiring appointment availability within six hours in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm or death to self or others.

Exclusions

Specific conditions or circumstances listed in the Member’s benefit plan for which the policy or plan will not provide coverage reimbursement under any circumstances.

Facility

An entity that provides inpatient, residential, or ambulatory services and has contracted to deliver behavioral health care services to Members (also known as a network facility).

Facility Contract Manager

A UBH professional dedicated to managing contractual relationships with hospitals and freestanding behavioral health programs and services for the UBH network.

Fee Maximum

The maximum amount Provider may receive as payment for provision of Covered Services to a Member, including Member Expenses that are applicable to Provider pursuant to the Benefit Plan.

Federally Qualified Health Centers (FQHC)

A federally qualified health center is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-a-Likes. A FQHC Look-A-Like is an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.

Fraud

Knowing and willful deception, misrepresentation, or a reckless disregard of the facts with the intent to receive an unauthorized benefit. Fraud can only be determined by a court.

Group Practice

A group of individually credentialed clinicians who participate in the network under a group contract and share a single tax identification number. The group practice site(s) is the location of practice for at least the majority of each clinician’s clinical time. In addition,

medical records for all patients treated at the practice site are available to and shared by all clinicians as appropriate.

Health Plan

A health maintenance organization, preferred provider organization, insured plan, self-funded plan, or other entity that provides payments for health care services. This term also is used to refer to a plan of benefits.

HIPAA

The Health Insurance Portability and Accountability Act, by which a set of national standards are set for, among other topics, the protection of certain health care information. The standards address the use and disclosure of an individual's "Protected Health Information" (PHI) by organizations subject to the Privacy Rule ("covered entities"). These standards also include privacy rights for individuals to understand and control how their health information is used. For more information, please visit the Department of Health and Human Services Web site at www.hhs.gov.

Independent Review Organization

An independent entity/individual retained by a private health plan, state agency or federal agency to review adverse determinations (based on medical necessity) that have been appealed by, or on behalf of, a Member (also sometimes known as External Review Organizations).

Least Restrictive Level of Care

The Level of Care (LOC) at which the Member can be safely and effectively treated while maintaining maximum independence of living.

Level of Care (LOC) Guidelines

Objective, evidence-based admission and continuing stay criteria for MH/SUD services. These guidelines are intended to standardize care advocate decisions regarding the most appropriate and available level of care needed to support a Member's path to recovery.

liveandworkwell.com

A UBH Member Web site which provides resources for wellness information, MH/SUD intervention, network referrals, certifications, and account management.

Medical Necessity

Treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of covered services based upon the terms and conditions of the Member's Benefit Plan.

Member

An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan. Also may be referred to as a plan participant or enrollee.

MH/SUD

Mental Health and/or Substance Use Disorder.

Network Management

Consists of UBH Network Managers and Associates who provide service to UBH Providers. Additionally, they work within UBH to contract and retain experienced mental health and substance abuse treatment professionals.

Notification

A Benefit Plan requirement that Providers (or sometimes the Member) contact UBH when a Member accesses services. Notification, when required, should occur prior to the delivery of certain non-routine outpatient services and scheduled inpatient admissions and as soon as reasonably possible for an emergency admission. Notification requirements include clinical information to determine benefit coverage.

Payor

The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MH/SUD Services in accordance with the Agreement.

Prospective Review

A situation whereby a Provider's future claims (not yet processed) are subject to investigation and medical records requests based upon previously submitted claims matching suspected abusive patterns.

Quality Assurance

A formal set of activities to review and affect the quality of services provided. Quality Assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient services. Federal and state regulations typically require health plans to have quality assurance programs.

Quality Improvement

A continuous process that identifies opportunities for improvement in health care delivery, tests solutions, and routinely monitors solutions for effectiveness.

Routine

A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others.

School Based Health Center (SBHC)

An agency that provides a comprehensive array of behavioral health services, which is inclusive of outpatient, case management and telehealth services

State Licensed Outpatient Clinic (Non CMHC)

An institution that is licensed and or accredited by a state entity to provide mental health and/or substance abuse services.

ubhonline® (www.ubhonline.com)

The UBH Web site providing resources for Providers. General information, manuals, policies and procedures, forms and newsletters are available to Providers. A variety of secure, self-service transactions including authorization inquiry and claim entry are available to network clinicians and group practices.

Urgent

A situation in which immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation. Availability should be within 48 hours or less or as mandated by applicable law.

Waste

Generally refers to over-use of services, or other practices that result in unnecessary costs. In most cases, waste is not considered caused by reckless actions but rather the misuse of resources.

Wellness Assessment (WA)

A reliable, confidential, Member-driven instrument used to help identify targeted risk factors in addition to establishing a baseline for tracking clinical change and outcomes.

UBH NETWORK REQUIREMENTS

Clinical Network Development and Maintenance

UBH is responsible for arranging for the provision of a comprehensive spectrum of behavioral health services. In order to fulfill this responsibility, we administer a provider network including licensed qualified professionals in mental health and substance use disorders. This network represents an array of clinical and cultural specialties and includes facility-based programs that offer a wide variety of services. The diversity of our network allows us to meet the clinical, cultural, linguistic and geographic needs of our Members.

All Payor Provider Agreement

Our Payor definition is the entity or person that has the financial responsibility for funding payment of covered services on behalf of a Member, and that is authorized to access MH/SUD services in accordance with the Agreement.

Some patients may have access to the UBH network discounts through Network Lease Partners. A list of UBH Network Lease Partners can be found on [ubhonline](#). All claims for Members accessing your services through these arrangements are processed, paid by and the responsibility of the Network Lease Partners and not UBH. Please submit claims directly to these network lease partners for processing. Claims submission information is available on the back of the Member's insurance card.

Non Discrimination

UBH does not deny or limit the participation of any Provider in the network, and/or otherwise discriminate against any Provider, based solely on any characteristic protected under state or federal discrimination laws.

Furthermore, UBH has never had a policy of terminating any Provider because the Provider or Provider representative: (1) advocated on behalf of a Member; (2) filed a complaint against UBH; (3) appealed a decision of UBH; or (4) requested a review of a termination decision or challenged a termination decision of UBH. Moreover, consistent with the terms of the Settlement Agreement entered into in *Holstein v. Magellan Behavioral Health*, UBH has adhered to this practice both before and since the Settlement Agreement was executed. UBH has not, and will not, terminate any Provider from its network based on any of the four grounds enumerated above. Nothing in the Agreement should be read to contradict, or in any way modify, this long-standing policy and practice of UBH.

Clinician Credentialing and Recredentialing

UBH uses the Universal Provider Data Source[®], developed by the [Council for Affordable Quality Healthcare \(CAQH\)](#), to obtain the data needed for credentialing and recredentialing of our network clinicians, and many clinicians who are contracted with us through a group practice, unless otherwise required by law. The CAQH web-based credentialing tool streamlines the credentialing process by enabling you to complete your credentialing

application online. This free service for healthcare professionals is available 24 hours a day, 365 days a year. The online application allows you to save your work and return later to finish the process. Once completed, CAQH stores the application online and enables you to make updates to your information as needed. By keeping your CAQH information current, future re-credentialing is quick and easy.

Once your application is completed with CAQH, UBH may utilize Aperture, an NCQA certified Credentials Verification Organization (CVO), to review the application packet for completeness and collect any missing or incomplete information.

Clinician Credentialing

UBH credentials clinicians according to rigorous criteria that reflect professional and community standards, as well as applicable laws and regulations. These criteria include, but are not limited to, satisfaction of the following standards:

- Independent licensure or certification in your state(s) of practice, except as required by applicable state law
- License is in good standing and free from restriction and/or without probationary status
- Board Certification or Board Eligibility (to complete prior to the recredentialing cycle) for psychiatrists
- Current certification through the Federal Drug Enforcement Agency (DEA) for prescribing clinicians in each state in which they practice
- Professional Liability Coverage: a minimum of \$1 million occurrence/\$1 million aggregate for master's-level and doctoral-level clinicians and a minimum of \$1 million/\$3 million for physicians (exceptions to these required insurance amounts may be made as required by applicable state law)
- Free from any exclusion from government programs in

For a more specific list of criteria, please refer to the Credentialing Plan.

You will be asked to sign a release of information granting UBH and its agents access to information pertaining to your professional standing. This is required for primary verification and/or review of records from any professional society, hospital, insurance company, present or past employer, or other entity, institution, or organization that may have information pertaining to your professional standing. Obtaining and reviewing this information is necessary to complete the credentialing process. Failure to provide such a release will preclude completion of your credentialing and prevent your participation in the network.

UBH has specific requirements for identified specialty areas. A comprehensive list of specialty areas is available on the Network Participation Request Form, which can be found in the “Our Network” section at [ubhonline](http://ubhonline.com)[®]. If you request recognition of a specialty area, an attestation statement may be required documenting the specific criteria met for the identified specialty. Current competency of a designated specialty may be randomly audited

to ensure that network clinicians remain active and up-to-date in their specialty field attestations.

The Credentialing Plan addresses the requirements for participation, continued participation (maintaining unrestricted license, cooperating with complaints investigation, etc.) , and information regarding disciplinary action up to and including termination of participation in the network. [The Credentialing Plan](#) is available at [ubhonline](#), or you may request that a paper copy be mailed to you by contacting Network Management.

Clinician Re-credentialing

In accordance with our commitment to the highest quality of clinical treatment, we re-credential clinicians every 36 months unless state law or client policies require a different re-credentialing cycle. During recredentialing, we will access your information through your CAQH application, unless otherwise required by law. In addition, you will be required to provide your current copy of:

- Professional licensure and/or certification
- Federal Drug Enforcement Agency (DEA) certificate (if applicable) for each state in which you practice
- Controlled Dangerous Substances (CDS) certificate (if applicable)
- Professional and general liability insurance
- Curriculum vitae

You may also be asked to:

- Attest to your areas of clinical specialty and appropriate training supporting the identified specialties.
- Sign a release of information granting access to information pertaining to your professional standing. This is required for primary verification and/or review of records from any professional society, hospital, insurance company, present or past employer, or other entity, institution, or organization that does or may have information pertaining to your professional standing. Failure to provide such a release will preclude completion of your re-credentialing and prevent your continued participation in the network.

You are required to provide a copy of all professional documents whenever they renew or change.

Facility / Agency Credentialing and Re-credentialing

UBH follows the guidelines of National Committee for Quality Assurance (NCQA) for credentialing and recredentialing unless otherwise required by law. As part of the credentialing and re-credentialing process, facilities and agencies are required to submit documentation supporting their professional and community standing and defining their program offerings. This documentation includes, but is not limited to:

- Current copies of all licenses required by your state for the services you offer
- Current copy of accreditation certificate and/or letter from each accrediting body
- General and professional liability insurance certificates
- W-9 forms
- Disclosure Ownership Form (if applicable)
- Signed malpractice claims statement/history
- Staff roster, including attending physicians
- Daily program schedules
- Program description
- Facility Billing Information Form

In the event that your facility/agency is not accredited by an entity recognized by UBH, an On-site Audit will be required prior to credentialing and again prior to re-credentialing (see “On-site Audits” in the Quality Improvement section of this manual for more information).

The Credentialing Plan addresses the requirements for participation, continued participation (maintaining unrestricted license, cooperating with complaints investigation, etc.), and information regarding disciplinary action up to and including termination of participation in the network. [The Credentialing Plan](#) is available at ubhonline, or you may request that a paper copy be mailed to you by contacting your Facility Contract Manager.

Board Certified Behavior Analyst (BCBA)

UBH has added a new provider type to its network, specifically to provide Applied Behavior Analysis (ABA) in the treatment of children with Autism Spectrum Disorders (ASD).

Qualified Board Certified Behavior Analysts (BCBA) are eligible to apply for participation in this unique Applied Behavior Analysis Network. BCBA applicants must demonstrate expertise by meeting the minimum requirement of 6 months supervised experience or training in the treatment of ASD, in addition to active BCBA certification from the national Behavior Analyst Certification Board.

Qualified ABA professional organizations providing ASD treatment services and using a staff model that includes individual BCBA's providing oversight to paraprofessional staff are also eligible to apply for participation in this ABA network

Credentialing and Re-credentialing Rights and Responsibilities

As an applicant to the UBH network, or as a network Provider in the process of re-credentialing, you are entitled to:

- Be informed of your rights
- Be informed of credentialing or re-credentialing status upon request
- Review information submitted to support your credentialing or re-credentialing application, excluding personal or professional references, internal UBH documents, or other information that is peer-review protected or restricted by law

- Make corrections to erroneous information identified by UBH in review of credentialing or recredentialing application

In addition to the above rights, you have the responsibility to submit any corrections to your credentialing or re-credentialing application in writing within 10 business days of your notification by UBH.

Written Notification of Status Changes

You are required to notify UBH in writing within 10 calendar days of any changes to:

- The status of the practice, including changes in practice location, billing address, or telephone or fax number
- Changes in facility, agency, or group ownership)
- The status of professional licensure and/or certification such as revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, monitoring or any other adverse action
- The status of professional liability insurance
- Potential legal standing (any malpractice action or notice of licensing board complaint filing)
- The Tax Identification Number (TIN) used for claims filing
- The programs you offer (services you provide must continue to meet our credentialing criteria)

Registered users of [ubhonline](#), except facilities and agencies, are strongly encouraged to use the “My Practice Info” function to update this information. Otherwise, clinicians and group practices should submit changes in writing, via fax or mail, to your state-specific Network Management team. Facilities and agencies should submit their changes, in writing, via fax or e-mail, to the Facility Contract Manager or Network Manager for your state. For information on how to contact Network Management, see the UBH Resource Guide section of this manual.

Practice Locations and Contract Status

Individually Contracted Clinician

Your Agreement is between you and UBH. It is an agreement to see all Members eligible to access this Agreement. Your Agreement with UBH is not specific to a single location or Tax Identification Number. It is important to provide UBH with all practice locations and the Tax Identification Numbers under which you may bill to facilitate proper reimbursement.

Clinicians Participating Under a Group Contract

The Agreement is between the group practice and UBH. It is an agreement to see all Members eligible to access this Agreement at all locations affiliated with the group. The group must provide UBH with all practice locations and Tax Identification Numbers under which you may bill to facilitate proper reimbursement. Additional group Tax Identification Numbers may require a contract amendment.

Facility/Agency Contracts

The Agreement is between the facility/agency and UBH. It is an agreement to see all Members eligible to access this Agreement. The Agreement with UBH is specific to a single Tax Identification Number, but may include multiple practice locations. It is important to provide UBH with all practice locations and the Tax Identification Number under which you may bill to facilitate proper reimbursement.

Provider Initiated Unavailable Status

Individual clinicians may request to be made unavailable for new referrals at one or more of your practice locations for up to six months. You are required to notify Network Management within 10 calendar days of your lack of availability for new referrals. You may make this notification through secure “Transactions” on [ubhonline](#), or by contacting the Network Manager for your state. You will be sent a letter confirming that your request has been processed.

When you have been on unavailable status for five consecutive months, we will send you a letter reminding you that you will be returned to active status within 30 calendar days. You may contact Network Management to request an extension of your unavailable status. Should you decide that you want to return to active status sooner than expected, you may update your status on [ubhonline](#) or notify Network Management for your state.

Some common reasons for requesting unavailable status are extended illness, vacation or leave plans, and lack of available appointments. Please note that while on unavailable status your Agreement remains in effect.

Group practices and facilities/agencies that wish to be made unavailable should contact Network Management for their state.

On-Call and After-Hours Coverage

You must provide or arrange for the provision of assistance to Members in emergency situations 24 hours a day, seven days a week. You should inform Members about your hours of operation and how to reach you after-hours in case of an emergency. In addition, any after-hours message or answering service must provide instructions to the Members regarding what to do in an emergency situation. When you are not available, coverage for emergencies should be arranged with another participating clinician.

Psychological Assistants and Interns

In accordance with the Agreement, the services you provide must be provided directly by you for all Members. Participating clinicians may not submit claims in their name for treatment services that were provided by a psychological assistant, nurse practitioner, intern, or another clinician. For information regarding test administration by a psychometrist or psychometrician please refer to the Operational Guide for Psychological and Neuropsychological Testing. This guide also addresses other procedures related to testing

and report writing. You can also contact the appropriate Care Advocacy Center for assistance with such questions.

Physician Assistants and Residents in Facility Settings

Attending physicians must provide services directly to all UBH Members. In general, attending physicians may not submit claims in their name for treatment or psychodiagnostic services that were provided by a resident, psychological assistant or intern. UBH expects network physicians to be assigned as the attending doctor for UBH Members.

Termination or Restriction of Network Participation

A Provider's participation with UBH can end for a variety of reasons. Both parties have the right to terminate the Agreement with UBH, upon written notice, pursuant to the terms of the Agreement.

If you need clarification on how to terminate your Agreement, you may contact Network Management or your Facility Contract Manager.

In some cases, you may be eligible to request an appeal of a UBH initiated termination or restriction of your participation. If you are eligible for an appeal, UBH will notify you of this in writing within 10 calendar days of the adverse action. The written request for appeal must be received by UBH within 30 calendar days of the date on the letter which notified you of any adverse action decision. Failure to request the appeal within this timeframe constitutes a waiver of all rights to appeal and acceptance of the adverse action.

The appeal process includes a formal hearing before at least three (3) clinicians, appointed by UBH. The Appeal Committee members are not in direct economic competition with you, and have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. You may be represented by a person of your choice at the appeal hearing, including legal counsel. At the conclusion of the hearing you have five business days to submit further documentation for consideration. The Appeal Committee's decision is by a majority vote of the members. The decision of this Committee is final, and may uphold, overturn, or modify the recommendation of UBH. A certified letter with the specific reasons for the decision is sent to you within 30 calendar days of your documentation submission deadline.

Continuation of Services after Termination

Network Clinicians, Group Practices and Agencies who withdraw from the UBH network are required to notify UBH, in writing, 90 calendar days prior to the effective date of termination, unless otherwise stated in your Agreement or required by state law. With the exception of terminations due to quality-related issues, suspected fraud, waste or abuse or change in license status, clinicians are obligated to continue to provide treatment for all UBH members under their care. The timeline for continued treatment is up to 90 calendar days from the effective date of the contract termination, or as outlined in your Agreement or until one of the following conditions is met, whichever is shortest:

- The Member is transitioned to another UBH clinician
- The current episode of care has been completed
- The Member's UBH benefit is no longer active

Please note that state-specific laws will be followed when they provide for a different post-termination timeframe.

To ensure continuity of care, UBH will notify Members affected by the termination of a clinician, group practice or agency at least 30 calendar days prior to the effective date of the termination whenever feasible. UBH will assist these Members in selecting a new clinician, group or agency. You are also expected to clearly inform Members of your impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date, in compliance with your Agreement.

Network facilities that withdraw from the network are required to notify UBH, in writing, 120 calendar days prior to the date of termination unless otherwise stated in your Agreement or required by state law. The Care Advocate may continue to issue authorizations for treatment during the termination period at the UBH contracted rate, as provided by your Agreement.

To ensure there is no disruption in a Member's care, UBH has established a 120 calendar-day transition period for voluntary terminations. In the event that a facility's participation is terminated due to quality-related issues, fraud or change in license status requiring immediate transfer of a member to another facility, UBH and the facility will coordinate to ensure a safe and effective transition of care.

In some cases, you and the Care Advocate may determine it is in the best interest of a member to extend care beyond these timeframes. UBH will arrange to continue authorization for such care at the UBH contracted rate. You may continue to collect all applicable co-payments and deductible amounts. The facility continues under contract at the existing rates through the completion of the episode of care at any level of care provided by the facility. Members may not be balance billed.

BENEFIT PLANS, AUTHORIZATIONS, EAP, AND ACCESS TO CARE

UBH establishes guidelines and requirements for Providers. Where required by law, more stringent standards may be applied. However, if state law permits the application of less stringent standards, the UBH standards specified herein shall still be applied pursuant to the terms of your Agreement.

Benefit Plans

UBH administers managed behavioral health care Benefit Plans for Members nationwide. These plans vary in types of benefits and amounts of coverage. All Members shall be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other patients of the Provider. Covered services will be available and accessible to all Members.

Care Advocacy

Care Advocacy Centers (CACs) focus on activities that impact Members' stabilization and recovery, and promote active participation in their care. This approach consists of targeted interventions intended to facilitate Member services, identify Members who may be at risk, and to assist you in the coordination and delivery of care to Members. This approach supports a collaborative relationship between you and the Care Advocate. Care Advocacy activity may include:

- Emphasizing the integration of medical and behavioral care by promoting communication among all treating Providers involved in Members' care
- Ensuring that Members being discharged from facility-based care have appropriate discharge plans, that they understand them and that they are able to access and afford the recommended services
- Using the information on the Wellness Assessments to identify Members who may be at-risk
- Proactively reaching out to Providers to discuss Members' care when an individual has been identified as being at-risk
- Offering clinical consultations with UBH medical staff
- Reaching out to Members in some circumstances to educate, evaluate risk, and offer assistance
- Supporting Members to actively participate in treatment and follow-up care
- Referencing web-based and written information for Members and treating clinicians regarding behavioral health conditions, designed to support informed decision-making

Care Advocate Availability

Each Care Advocacy Center is open for standard business operations Monday through Friday from 8 a.m. to 5 p.m. in their respective time zones. In addition, Care Advocates are

available twenty-four hours a day, seven days a week, including holidays and weekends, to discuss urgent and emergent situations such as inpatient admissions, clinical benefit determinations and decisions, appeals, or any other questions about the care advocacy process. Call the toll-free number on the back of the Member's insurance card to reach the appropriate Care Advocacy staff member.

Affirmative Incentive Statement

Care Advocacy decision-making is based only on the appropriateness of care as defined by the [Level of Care Guidelines](#), Coverage Determination Guidelines, [Psychological and Neuropsychological Testing Guidelines](#), the Member's Benefit Plan, and applicable state and federal laws. The Level of Care Guidelines were developed to produce consistency in decision-making by the Care Advocacy and medical staff and to help you reach optimal clinical outcomes. You will find these, along with the [Best Practice Guidelines](#), [Supplemental and Measurable Guidelines](#), and the Coverage Determination Guidelines at [ubhonline](#) or you can receive a paper copy from Network Management. UBH expects all treatment provided to UBH Members be outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. UBH does not reward its staff, practitioners or other individuals for issuing denials of coverage or service care. Utilization management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

Eligibility Inquiry

The services a Member receives are subject to the terms and conditions of the Benefit Plan with which he or she participates. It is important that you inquire about what services are covered and the Member's enrollment status before providing services. This will help to ensure that you see Members eligible to access this agreement and the services you provide.

We encourage you to use [ubhonline](#) secure "Transactions" to conduct eligibility inquiries. This service is only available to UBH-contracted Providers who are registered with [ubhonline](#). First-time users may [request a user id online](#) or by calling 1-866-209-9320. You may also inquire about eligibility by calling the phone number on the Member's insurance card. Be prepared to provide the following information: the Member's name, address, and identification number, as well as the subscriber's name and date of birth. In addition, in the event that a authorization is required but is not already in place, Providers may initiate a request for pre-authorization of routine outpatient services online.

In addition to contacting UBH to inquire about eligibility, we encourage you to discuss with the Member the importance of keeping you informed of changes in coverage or eligibility status. UBH will not always have the eligibility information at exactly the same time as the organization that controls the eligibility decisions. In addition, COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) rights, including election and payment grace periods, result in significant time during which UBH may not know the exact status of a Member's coverage. Therefore, the Member is often your best source for timely information about eligibility and coverage changes. The Agreement states that if an individual was not eligible for coverage for services rendered, those services shall not be eligible for payment by

UBH. Members who are no longer eligible to access this Agreement under a Benefit Plan revert to the status of being a private paying patient, and you may bill them directly in accordance with applicable law.

Routine Outpatient Services

Authorization or Notification for Mental Health/Substance Use Disorder Benefits

In accordance with the Agreement and many Benefit Plans, some in-network outpatient behavioral health services require an initial pre-authorization or notification. Clarification of these requirements may be obtained through a telephone contact between the Member or family member and UBH staff. The Member web site, liveandworkwell.com, is another avenue for Members to request authorization. However, if a required pre-authorization has not been issued or notification has not been made at the time you are inquiring about eligibility, then you need to initiate it. Eligibility inquiries and authorization requests may be completed on [ubhonline](http://ubhonline.com) or by phone. Be prepared to provide the following information: the Member's name, address, and identification number, as well as the subscriber's name and date of birth.

When a Member calls seeking referrals, UBH staff will collect demographic information, request coordination of benefits information, explain the services available under the Member's Benefit Plan, and obtain a brief description of the presenting problem(s). Referrals are based on the clinical, cultural, and geographic needs of the Member. The Member is responsible for contacting the clinician to schedule an appointment. The Member is advised of the number of sessions available under the Benefit Plan and any deductible, co-payment, and/or coinsurance amount for which he or she will be financially responsible. The Member will be given multiple clinician names and numbers from which to choose to schedule an appointment. Routine authorization or notification letters are mailed directly to the Member. The authorization of benefits is valid for any participating UBH network clinician for routine outpatient services.

When pre-authorization or notification is required, Members are instructed to bring the letter to their initial session. This document includes Member information needed to check benefits and limits of coverage through the secure functions available at [ubhonline](http://ubhonline.com) or when calling UBH. If the Member does not bring the letter to the session, you should contact UBH to ensure that an authorization or notification has been issued.

This initial session is also the time to initiate the ALERT[®] process with the administration of the first Wellness Assessment. For greater detail about ALERT, please see "Clinical Outcomes Model: ALERT" and "Wellness Assessments" in this section of the manual. There is also an [ALERT page on ubhonline](#) that provides additional information.

This authorization or notification will be valid for one year from the date of issue subject to the Member's continued eligibility and terms of the Benefit Plan. UBH expects all treatment provided to UBH Members be outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. If the Member is still in treatment

when the authorization or notification expires, you will need to request continued authorization or notification using secure “Transactions” at [ubhonline](#) or by calling the number on the back of the Member’s insurance card.

Clinical Outcomes Model: ALERT

UBH is committed to partnering with our network to achieve optimal therapeutic outcomes for the individuals we mutually serve. This approach focuses on assisting the network to make consumer-directed, outcomes-based, cost-effective and clinically necessary treatment decisions. With that goal in mind, we have developed the ALERT model, which includes an authorization or notification process, when required.

ALERT stands for ALgorithms for Effective Reporting and Treatment. The system uses member responses to a validated tool, the one-page Wellness Assessment (WA), along with claims data. Both WA and claims information are analyzed through a set of algorithms to determine a Member’s behavioral health status and potential risks. In addition, the algorithms identify cases that may benefit from a review. Such reviews may include consideration of [Best Practice Guidelines](#), Coverage Determination Guidelines, or [Level of Care Guidelines](#). The ALERT algorithms offer opportunities for earlier intervention on potential treatment complications. Care Advocacy will use a combination of letters and/or calls to inform you about any targeted risk or the requirement to complete a review. This allows us to work together more efficiently focusing on those Members with the greatest potential for benefit from such collaboration.

The WA is completed at multiple points rather than at a single point in treatment. This offers more immediate feedback on changes in health status and functioning which may inform further treatment planning, including level of care changes or coordination with medical professionals.

Psychiatrists and prescribing nurses are not required to submit Wellness Assessments, unless they want to participate in the [Campaign for Excellence \(CFE\)](#) outcomes recognition program. Please note that claims-based ALERT algorithms do apply to prescribing clinicians and may require Care Advocacy reviews, as noted above.

Wellness Assessments

The WA includes a range of questions to measure symptom severity and overall well-being, and screens for functional impairment, substance abuse and medical co-morbidity risks. The following process is for UBH members who are receiving routine MH/SUD outpatient services:

- Member contacts UBH, either online or by phone, to request authorization when required by the Benefit Plan for outpatient treatment. If not required by the Benefit Plan, the Member may still call for referrals.
- UBH provides referrals to in-network clinicians or groups based on clinical and geographic needs. If required, an authorization is generated, allowing the Member to see any UBH-contracted clinician for routine outpatient psychotherapy services.

- Member calls the clinician directly to schedule an appointment. When applicable, the UBH Member brings a copy of the authorization to the initial appointment. To determine if a member's plan requires authorization, go to the [ubhonline](#) "Eligibility & Benefits" section available in secure "Transactions", or call the number on the back of the Member's insurance card. Failure to obtain a required authorization may result in denial of claim payment. To obtain a copy of an existing authorization or to initiate an authorization request:
 - Go to ubhonline, where registered users can access the authorization inquiry and authorization request functions in the secure "Transactions" area.
 - If you are not registered, you may call the number on the back of the Member's insurance card.
- You provide the one-page WA to each new UBH Member, or to the parent/guardian of a child or adolescent patient.
- You promptly return each completed WA to UBH as instructed on the form.
- A second WA is administered between session three and five. UBH reviews the WA and alerts you if a targeted risk is identified. You will either be notified by letter, or contacted by a Care Advocate to discuss the case and/or assist in coordinating additional services.
- A follow-up WA will also be sent by UBH directly to the Member approximately four months after the initial evaluation.

The information contained in the Wellness Assessment (WA) is confidential and will not be shared with the Member's employer, medical Benefit Plan or medical clinicians without the Member's consent. A Member may also decline to participate in ALERT. If this occurs, submit a WA to UBH by completing the clinician and Member demographic sections and filling in the "MRef"(member refusal) bubble located in the top demographic section of the WA. In the case of Members who are minors (except for those who are emancipated or able to consent to their own treatment under the laws of your state), the parent or guardian should be asked to complete the form.

The two versions of the Wellness Assessment, Adult and Youth, are also available in Spanish. WA forms can be obtained from [ubhonline](#) or by calling the Forms Hotline at **(800) 888-2998 ext. 415-547-5354**. You may go to [ubhonline](#) for detailed information about [completing and downloading WAs](#).

Practice Management

Practice Management staff, in coordination with other UBH Departments, works with our high volume Network Providers on the following key elements of the ALERT program:

- Tracking and monitoring of compliance with the submission of Wellness Assessments
- Evaluating compliance with Care Advocacy processes and contractual obligations
- Managing outliers, through the identification of practice patterns that appear to fall outside typical patterns, including the measurement of improvement over time
- Identifying and resolving potential practice patterns that may constitute Fraud, Waste and/or Abuse (see Fraud, Waste and Abuse section)

WorkLife

A Member who is actively engaged in an Employee Assistance Program (EAP) or in Behavioral Health treatment may also possess WorkLife (WL) benefits. In many cases, the WorkLife benefit can complement needs while in treatment, by providing educational materials or verified community resources. Support groups, financial assistance programs, and referral to community social service agencies are only some examples of what can be provided. To secure WorkLife services a Member or family member may access liveandworkwell.com. Each Member can use an employer-specific access code to enter a tailored [liveandworkwell](http://liveandworkwell.com) web site covering employer-specific benefit information. If they do not know their access code, please direct the Member or family member to call the EAP/WL or Behavioral Health number on their enrollment card. Members will be directed to a WorkLife Specialist who will assess and consult with the caller about how to best meet his or her needs.

Employee Assistance Program (EAP) Benefit and Authorization

The EAP benefit is designed to provide assessment and referral, as well as a brief counseling intervention for Members and their families. The typical EAP benefit offers a limited number of sessions with an MH/SUD clinician and is not designed to provide a complete course of psychotherapeutic treatment. Not all UBH Members have an available EAP benefit, but those who do can generally see any contracted UBH clinician for EAP services (there are some limitations around the use of EAP benefits with psychiatrists). Authorizations for EAP services are clinician-specific and must be initiated by Members or network clinicians. In either case, the EAP Authorization letter is sent to the clinician.

UBH makes every effort to refer Members with EAP benefits to EAP specialty clinicians. However, when an EAP specialist is not available in the area, UBH will refer to an appropriate network clinician based on the Member's presenting needs. As a clinician in the UBH network, you are expected to accept Members who present with an EAP benefit in compliance with your Agreement.

In an EAP benefit, all pre-authorized sessions are paid by UBH at 100 percent of the UBH contracted rate of reimbursement. The Member has no financial responsibility (i.e., the Member does not have a deductible, co-payment, or coinsurance amount). The specific policies and procedures for each EAP product may vary, and specific instructions for each plan will be provided on an authorization of benefits form.

EAP benefits require specific pre-authorization. In the authorization of routine MH/SUD benefits the Member receives the authorization letter; in the EAP process, you receive the authorization letter. To obtain an EAP authorization, call the number on the back of the Member's insurance card. Most Members have a dedicated EAP or MH/SUD number. Members are able to request EAP authorization through liveandworkwell.com.

You must obtain a new EAP authorization when a new benefit year begins.

EAP Transition to MH/SUD Benefits

Some Members will have a managed behavioral health care benefit through UBH in addition to their EAP benefit. In some instances, an authorization or notification may be necessary for those Members who transition from EAP to MH/SUD benefits for routine psychotherapy services. To obtain an authorization or notification, use the “Auth Request” function through [ubhonline](#), or send the Benefit Transition Notification (BTN) form, enclosed with your EAP authorization to UBH. Upon completion of the ubhonline “Auth Request” or receipt of the BTN form UBH will generate an MH/SUD benefit authorization. The Member will receive a letter indicating that routine outpatient psychotherapy services are authorized. You will not receive a copy of this letter from UBH, but can obtain a copy at [ubhonline](#). Members will be instructed to bring this letter to their initial MH/SUD session with you. It is not necessary to wait for the Member to bring in the authorization letter before continuing services.

If a Member chooses not to continue treatment with the EAP provider, they can bring the authorization or notification, when required, to any in-network MH/SUD provider. The Member has been instructed to bring a copy of the letter to the first MH/SUD session. If the Member does not bring this letter you may check [ubhonline](#) to see whether or not the Member has an MH/SUD authorization or notification. You may also call the number on the back of the Member’s insurance card. If an authorization or notification is not in place, you may request it online or by phone at the time of your initial inquiry.

Once a Member’s benefits have transitioned from EAP to MH/SUD coverage, his or her financial responsibility will vary according to the Member’s Benefit Plan. The Member may be responsible for a deductible, co-payment and/or coinsurance amount.

EAP and Medication Management

Medication management services covered under EAP services may require prior authorization or notification.

EAP and ALERT

If the Member you are seeing has a combined EAP and MH/SUD benefit through UBH, administer the Wellness Assessment (WA) at the initial EAP session. If the member eventually transitions to MH/SUD benefits it is not necessary to have them complete another initial WA at the time of the transition. However, you should administer the second WA between sessions three and five. For greater detail about ALERT, please see “Outcomes Clinical Model: ALERT” and “Wellness Assessments” in this section of the manual.

MH/SUD Medication Management Services

Psychiatrists and prescribing APRNs are not required to obtain prior authorization for the initial consult, routine medication management sessions and other routine outpatient services, such as the 90801, 90805, 90806, and 90862.

Pharmaceutical Management

Pharmacy benefits are not managed by UBH. For information about formularies, pharmacy benefits and cost management programs, please contact the medical or pharmacy number on the Member's insurance card.

Applied Behavioral Analysis Services

Coverage for Applied Behavioral Analysis (ABA) services requires prior authorization by a UBH Autism Care Advocate. Please be aware that not all Benefit Plans provide coverage for ABA services and prior to beginning care, network Board Certified Behavior Analysts (BCBA) and ABA agencies must contact UBH to verify eligibility, review treatment plans and obtain authorization.

Authorization of Benefits for Non-Routine Outpatient Services

Non-routine outpatient services, including but not limited to psychological testing, or extended sessions, require ongoing authorization prior to providing services. To pursue authorization, please call the number on the back of the Member's insurance card. Authorizations for non-routine outpatient services are specific to the clinician. The clinician will receive a copy of this authorization.

Authorization or Notification for Inpatient and Subacute Services

In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists. All inpatient and subacute level of care admissions require notification or pre-authorization by a Care Advocate. Be prepared to discuss clinical issues related to the Member, such as symptom severity, functional impairment and risk factors. A complete copy of the [Level of Care Guidelines](#) is available at [ubhonline](#). You may also request a paper copy of these guidelines from Network Management.

Services provided to Members in an inpatient psychiatric or substance abuse unit are reviewed initially and may be reviewed concurrently by licensed clinicians. These reviews provide information regarding the patient's status and need for continued inpatient care. UBH reserves the right to require a direct conversation with the attending psychiatrist before authorizing benefits for any inpatient stay. For all potential adverse determinations based on relevant UBH guidelines, UBH makes a peer reviewer available to you before the decision is made so that you may provide additional information about the case. If you do not contact UBH prior to the expiration of the decision time frame, the peer reviewer will still be available to discuss the basis of an adverse determination. If you have received an authorization letter or an adverse determination letter and you wish to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, please call the toll-free number in the letter. In the event benefits are not authorized, UBH will support clinicians or facility staff to maximize benefits that are available.

Emergency Admissions

In the event of an emergency admission for a Member requiring immediate treatment and stabilization due to an MH/SUD condition, facilities should stabilize and treat the Member as soon as possible. Circumstances that warrant an emergency admission are those in which there is a clear and immediate risk to the safety of the Member or another person as a direct result of mental illness or substance use disorder. Facilities should also immediately notify UBH.

A medically necessary admission following stabilization in an emergency room may require authorization or notification prior to the admission. Depending on the Member's Benefit Plan and your facility Agreement, charges for ER services may be considered part of the facility inpatient per diem in the event the Member is admitted to the facility.

If appropriate, UBH will retrospectively certify coverage of admissions for emergency services provided; however, depending on the specific circumstances of each individual case, UBH reserves the right to deny coverage for all or part of an admission. All requests for retrospective reviews must be received by UBH within 180 calendar days of the date the services were provided to the Member, unless state law mandates otherwise.

Retrospective Review Process

A retrospective review occurs only on those rare occasions when an initial request for authorization or notification, when required, is made after services have already been delivered but no claim has been filed. Retrospective review requests must be submitted within 180 calendar days following the date(s) of service unless otherwise mandated by state law. For all retrospective reviews, UBH will issue a determination within 30 calendar days of receipt of the request, unless otherwise required by state law. Any retrospective review requests received outside the established time frame will not be processed by UBH.

Pilot Projects Affecting Authorization Requirements

UBH may occasionally launch pilot projects that alter the pre-authorization requirements described above.

We will advise you of any initiatives affecting authorization requirements in a separate communication. Follow the expected pre-authorization requirements unless you have received notification from UBH of your inclusion in a pilot project.

Psychological Testing

All psychological testing must be pre-authorized for both outpatient and inpatient services. Psychological testing is considered after a standard evaluation (including clinical interview, direct observation and collateral input, as indicated) has been completed and one of the following circumstances exists:

- There are significant diagnostic questions remaining that can only be clarified through testing
- There are questions about the appropriate treatment course for a patient, or a patient has not responded to standard treatment with no clear explanation, and testing would have a timely effect on the treatment plan
- There is reason to suspect, based on the initial assessment, the presence of cognitive, intellectual and/or neurological deficits or impairment that may affect functioning or interfere with the patient’s ability to participate in or benefit from treatment, and testing will verify the presence or absence of such deficits or dysfunction

Generally, psychological testing purely for educational evaluations, learning disabilities, developmental delays, admission to organizations, or judicial requirements is not covered. Also not covered are tests performed routinely as part of an assessment or tests to determine the extent of potential neurological damage. Requests for neurological assessments are most often channeled through a neurologist for initial evaluation. This service is typically covered under the Member’s medical Benefit Plan, and may not be considered a behavioral health benefit. To determine benefit coverage you should pursue a benefits determination in order to coordinate financial responsibilities with the Member.

If you have questions regarding coverage for psychological testing, interpretation or report writing you will find Testing Guidelines and Operational Guidelines at [ubhonline](#) under “Guidelines/Policies,” then “Psychological/Neuropsychological Testing Guidelines.” You may also contact the appropriate Care Advocacy Center.

Access to Outpatient MH/SUD and EAP Care

As part of our Quality Improvement Program, and to ensure that all Members have access to appropriate treatment as needed, we develop, maintain, and monitor a network with adequate numbers and types of clinicians and outpatient programs. We require that the network adhere to specific access standards, which are outlined as follows:

- Respond within 24 hours to a Member request for routine outpatient care
- An initial MH/SUD appointment must be offered within 10 business days of the request
- An initial EAP appointment must be offered within three business days
- Urgent appointments must be offered within 48 hours
- Non-life-threatening emergencies must be offered within six hours
- An immediate appointment must be offered for any life-threatening emergencies

If more stringent time frames are required by state or federal law, we require that the network adhere to the more stringent time frames.

UBH expects that Members will generally have no more than a 15 minute wait time for their appointment in your office. In addition, any rescheduling of an appointment must occur in a manner that is appropriate for the Member’s health care needs and ensures continuity of care consistent with good professional practice.

In cases where a Member is being discharged from acute inpatient care, UBH expects a follow-up outpatient appointment to occur within seven (7) days from the discharge date. This appointment should be included in the facility discharge plan.

If you are unable to take a referral, immediately direct the Member to the number on the back of his or her insurance card so that he or she can obtain a new referral.

Continuation of Services after Termination

Network clinicians, group practices and agencies who wish to withdraw from the UBH network are required to notify UBH, in writing, 90 calendar days prior to the effective date of termination, unless otherwise stated in your Agreement or required by state law. With the exception of terminations due to quality-related issues, change in license status, or suspected fraud, waste or abuse, clinicians are obligated to continue to provide treatment for all UBH members under their care for 90 calendar days after the effective date of the contract termination until one of the following conditions is met (whichever is shortest):

- The member is transitioned to another UBH network clinician
- The current episode of care has been completed
- The member's UBH benefit is no longer active

Please note that state-specific laws will be followed when they provide for a different post-termination timeframe.

To ensure continuity of care, UBH will notify members affected by the termination of a clinician, group practice or agency at least 30 calendar days prior to the effective date of the termination whenever feasible. UBH will assist these Members in selecting a new clinician, group or agency. You are also expected to clearly inform Members of your impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date, in compliance with your Agreement.

Network facilities that withdraw from the UBH network are required to notify UBH, in writing, 120 calendar days prior to the effective date of the termination, unless otherwise stated in your Agreement or required by state law. The Care Advocate may continue to issue authorizations for treatment during the termination period at the UBH contracted rate as provided by your Agreement. To ensure there is no disruption in a Member's care, UBH has established a 120-calendar-day transition period for voluntary terminations. In the event that a facility's participation is terminated due to quality-related issues, fraud or change in license status requiring immediate transfer of a Member to another facility, UBH and the facility will coordinate to ensure a safe and effective transition of care.

In some cases, you and the Care Advocate may determine it is in the best interest of the Member to extend care beyond these timeframes. UBH will arrange to continue authorization for such care at the UBH contracted rate. You may continue to collect all applicable co-payments and deductible amounts. The facility continues under contract at the existing rates through the completion of the episode of care at any level of care provided by the facility. Members may not be balance billed.

TREATMENT PHILOSOPHY

UBH is committed to creating and maintaining relationships with network Providers. We believe that optimal treatment is attained when delivered in the setting that is both the least restrictive and the one with the greatest potential for a favorable outcome. Based on more than 20 years of experience, we know it is the efforts of our clinical network that give our Members the best opportunity to achieve a level of functioning that supports their quest to live healthier lives. As a result, our priority is creating relationships with network Providers that ensure appropriate, time-effective clinical treatment. Through this partnership we look to foster positive outcomes for Members receiving behavioral health services.

In accordance with your Agreement, you are required to provide services in a manner that is consistent with professional and ethical standards as set forth by national certification and state licensing boards, and applicable law and/or regulation regardless of a Member's Benefit Plan or terms of coverage. Resources are available to you which outline the expectations for UBH network treatment quality. This manual addresses assessment, treatment and discharge planning, coordination of care, and member rights and responsibilities (see also the "Treatment Record Documentation Requirements" section of this manual). Additional resources in these areas can be found at [ubhonline](#)[®]. Select "Clinical Resources", and then click on "Guidelines/Policies", "Patient Education" or "Forms". You will also find the following guidelines, including but not limited to:

- Level of Care Guidelines
- Psychological/Neuropsychological Testing Guidelines
- Coverage Determination Guidelines
- Best Practice Guidelines
- Supplemental and Measurable Guidelines

UBH participates with NCQA quality of care measures and incorporates these standards into our requirements and guidelines. In addition to [ubhonline](#), the newsletter, *Network Notes*, serves as a bi-annual communication for news and policy updates of interest to the UBH network.

Level of Care Guidelines

The UBH [Level of Care Guidelines](#) are intended to promote optimal clinical outcomes and consistency in the authorization of benefits by Care Advocacy and medical staff. They are available at [ubhonline](#) or you may request a paper copy by contacting Network Management.

Best Practice Guidelines

UBH adopted [Best Practice Guidelines](#) from external nationally recognized organizations. The guidelines cover a number of, but not all, diagnostic categories. Included in these guidelines are high-volume diagnostic categories and disorders that have significant evidence of being "high risk". In addition, UBH has created [Supplemental and Measurable Guidelines](#)

which provide objective and evidence-based measurable components for some conditions. Links to these guidelines may be found at [ubhonline](#).

Coverage Determination Guidelines

UBH's Coverage Determination Guidelines are intended to standardize the interpretation and application of terms of the Member's Benefit Plan including terms of coverage, Benefit Plan exclusions and limitations. They are available on [ubhonline](#) or you may request a paper copy by contacting Network Management.

Managing Expectations through Education

We encourage you to educate Members about what to expect during treatment. Members benefit from clear explanations about their diagnosis, prognosis, treatment plan, including the projected length and course of treatment, and the potential benefits of medication, if medication is indicated. You can assist Members in managing their expectations by explaining that treatment will be focused on their current presenting problems and symptoms. Establishing realistic expectations sets the stage for greater treatment adherence.

We encourage you to discuss all treatment options and the associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this manual is intended to interfere with your relationship with Members as patients.

Assessment

Thorough clinical assessments are required, and should be included in the clinical record.. The biopsychosocial history includes previous medical and behavioral health conditions,, interventions, outcomes, and lists current and previous medical and behavioral health providers. The mental status exam includes an evaluation of suicidal or homicidal risk. A substance use screening should occur for Members over the age of 11 years, noting any substances abused and treatment interventions. Other areas to be covered in the assessment are developmental history, education, legal issues, and social support. Cultural and spiritual considerations should be covered. A note should also be made of any community resources accessed by the Member. A culmination of these assessment aspects, including negative findings, will yield a solid treatment diagnosis utilizing all current DSM axes. For routine outpatient services, a Wellness Assessment is to be part of every new treatment episode. This tool contributes to comprehensive treatment planning (see the "Benefit Plans, Certification, EAP, and Access to Care" chapter of this manual).

Treatment Discharge Planning

Effective discharge planning addresses how a Member's needs will be met during transition from one level of care to another or to a different treating clinician. This planning begins with the onset of care and should be documented and reviewed over the course of care. Treatment planning will focus on achieving and maintaining a desirable level of functioning after the completion of the current episode of care. Effective treatment and discharge

planning is a key indicator of the ongoing health and well-being of a Member following acute care. (See also the “Treatment Record Documentation Requirements” section of this manual.)

Care Advocates will work with you to begin the discharge or treatment planning process for Members at the time that services are initiated. As appropriate, the discharge or treatment planning process will involve you, a Care Advocate, the Member, the Member’s family and/or representative, the clinician at the next level of care, and/or relevant community resources. Discharge planning involves assessment of the Member’s needs including current functioning, resources, and barriers to treatment access or compliance.

Discharge instructions should be specific, clearly documented and provided to the Member prior to discharge. For discharge from an acute inpatient level of care, UBH expects that a patient’s follow-up appointment will be scheduled prior to discharge and within seven (7) days of the date of discharge. This time frame is part of the Healthcare Effectiveness Data and Information Set (HEDIS[®]) measure established by NCQA to compare health plans on meeting this follow-up standard for mental health services. It is assessed on an annual basis. Throughout the treatment and discharge planning process, it is essential that Members be educated regarding the importance of enlisting community support services, communicating treatment recommendations to all treating professionals, and adhering to follow-up care. Members have the right to decline permission to release information to other treating professionals, but should be informed about the potential risks and benefits of this decision and how it affects coordination of care.

Communication with Primary Physicians and Other Health Care Professionals

To coordinate and manage care between behavioral health and medical professionals, UBH expects that you will seek to obtain the Member’s consent to exchange appropriate treatment information with medical care professionals (e.g., primary physicians, medical specialists) and/or other behavioral health clinicians (e.g., psychiatrists, therapists). Coordination and communication should take place at: the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate. Coordination of services improves the quality of care to Members in several ways:

- It confirms for a primary physician that his or her patient followed through on a behavioral health referral
- It minimizes potential adverse medication interactions for Members who are prescribed psychotropic medication
- It allows for better management of treatment and follow-up for Members with coexisting behavioral and medical disorders
- It can reduce the risk of relapse with members in some populations, as with substance use disorders

The following guidelines are intended to facilitate effective communication among all treatment professionals involved in a Member’s care:

- During the diagnostic assessment session, request the Member's written consent to exchange information with all appropriate treatment professionals
- After the initial assessment, provide other treating professionals with the following information within two weeks:
 - Summary of Member's evaluation
 - Diagnosis
 - Treatment plan summary (including any medications prescribed)
 - Primary clinician treating the Member
- Update other behavioral health and/or medical clinicians when there is a change in the Member's condition or medication(s)
- Update other health care professionals when serious medical conditions warrant closer coordination
- At the completion of treatment, send a copy of the discharge summary to the other treating professionals
- Attempt to obtain all relevant clinical information that other treating professionals may have pertaining to the patient's mental health or substance use problems

Some Members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. UBH, as well as accrediting organizations, expect you to make a “good faith” effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the member.

Member Rights and Responsibilities

You will find a copy of the UBH Member Rights and Responsibilities at the end of this manual. You may request a paper copy by contacting Network Management. These rights and responsibilities are in keeping with industry standards. All Members benefit from reviewing these standards in the treatment setting. UBH requests that you display the Patient Rights and Responsibilities in your waiting room, or have some other means of documenting that these standards have been communicated to UBH Members.

The Clinical Technology Assessment Committee (CTAC)

The CTAC meets quarterly to review current medical and scientific literature. A UBH Medical Director chairs this multidisciplinary committee that includes at least one external clinician on a standing basis. In addition, this committee consults on an as-needed basis with professionals who are actively working with relevant technology and/or clinical issue(s) that may be impacted by the technology under review. This Committee examines the use of new technologies and new applications of existing technologies for the assessment and treatment of behavioral health conditions. The Committee also reviews existing technologies when questions arise as to their application. The Committee recommends as “best practices” those treatments for which there is published scientific evidence of efficacy and safety. This evidence must consist of controlled studies of adequate sample size, published in established peer-reviewed journals. State and federal regulations are reviewed to determine whether any regulations are in place that may support or have proven the use of a technology.

If you have a technology that you would like to have reviewed by this committee, please contact the Care Advocacy Center with which you most often work. Make your request to the Medical Director for that region and he or she will notify the committee chair of your interest.

Services of Interpreters

It is typically your responsibility to arrange for the services of interpreters, when indicated, for Members under your care. Financial responsibility for such services varies depending on the Benefit Plan and/or governing law; accordingly, these costs may be assigned to you, to UBH, to the member or may be shared between any or among all of these parties. You may contact a Care Advocate to determine who is financially responsible.

TREATMENT RECORD DOCUMENTATION REQUIREMENTS

In accordance with your Agreement, you are required to maintain high quality medical, financial and administrative records related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community, and conform to all applicable laws and regulations including, but not limited to, state licensing and/or national certification board standards.

In order to perform required utilization management and quality improvement activities, UBH may request access to such records, including, but not limited to, claims records and treatment record documentation. You are permitted under HIPAA Treatment, Payment or Healthcare Operations to provide requested records as contractually required. In accordance with HIPAA and the definition of Treatment, Payment or Healthcare Operations, you must provide such records upon request. Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to UBH and its Payors, customers, clinicians, and facilities.

UBH may review your records during a scheduled On-Site Audit or may ask you to submit copies of the records to UBH for review. An On-Site Audit and/or Treatment Record Review may occur for a number of reasons, including, but not limited to:

- Reviews of facilities without national accreditation such as The Joint Commission, CARF or other agency approved by UBH
- Audits of high-volume clinicians
- Routine random audits
- Audits related to claims coding or billing issues
- Audits concerning quality of care issues identified by UBH or brought to UBH's attention by members, family members or their representatives
- Audits of clinicians with a home office
- Audits related to a member complaint regarding the physical environment of an office or facility

The audits may focus on the physical environment (including safety issues), policies and procedures, and/or thoroughness and quality of documentation within treatments records. UBH has established a passing performance goal of 85% for both the Treatment Record Review and On-Site Audit. On-Site Audit or Treatment Record Review scores under 85% will require a written Corrective Action Plan (CAP). Scores under 80% require submission of a written CAP and a re-audit within six months of the implementation of the CAP.

Treatment Record — Content Standards

UBH expects that all non-electronic treatment records are written legibly in blue or black ink, and at a minimum include:

- The Member's name or identification number on each page of the record
- 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
- Treatment record entries include the date and start and stop time of service, CPT code billed, notation of session attendees, the responsible clinician's name, professional degree, license, and relevant identification number
- Treatment records should be made contemporaneously with treatment description and include the date of entry; if records are not contemporaneously made with treatment, then the date of service should be noted along with date of entry
- Clear and uniform modifications; any error is to be lined through so that it can still be read, then dated and initialed by the person making the change
- Clear documentation of medication allergies, adverse reactions and relevant medical conditions; if the member has no known allergies, history of adverse reactions or relevant medical conditions, this should be prominently noted
- Clear and uniform medication tracking that provides a thorough picture of all medications taken by the patient from the onset of care through discharge includes the following:
 - Standing, P.R.N. and STAT orders for all prescription and over-the-counter medications
 - The date medications are prescribed along with the dosage and frequency
 - Informed member consent for medication, including the member's understanding of the potential benefits, risks, side effects, and alternatives of the medications
 - Changes in medication and/or dosage should be clearly documented along with the clinical rationale for the changes
 - Discharge summaries should specify all medications and dosages at the time of discharge
- A clear summary of presenting problems, the results of mental status exam(s), relevant psychological and social conditions affecting the Member's medical and psychiatric status, and the source of such information
- Prominent documentation (assessment and reassessment) of special status situations, when present, including but not limited to imminent risk of harm, suicidal or homicidal ideation, self-injurious behaviors, or elopement potential. It is also important to document the absence of such conditions
- A medical and psychiatric history including previous treatment dates, clinician or facility identification, therapeutic interventions and responses, sources of clinical data, and relevant family information
- For children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic)
- For Members 12 years of age and older, documentation includes past and present use of cigarettes or alcohol, as well as illicit, prescribed or over-the-counter medications

- Documentation of a DSM-IV-TR diagnosis, including all five axes, consistent with the presenting problem(s), history, mental status examination, and other assessment data
- Treatment plan documentation needs to include the following elements:
 - Specific symptoms and problems related to the Axis I diagnosis of the treatment episode
 - Critical problems that will be the focus of this episode of care are prioritized
 - Relates the recommended level of care to the level of impairment
 - Member (and, when indicated, family) involvement in treatment planning
 - Treatment goals must be specific, behavioral, measurable, and realistic
 - Treatment goals must include a time frame for goal attainment
 - Progress or lack of progress towards treatment goals
 - Rationale for the estimated length of the treatment episode
- Progress notes include
 - Member strengths and limitations in achieving treatment plan goals and objectives
 - Treatment interventions that are consistent with those goals and objectives
 - Dates of follow up visits
 - Documentation of missed appointments
- Documentation of on-going discharge planning (beginning at the initiation of treatment) includes the following elements:
 - Criteria for discharge
 - Identification of barriers to completion of treatment and interventions to address those barriers
 - Identification of support systems
- A discharge summary is completed at the end of the treatment episode that includes the following elements:
 - Reason for treatment episode
 - Summary of the treatment goals that were achieved
 - Specific follow up activities/aftercare plan
- Documentation of coordination of care activities between the treating clinician or facility and other behavioral health or medical clinicians, facilities, or consultants. If the member refuses to allow coordination of care to occur, this refusal and the reason for the refusal must be documented. Coordination of care should occur:
 - At the initiation of treatment
 - Throughout treatment as clinically indicated
 - At the time of transfer to another treating clinician, facility, or program
 - At the conclusion of treatment
- Documentation of referrals to other clinicians, services, community resources, and/or wellness and prevention programs
- When care involves more than one family member, separate treatment records must be maintained
- Billing records should reflect the member who was treated and the modality of care

Guidelines for Storing Member Records

Below are additional guidelines for completing and maintaining treatment records for Members.

- Practice sites and facilities must have an organized system of filing information in treatment records
- Treatment records must be stored in a secure area and the site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable laws and regulations, including HIPAA
- The site must have a process in place to ensure that records are available to qualified professionals if the treating clinician is absent
- Treatment records are required to be maintained for a minimum period of seven years from the date of service, or in accordance with applicable state or federal laws or regulations, whichever is longer. Termination of the Agreement has no bearing on this requirement
- Financial records concerning covered services rendered are required to be maintained from the date of service for ten (10) years, or the period required by applicable state or federal law, whichever is longer. Termination of the Agreement has no bearing on this requirement

Member Access to Medical/Mental Health Records

A Member, upon written request and with proper identification, may access his/her records that are in the possession of UBH. Before a Member is granted access to his/her records, the record will first be reviewed to ensure that it contains only information about the Member. Confidential information about other family members that is in the record will be redacted.

PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law enacted to ensure privacy and security of a consumer's Protected Health Information (PHI). PHI is basically defined as individually identifiable health information that is transmitted or maintained in any form or medium. A few examples of PHI include an individual's name, social security number or consumer identification number, address, and date of birth.

All aspects of UBH operations are compliant with the required HIPAA privacy practices as well as other applicable state and federal laws. Below are some of the highlights of these practices.

Uses and Disclosures of PHI

UBH has established policies relating to requests for and disclosure of PHI in accordance with HIPAA and other applicable federal and state laws. These policies ensure that only the minimum amount of information necessary is disclosed to accomplish the purpose of the disclosure or request.

Release of Information

It is UBH policy to release information only to the individual, or to other parties designated in writing by the individual, unless otherwise required or allowed by law. For each party that the individual designates permission to access their PHI, he or she must sign and date a Release of Information specifying what information may be disclosed, to whom, and during what period of time. This policy is not applicable to PHI being exchanged with a UBH network clinician, facility or other entity designated by HIPAA for the purposes of Treatment, Payment, or Health Care Operations¹.

Identification and Authentication

UBH requires that anyone requesting access to PHI be appropriately identified and authenticated. Members and personal representatives, for example, are required to provide the Member identification number or subscriber number and the Member's or subscriber's date of birth. You or your administrative staff are identified and authenticated in a number of ways and may be asked for your federal tax identification number or physical address as part of this verification process.

Internal Protection of Verbal, Written, and Electronic PHI

UBH works with the UnitedHealth Group, UBH's parent organization, to ensure that all physical and logical safeguards are in place to protect against the unauthorized use, disclosure, modification, and destruction of PHI across all media (e.g., paper records and electronic files). All employees of UBH receive training and are familiar with the HIPAA privacy practices relevant to their job duties and responsibilities.

¹“Treatment, Payment, or Health Care Operations” as defined by HIPAA include: 1) Treatment – Coordination or management of health care and related services; 2) Payment purposes – The activities of a health plan to obtain premiums or fulfill responsibility for coverage and provision of benefits under the health plan; and 3) Health Care Operations – The activities of a health plan such as quality review, business management, customer service, and claims processing

Disclosure to Plan Sponsors or Employers

Summary health information may be released to a Plan Sponsor¹ without the authorization of the affected individual. This information may be used for the purpose of obtaining premium bids or modifying, amending, or terminating the Group Health Plan. It may also be used for providing access to employees of an employer or Plan Sponsor to carry out administrative duties of a Health Plan related to Treatment, Payment or Health Care Operations.

UBH Members receive Privacy Notices outlining the uses and disclosures of their PHI and their rights, as well as the legal duties of their health plan to ensure protection of their PHI under HIPAA. This Privacy Notice is posted on our member web site, liveandworkwell.com and [ubhonline](http://ubhonline.com)[®] under “[Privacy & HIPAA](#)”, or is available in paper copy by contacting Network Management for your state.

National Provider Identifier

The purpose of a National Provider Identifier (NPI) is to improve the efficiency and effectiveness of the electronic transmission of health information. The implementation of this provision in 2007 is in compliance with HIPAA. UBH requires the billing clinician to include NPI information on all electronic claims. In addition to all electronically submitted claims, some states mandate that the NPI be used on all claims (whether paper or electronic submission is used). For more information about obtaining an NPI, you may contact the Center for Medicare and Medicaid Services at [Centers for Medicare & Medicaid Services](#). To ensure alignment with UBH and claims processing, visit [ubhonline](http://ubhonline.com). From the left side “Quick Links” menu, select “NPI”.

¹ “Plan Sponsor” as defined in ERISA, means the employer in the case of a Group Health Plan maintained by a single employer, the employee organization in the case of a plan maintained by such organization, or the committee or similar group or representatives in the case of a plan maintained by two or more employers or jointly by one or more employers and employee organizations.

QUALITY IMPROVEMENT

Participation in the UBH Quality Improvement Program

UBH is committed to the highest quality of care provided in a manner consistent with the dignity and rights of Members and to meeting or exceeding customer expectations. The UBH Quality Improvement (QI) Program monitors: accessibility; quality of care; appropriateness, effectiveness and timeliness of treatment; and Member satisfaction. The QI Program is comprehensive and incorporates the review and evaluation of all aspects of the managed behavioral health care delivery systems. If you have any feedback regarding QI projects and processes, please contact Network Management.

UBH has established committees that address concerns related to Members, clinicians, facilities, and UBH. These committees include Regional Quality Improvement Committees, Network Clinician Advisory Committees, and Peer Review Committees. Compliance with the UBH QI Program is required in accordance with your Agreement, including cooperation with UBH and customers in their efforts to adhere to all applicable laws, regulations and accreditation standards.

The key components of the QI Program required of you as a participating provider include, but are not limited to:

- Ensuring that care is appropriately coordinated and managed between you and the Member's primary medical physician and other treating clinicians and/or facilities
- Cooperation with On-site Audits and requests for treatment records
- Cooperation with the Member complaint process (e.g., supplying information necessary to assess and respond to a complaint)
- Cooperation with the Campaign for Excellence (CFE) and Facility Quality Measure (FQM) programs (Please refer to the CFE and FQM sections for more information)
- Responding to inquiries by UBH Regional Quality Improvement Committee staff or UBH Corporate Quality Improvement staff
- Participation in UBH Regional Quality Improvement initiatives related to enhancing clinical care or service for Members
- Assisting UBH in maintaining various accreditations as appropriate and as requested by UBH
- Submission of information related to the UBH Patient Safety Program
- Helping to ensure Members receive rapid follow-up upon discharge from an inpatient level of care

Upon request, UBH makes information available about the QI Program, including a description of the QI Program and a report on UBH's progress in meeting its goals. Some of the activities that may involve you are described in more detail below.

Sentinel Events

Sentinel events are defined as unexpected occurrences involving death or serious physical or psychological injury, or risk thereof, which occur during the course of a Member receiving behavioral health treatment. If you are aware of a sentinel event involving a Member, you must notify UBH Care Advocacy within one business day of the occurrence.

UBH has established processes and procedures to investigate and address sentinel events. This includes a centralized Sentinel Event Committee, chaired by medical directors within UBH, and incorporates appropriate representation from the various behavioral health disciplines. You are required to cooperate with sentinel event investigations.

UBH supports the Joint Commission's National Patient Safety Goals as they apply to behavioral health care. These Safety Goals are available on the Joint Commission web site at www.jointcommission.org.

Member Satisfaction Surveys

On at least an annual basis, UBH conducts a Member Satisfaction Survey of a representative sample of Members receiving outpatient and inpatient behavioral health services within the UBH network. The results of the survey are compared to performance goals. Improvement action plans are developed to address any areas not meeting standards. Both the survey results and action plans are shared as appropriate with Members, customers, clinicians, and facilities.

Clinician Satisfaction Surveys

UBH regularly conducts a satisfaction survey of a representative sample of clinicians delivering behavioral health services to UBH Members. This survey obtains data on clinician satisfaction with UBH services including intake, care advocacy, clinician services, and claims administration.

The results of the survey are compared to performance goals and to previous years for tracking and trending. Improvement action plans are developed to address any areas not meeting standards. Both the survey results and action plans are shared as appropriate with customers, clinicians, and facilities.

Preventive Behavioral Health Services

UBH selects and designs its preventive behavioral health programs based on the demographic, cultural, clinical, and risk characteristics of Members. You may be enlisted to participate in the design and implementation of preventive behavioral health programs. UBH encourages all clinicians and facility-based clinical staff to review the content and process of UBH preventive health programs. These programs are described at [ubhonline](http://ubhonline.com)[®]. If you would like a paper copy of these programs please contact Network Management. UBH periodically communicates additional information about these programs, including

modifications in program process and content, on ubhonline and in the newsletter, *Network Notes*.

Practice Guidelines

UBH has adopted clinical guidelines from nationally recognized behavioral health organizations and groups. We also have Supplemental and Measurable Guidelines based on existing nationally recognized guidelines, additional literature review and clinician input. The development of these Supplemental and Measurable Guidelines is driven by quality initiatives aimed at improving clinical outcomes for Members. The adopted **Best Practice Guidelines** and the **Supplemental and Measurable Guidelines** are available through **ubhonline**. On the home page left sidebar “Quick Links” menu, select “Guidelines/Policies”. Your feedback is encouraged on all guidelines and any suggestions on new guidelines to be considered for adoption are welcome. If you would like a paper copy of these guidelines please contact Network Management.

Complaint Investigation and Resolution

You are required to cooperate with UBH in the complaint investigation and resolution process. If UBH requests written records for the purpose of investigating a Member complaint, you must submit these to UBH within 14 business days, or sooner as requested. Complaints filed by Members should not interfere with the professional relationship between you and the Member.

QI staff, in conjunction with Network Management staff, monitors complaints filed against all clinicians and facilities, and solicits information from them in order to properly address Member complaints. In general, resolution of most complaints is communicated to the Member when the complaint is received from, or on behalf of, the Member. QOC complaints do not generally include notification of resolution except as required by state law.

UBH requires the development and implementation of appropriate Corrective Action Plans (CAP) for legitimate problems discovered in the course of investigating complaints. Such action may include, but is not limited to, having UBH:

- Require you to submit and adhere to a CAP
- Monitor you for a specified period, followed by a determination about whether substandard performance or noncompliance with UBH requirements is continuing
- Require you to use peer consultation for specific types of care
- Require you to obtain specific additional training or continuing education
- Limit your scope of practice in treating Members
- Hold referrals of any Members to your care by changing your availability status to “unavailable” and/or reassigning Members to the care of another participating clinician or facility
- Terminate your participation status with UBH

Cooperation with an unavailable status associated with complaint, quality-of-care or sentinel event investigations may include:

- Informing Members of unavailable status at the time of an initial request for services, and identifying other network clinicians or facilities to provide services or referring the Member to UBH for additional referrals
- Informing current Members of status and their option to transfer to another network clinician or facility
- Assisting with stable transfers to another network clinician or facility at the Member's request

Audits of Sites and Records

On-site and record-only audits may occur with any contracted provider. Both types of audits involve reviewing a sampling of treatment records. The on-site audit also involves a review of policies and procedures, including policies related to hiring and supervision of staff, discussion of services that are offered and a tour of the facility or office site.

UBH representatives conduct site visits at clinician offices, agencies such as community mental health centers (CMHCs), facilities, and group provider locations. On-site audits are routinely completed with high-volume clinicians, clinicians who have a clinical office in their home or who offer services in the homes of Members, and CMHCs and facilities without national accreditation. In addition, audits are completed to address specific quality of care issues or in response to Member complaints about the quality of the office or facility environment.

Facilities and CMHCs that hold national accreditation through organizations such as the Joint Commission, CARF, COA, HFAP, NIAHO, CHAP, and/or AAAHC receive credit for meeting those standards of care for the identified accredited services or programs without additional review prior to the initial credentialing process. Facilities and CMHCs that are not accredited will be required to participate in an on-site audit prior to credentialing and a recredentialing audit prior to their specified recredentialing timeframe. Any facility or CMHC, regardless of their accreditation status, may be subject to an on-site audit for any Member complaints or suspected quality of care concerns brought to the attention of UBH.

During on-site and record-only audits for all types of providers, chart documentation is reviewed, including (but not limited to) the assessment, diagnosis, treatment plan, progress notes, coordination of care activities, and discharge planning. This process also verifies that services were provided to Members. You are expected to maintain adequate medical records on all Members and document in the record all services that are provided. Prior to the audit, you will be notified of the specific types of charts that will be reviewed. Failure to adequately document services that are rendered and/or dates of services may lead to a request for a Corrective Action Plan (CAP). Please see the "Treatment Record Documentation Requirements" section of this manual for more information.

The audit tools are based on NCQA, the Joint Commission and UBH standards. These forms are used during audits and are available at [ubhonline](http://ubhonline.com) for reference.

Member Education

A variety of Health and Wellness Tip sheets have been developed by UBH for Members. These are educational materials, written in common, everyday language. Topics include, but are not limited to general therapy issues, self-help, mood and anxiety disorders, and substance use disorders and address child, adult and elderly populations. You are encouraged to distribute these to Members as appropriate. [Health and Wellness Tips](#) are available at [ubhonline](#) or you can request paper copies by contacting Network Management.

FACILITY QUALITY MEASURE

Facility Quality Measure (FQM) was developed in response to both Member and customer requests for increased transparency, value and choice within behavioral health services. This program provides facilities with a scorecard of their relative performance using industry-standard quality and efficiency metrics. The FQM scorecard is a tool to enhance the partnership between United Behavioral Health (UBH) and network facilities and to foster collaborative discussions on ways to improve quality processes and clinical outcomes. This program recognizes facilities that demonstrate solid clinical outcomes by consistently meeting or exceeding normed results.

Criteria for Inclusion in Facility Quality Measure (FQM)

The facility scorecard data is generated once per quarter. The scorecard takes into account data from a “rolling” calendar year, encompassing four previous quarters (12 months) of data.

For more information regarding specific criteria to qualify for a scorecard, please visit [ubhonline®](#). Select **FQM** under “Quick Links” on the home page.

Data

The quality metrics capitalize on the availability of long-standing data sets. Admissions, claims, and discharge data are compiled to arrive at the metrics used in FQM. These quality metrics are based on industry standards which are similar to Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

FQM includes aggregated data from inpatient discharges for commercial, Medicare, and Medicaid business.

FQM Data Elements

Quality elements of the facility scorecard include, but are not limited to, the following:

Metric	Commercial	Medicare/Medicaid
Number of Member discharges	•	•
30-day readmission rate	•	•
Percentage of follow-up appointments scheduled to occur within 7 days of discharge	•	•
Percentage of follow-up appointments kept within 7 days of discharge	•	•
180-day readmission rate	•	•
Community tenure	•	•
Comparative geographical data	•	•

Once quality benchmarks are met, the following efficiency measures are factored into the scorecard:

- Average Length of Stay (ALOS)
- Case-Mix Adjusted Utilization data

Many factors may contribute to a facility's ALOS differing from the national average of other contracted facilities. The most notable reason would be the diagnostic characteristics of the Members treated by a facility. Members with more chronic or severe diagnoses may require a longer length of stay. A facility's length of stay has been statistically adjusted to reflect norms for a client population of similar composition. In addition to client diagnoses, FQM's statistical adjustment model also takes into consideration client demographic and geographic characteristics.

Access to FQM Scorecards

Facility scorecards are accessible at [ubhonline](#). You need a User ID and Password to perform online, self-service secure Transactions. If you have not yet registered for a login, please go to [ubhonline](#) and click on the "First-time User" link at the top right of the page. Once you are registered, follow these steps to access your scorecard:

- Log on to [ubhonline](#)
- Select the "Provider Reports Tab"
- Select "FQM" and the scorecard will populate
- The scorecard can be printed

Tiering: Methodology and Recognition

A facility's tier assignment (Tier 1, 2, or 3) is determined by weighting and combining scores from both commercial and Medicare/Medicaid metrics. A facility must achieve a high score on the quality portion of the metrics before the efficiency metrics will be factored into the tier designation. To be in the highest tier (Tier 1), a facility must perform well on both quality and efficiency metrics.

FQM recognizes network facilities who exhibit exemplary performance on industry-standard quality metrics by using a star designation on the member search web site. Facilities will receive one star if they have met or exceeded quality benchmarks (a facility that achieves an average quality score greater than 2 on the FQM scorecard). A second star will be added for those facilities that also meet or exceed efficiency metrics (a facility that achieves an in-range ranking for efficiency on the FQM scorecard).

Information on FQM can be found at [ubhonline](#) and select FQM under "Quick Links" on the home page.

CAMPAIGN FOR EXCELLENCE

Campaign for Excellence (CFE) is a voluntary clinician recognition program that allows United Behavioral Health (UBH) to recognize clinicians for excellence in clinical care. The CFE Program enhances the partnership between UBH and network clinicians, cultivating a collaborative approach to Member services and care. CFE reinforces our shared belief that Member outcomes are the most important indicator of quality. Clinicians enrolled in CFE are eligible to receive feedback regarding their clinical outcomes.

UBH established CFE in response to requests from Members and customers for increased transparency, value, and choice within behavioral health services. CFE is driven by input from our National Advisory Council and network clinicians regarding measurement of performance and is guided by current clinical outcomes research.

CFE is built upon our ALERT[®] (ALgorithms for Effective Reporting and Treatment) model that includes use of the Wellness Assessment, a psychometrically-tested instrument for identifying and monitoring change and psychological distress, identifying chemical dependency risks and medical comorbidity, and measuring workplace function. Review the ALERT section of this manual or visit the **ALERT pages** of **ubhonline[®]** for more information.

Benefits

CFE provides evaluation of outcomes and recognition for clinical quality achieved. CFE publicly recognizes clinicians in the clinician directory available on the Member web site, www.liveandworkwell.com. In addition, CFE enrolled clinicians are eligible for the CFE Business Partner Rewards Program which includes discounts and special offers from national merchants. For more information about the Business Partner Rewards Program log into the secure Transactions section of **ubhonline** (top right-hand corner of main page). Select My Practice Info > View My CFE Data > CFE Business Partner Rewards Program.

Accessing Your CFE Score and Outcomes Data

The secure Transactions feature of **ubhonline** offers access to CFE scores for enrolled clinicians who have sufficient data. CFE enrolled clinicians receive an e-mail announcing the availability of current CFE data online.

Tiering and Methodology and Recognition

CFE has minimum data thresholds that must be met before scores can be compiled. Requirements include:

- Having a minimum of 10 Members with at least two ALERT Wellness Assessment (WA) data points for each Member

- Initial global assessment scores as measured by the WA must be within our published clinical range

Outcomes information is derived from ALERT-based measures of therapeutic change in Global Distress scales and is adjusted for case-mix including severity.

A key element of the CFE methodology is the use of Severity Adjusted Effect Size (SAES). The SAES is a measure of clinician effectiveness that takes the commonly used effect size measure of treatment effectiveness a step further by incorporating statistical adjustments for each clinician's case-mix (e.g., severity). A more detailed explanation of the methodology is available on [ubhonline](#). The SAES measure is used to differentiate (tier) clinicians in the UBH network. Tiering supports the public recognition on the online clinician directory available to members.

For more detailed information on the statistical methodology used to determine SAES scores, please click on the link on the [ubhonline](#) Web site to access the [CFE SAES and Network Tiers](#) paper.

Business Partner Rewards Program

To express our appreciation to CFE clinicians for their commitment to quality, UBH has launched our Business Partner Rewards Program. The Business Partner Rewards Program allows clinicians enrolled in CFE to access discounts and special offers from a variety of national merchants. To access a list of current Business Partners, clinicians simply log into the secure transactions section of [ubhonline](#) using your User ID and password. Once logged in, you will click on “Update Practice Info” in the top right-hand corner, followed by “View My CFE Data” under My Practice Info – Review Clinician Profile. Follow the links to “CFE Business Partner Rewards Program” to obtain information about each participating business partner's discount as well as instructions on how to obtain the discount.

Enrollment

In order to participate in CFE, the following entry criteria are required:

- ALERT Wellness Assessment submission at the initial appointment and at session 3, 4, or 5
- Have a secure (password protected) e-mail address on file with UBH
- Agree to submit claims electronically

To enroll, please visit www.ubhonline.com. Registered users of [ubhonline](#) can log in and then enroll in CFE through the secure “My Practice Info” feature. Please review the Resource section of this manual for information on becoming a registered user of [ubhonline](#).

For the most current information about CFE, go to the CFE information web page. This page is accessible through the “Quick Links” on the home page of [ubhonline](#).

COMPENSATION AND CLAIMS PROCESSING

Compensation

The network rate for eligible outpatient visits is reimbursed to you at the lesser of (1) your customary charge, less any applicable co-payments, coinsurance and deductibles due from the Member, or (2) the UBH fee maximum, less any applicable co-payments, coinsurance and deductibles due from the Member. Fee maximums can vary based on different insurance plans and are available upon request.

The contracted rate for facilities is referenced in the Payment Appendix of the facility Agreement and defines rates applicable to inpatient and/or outpatient care through that facility. When the contracted rates include physician fees, the facility is responsible for payment of all treating physicians and for notifying the physicians that payment will be made by the facility and not UBH.

Financial records concerning covered services rendered are required to be maintained from the date of service for the greater of 10 years, or the period required by applicable state or federal law, whichever is longer. Any termination of the Agreement has no bearing on this legal obligation.

Co-payments, Coinsurance and Deductibles

In most Benefit Plans, Members bear some of the cost of behavioral health services by paying a co-payment, coinsurance, and/or deductible. Deductible amounts and structure may vary from plan to plan. Some deductibles are combined with medical services or there may be separate individual or family deductible amounts. Members should be billed for deductibles after claims processing yields an Explanation of Benefits indicating Member responsibility. For co-payments, we encourage you to require payment at the time of service. It is your sole responsibility to collect Member payments due to you. Members are never to be charged in advance of the delivery of services. Benefit Plans often provide for annual co-payment or coinsurance maximums. If a Member states that he or she has reached such a maximum, call the telephone number listed on the Member's insurance card to confirm the amount and status of the Member's co-payment maximum. If a specific behavioral health number is not listed, call the medical number and follow the prompts for behavioral health.

Balance Billing For Covered Services Is Prohibited

Under the terms of the Agreement, you may not balance bill Members for covered services provided during eligible visits, which means you may not charge Members the difference between your usual and customary charges and the aggregate amount reimbursed by UBH and Member co-payments.

Billing for Non-Covered Services and "No Shows"

In the event that you seek prior authorization of benefits for behavioral health services or authorization for continued treatment, and UBH does not authorize the requested services,

the Member may be billed under limited circumstances. The Member may be billed only if a written statement is signed by the Member, concurrent with the adverse benefit determination and in advance of receiving such services. Please note that a signed financial responsibility waiver signed by the Member at the onset of treatment or at the time of admission is not applicable. The signed statement must include:

- That you have informed the Member that UBH is unable to authorize such services for coverage under the Member's Benefit Plan;
- The reason given by UBH for not authorizing the services; and
- That as a result, the Member may not receive coverage for such services under their Benefit Plan and will be financially responsible.

In the event a Member exhausts the covered benefits under the benefit contract, you may bill the Member directly for those services. Members may be charged no more than the network or facility contracted rate.

A Sample Patient Financial Responsibility Form may be found at [ubhonline®](#). We encourage you to use this or a similar form when billing Members for non-covered services.

UBH does not pay for sessions that a Member fails to attend. You may not bill UBH for such sessions or services. A Member who misses a scheduled appointment may be billed directly, provided you have advised the Member in advance that this is your policy and the Member has acknowledged the policy in writing. The Member should be billed no more than the network or facility contracted rate. Note that some plan designs, as well as the government-funded programs Medicaid and Medicare, prohibit billing Members for no-shows under any circumstance. Members are never to be charged a deposit or advance payment for a potential missed appointment.

Claims Submission

Unless otherwise directed by UBH, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by UBH.

In addition, you are responsible for billing of all Members in accordance with the nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information on CCI billing standards can be found at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>.

Although claims are reimbursed based on the network fee schedule or facility contracted rate, your claims should be billed with your customary charges indicated on the claim. For information about fast and efficient electronic claims submission, please see [ubhonline](#) "Improve the Speed of Processing—Tips for Claims Filing."

Claim Entry through ubhonline: You should file UBH claims on [ubhonline](#). This secured, HIPAA-compliant transaction feature is designed to streamline the claim submission process. It performs well on all connection speeds, and submitting claims on ubhonline closely mirrors the process of completing a CMS-1500 form. In order to use this feature you must be a network clinician or group practice and have a registered user ID and password for ubhonline. To obtain a user ID, call toll-free **(866) 209-9320**. EAP claims are supported through this feature as well. We strongly encourage you to use this no-cost claims entry feature for claims submission at [ubhonline](#), which allows claims to be paid quickly and accurately.

EDI/Electronic Claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a Payor (UBH). You may choose any clearinghouse vendor to submit claims through this route. Because UBH has multiple claims payment systems, it is important for you to know where to send claims. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. For UBH claims use Payer ID #87726. Additional information regarding EDI is available on ubhonline “[Claims Tips](#)”.

Clinician Claim Forms: Paper claims can be submitted to UBH using the CMS-1500 claim form, the UB-04 claim form, or their successor forms. The claims should include itemized information such as diagnosis (DSM-IV-TR or its successor), length of session, Member and subscriber names, Member and subscriber dates of birth, Member identification number, dates of service, type and duration of service, name of clinician (i.e., individual who actually provided the service), credentials, tax ID and NPI numbers.

Facility Claim Forms: Paper claims should be submitted to UBH using the UB-04 billing format, which includes itemized information such as diagnosis (ICD-9), Member name, Member date of birth, Member identification number, dates of service, procedure (CPT-4) and/or revenue codes, name of facility and Federal Tax ID number of the facility, and billed charges for the services rendered. After receipt of all of the above information, participating facilities are reimbursed according to the appropriate rates as set forth in the facility’s Agreement. At this time, [ubhonline](#) is not an option for facilities to use in submitting claims but facilities may file claims through an EDI vendor and can view claim status on ubhonline.

UBH has a Fraud and Abuse Program in place. Please review the Fraud, Waste and Abuse section of this manual.

Online Claims Help

Contact information for Claims and Customer Service issues can be found in the “[Contact Us](#)” section of ubhonline.

To ensure proper processing of claims, it is important to promptly contact Network Management if you change your Tax ID number. You may make changes to your practice address online.

Customer Service Claims Help

UBH has dedicated customer service departments with staff available five days a week during regular business hours to assist our network with questions related to general information, eligibility verification or the status of a claim payment. The main UBH customer service phone numbers are listed below; however various Members may have account-specific customer service numbers. It is best to call the phone number listed on the Provider Remittance Advice.

Health Plan Groups (800) 557-5745
Employer Groups (800) 333-8724
U.S. Behavioral Health Plan, CA (877) 263-9952

Coordination of Benefits (COB)

Some Members are eligible for coverage of allowable expenses under one or more additional health Benefit Plans. In these circumstances, payment for allowable expenses shall be coordinated with the other plan(s).

If UBH is a secondary plan, you will be paid up to the UBH contracted rate. You may not bill Members for the difference between your customary charge and the amount paid by the primary plan(s) and UBH.

Processing and Payment of Claims

All information necessary to process claims must be received by UBH no more than 90 calendar days from the date of service, or as allowed by state or federal law or specific Member Benefit Plans. Claims received after this time period may be rejected for payment at the discretion of UBH and/or the Payor. You may not bill the Member for claim submissions that fall outside these established timelines. Any corrections or additions to a claim should be made within 90 days of receipt of the initial claim.

Claims should be submitted as directed by UBH. We strongly recommend that you keep copies of all claims for your own records. You permit UBH, on behalf of the payer, to bill and process forms for third-party claims or for third-party payers, and execute any documents reasonably required or appropriate for this purpose. In the event of insolvency of the Member's employer or UBH, your sole redress is against the assets of UBH or the applicable payer, not the Member. You must agree to continue to provide services to Members through the period for which premiums have been paid. Any termination of the Agreement has no bearing on this requirement.

Generally, claims that contain all of the required information and match the authorization, if applicable, will be paid within 45 calendar days after receipt, or as required by state and federal law. This may exclude claims that require Coordination of Benefits (COB) determinations. Benefits are payable provided coverage is in force at the time expenses are incurred, and are subject to all limitations, provisions and exclusions of the plan. You will be

paid for covered services by UBH and will not under any circumstances seek payment through UBH for plans for which UBH is not the payer or administrator.

UBH may occasionally make corrective adjustments to any previous payments for services and may occasionally audit claims submissions and payments to ensure compliance with applicable procedures, state and federal law. UBH may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law.

The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable state or federal laws.

FRAUD, WASTE AND ABUSE

United Behavioral Health (UBH) has guidelines to address suspected fraud, waste and/or abuse by Providers. In accordance with your Agreement, you are required to cooperate with the review process to include any requests for medical records.

UBH, in partnership with Ingenix, an information and research company, is committed to the detection and investigation of fraudulent, wasteful and/or abusive practices. Such practices include, but are not limited to, filing fraudulent claims, fraudulent authorization of claims, misrepresentation of services provided, abuse of services in order to obtain a benefit (including personal or commercial gain) from UBH or a Payor to which an individual or entity is not entitled. This identification process includes examining claims of Providers to identify outlier practice patterns.

Once suspected fraudulent, wasteful or abusive activity is identified, appropriate interventions are implemented. Possible interventions may include, but are not limited to: outreach meetings and/or written correspondence to Providers, record review and/or site audit, individual case peer-to-peer reviews, and referral to Ingenix. You are contractually required to cooperate in this process and participate in any activities related to the identification and correction of suspected fraud, waste, and abuse.

Once an intervention has occurred, UBH continues to monitor the practice patterns of an identified Provider to ensure that the suspected fraudulent, wasteful or abusive practice pattern has been corrected.

Some examples of fraud are as follows:

- Paying, soliciting, offering or receiving:
 - A kickback or bribe in connection with the furnishing of treatment, services or goods for which payment is or may be made in whole or in part under the Medicaid program
 - A rebate of a fee or charge made to a provider for referring a recipient to a provider
 - Anything of value, with intent to retain it, and knowing it to be in excess of amounts authorized or rates established under the Medicaid program, as a precondition of providing treatment, care, services or goods or as a requirement for continued provision of treatment, care, services or goods
- Providing the following with intent that a claim be relied upon for the expenditure of public money:
 - Treatment, services, or goods that have not been ordered by a treating provider
 - Treatment that is substantially inadequate when compared to generally recognized standards with the profession or industry
 - Merchandise that has been adulterated, debased, mislabeled or is outdated

- Presenting or causing to be presented for allowance or payments with intent that a claim be relied upon for the expenditure of public money, any false, fraudulent, excessive, multiple or incomplete claims

Examples of abuse include, but are not limited to:

- Inappropriate balance billing
- Inadequate resolution of overpayments
- Lack of integrity in computer systems
- Failure to maintain confidentiality of information/records
- High utilization of procedures or tests not medically necessary
- Providing services that are not medically necessary
- Providing poor quality medical services
- Unbundling/exploding charges (e.g., the unpacking and billing separately of services that would ordinarily be all-inclusive)
- Coding a service at a higher level than what was rendered (i.e., up-coding)
- Violation of Agreement by provider
- Breaches of Agreement that result in Consumers being billed for amounts not allowed by UBH
- Failure to collect coinsurance and deductible amounts
- Excessive charges for services
- Inappropriate documentation of services rendered

In the event that UBH suspects irregular billing practices or abusive activity, the allegation or complaint is forwarded to Ingenix. Ingenix determines which claims are appropriate to review. In addition, suspicious fraudulent billing patterns may be detected by Ingenix through established data tools and analysis. In general, identified claims, along with the Provider that submits these claims, are audited on a prospective basis. In accordance with our policy, audits of previously paid claims are completed on a retrospective basis.

All prospective reviews are completed in a timely manner, prior to a payment determination, to assess whether they validate the initial allegation. Any claim submitted a Provider that matches suspected patterns under investigation may trigger a request for medical records. In some cases, additional investigative steps may be used in order to obtain accurate information related to a claim.

Upon completion of the investigation the claim is adjudicated. Either timely payment is made or, in the event that a claim denial is issued, the denial notification includes the Provider's standard appeal rights.

Findings of billing inconsistent with UBH policies by in-network Providers may result in such actions as clarification of proper procedure, a CAP, a change in network availability status, or may result in termination of your Agreement. In the case of retrospective review, UBH reserves the right to pursue recoupment of funds paid. The Credentialing Committee may recommend termination. In that event, the clinician or facility is notified in writing and

provided with information about appeal rights, if applicable, and in compliance with state and federal laws.

As warranted, Providers will be reported to their respective State Department of Insurance, licensing board(s), and any other regulatory agencies based on the outcome of the investigation and as required by state and federal laws. Throughout this process, UBH adheres to state law, ERISA guidelines, and confidentiality standards.

APPEALS AND PROVIDER DISPUTE RESOLUTION

There are two distinct processes related to adverse determination regarding requests for services or payment: (1) Appeals and (2) Provider Dispute Resolution. An adverse determination, for the purposes of this section, is a decision by UBH to deny, in whole or in part, a request for authorization of treatment or of a request for payment. An adverse determination may be subject to the Appeals process or Provider Dispute Resolution process depending on the nature of the adverse determination, Member liability and your Agreement.

Care advocacy decision-making is based on the appropriateness of care as defined by the Level of Care Guidelines, the Psychological and Neuropsychological Testing Guidelines, and the Coverage Determination Guidelines as well as the existence of coverage for the requested service in the Member's plan.

The [Level of Care Guidelines](#), the [Psychological Neuropsychological Testing Guidelines](#) and the Coverage Determination Guidelines are available at [ubhonline®](#). To request a paper copy of these guidelines, please contact Network Management. All treatment certified by UBH must be outcome-driven, clinically necessary, rational, evidence-based, and provided in the least restrictive environment possible.

UBH does not specifically reward its staff, practitioners or other individuals for issuing denials of coverage or service nor does it provide any incentive to deny, limit or reduce treatment coverage.

Appeals Process

The Appeals process is available to Members, or their authorized representative which may be their treating clinician at any level of care, in the event of an adverse determination (ABD) when the Member may incur financial liability for the services. In the case of clinical reviews, UBH offers you the opportunity to discuss a request for services with an appropriate peer reviewer during the authorization of benefits process and before an adverse determination is made by UBH. If after such discussion occurs UBH issues a denial, in whole or in part, then such determination will be subject to the applicable Appeals process. The procedures for the Appeals process, including any applicable state and/or federal requirements for the filing and handling of an appeal, will be disclosed in the notice of the ABD sent to you and the Member.

Appeals may be handled as urgent or non-urgent appeals. Urgent appeals apply in situations where, in your opinion, application of non-urgent procedures could seriously jeopardize the Member's life, health or ability to regain maximum functioning. In these situations, you contact an Appeal Reviewer at an agreed upon time and as soon as possible after the adverse determination. If you do not telephone UBH for the urgent appeal review, UBH will make a reasonable effort to contact you prior to making a determination on the appeal. If UBH is unsuccessful in reaching you, an urgent appeal determination will be made based on the information available to UBH at that time. UBH will make the review determination, notify you by telephone, and send written notification of the appeal outcome to you and the member or authorized member representative within 72 hours of the appeal request or in

accordance with applicable state and/or federal laws, whichever is sooner. By definition, urgent appeals are not available in situations where services have already been provided.

For non-urgent situations, you may request a non-urgent appeal on behalf of the Member. A non-urgent appeal must be requested within 180 calendar days from the Member's receipt of the adverse determination letter or in accordance with state and/or federal laws, whichever is most beneficial to the Member. UBH will make an appeal determination and notify you and the Member or the authorized member representative. This notification will be provided in writing within 15 calendar days from receipt of the request if services have not yet been received by the Member or within 30 calendar days if services have already been received by the Member or in accordance with applicable state and/or federal laws, whichever is sooner.

If you have received an authorization letter or an adverse determination letter and you wish to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, please follow the instructions in the letter and call the toll-free number provided in the letter. For additional assistance, contact Network Management to help you identify and contact the Care Advocate or peer reviewer for your specific case. Authorization is not a guarantee of payment (except as required by law), payment of benefits is still subject to all other terms and conditions of the Member's plan and your Agreement.

A clinical peer who has not previously been involved in the adverse determination, and is not a subordinate of the person who made the initial adverse determination will review a clinical appeal request. The appeal reviewer will review all available information, including treatment records, in order to make a determination. For an inpatient case involving a clinical determination, the appeal reviewer will be a board-certified psychiatrist (from the same or similar specialty area as the treating clinician) with an active, unrestricted license. For an outpatient case involving a clinical determination, the appeal reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted license. For non-clinical administrative appeals, the appeals reviewer will be an appropriately qualified UBH professional who was not involved in the initial adverse determination and who is not a subordinate of any person involved in the initial adverse decision.

If the appeal decision is to uphold an adverse determination, UBH will notify you and the Member, or the Member Representative, of the outcome and any additional levels of appeal that are available, as applicable.

You may continue to provide service following an adverse determination, but the Member should be informed of the adverse determination by you in writing. The Member or the Member Representative should be informed that the care will become the financial responsibility of the Member from the date of the adverse determination forward. The Member must agree in writing to these continued terms of care and acceptance of financial responsibility. You may charge no more than the UBH contracted fee for such services, although a lower fee may be charged. The consent of the Member to such care and responsibility will not impact the appeals determination, but will impact your ability to collect reimbursement from the Member for these services. If the Member does not consent in writing to continue to receive such care and UBH upholds the determination regarding the cessation of coverage for such care, you cannot collect reimbursement from the Member pursuant the terms of your Agreement.

Provider Dispute Resolution Process

The Provider Dispute Resolution process is available to you, or your authorized representative, in a situation where the Member is not financially liable for the adverse determination issued by UBH, beyond applicable co-payments and deductibles. That is, the payment dispute is between you and UBH, and regulated by the Agreement, rather than the Member's Benefit Plan. You, or your authorized representative, have the right to dispute any adverse determination made by UBH when the benefit determination is adverse to you, rather than the Member.

The Provider Dispute Resolution process must be initiated in writing by contacting UBH at the address listed on the adverse determination notification, and must include the following information:

- Member identifying information
 - Name
 - Identification number
 - Date of birth
 - Address
- Each applicable date of service
- Your identifying information
 - Name
 - Tax identification number
 - Contact information
- Dollar amount in dispute, if applicable
- Any additional information you would like to have considered as part of the Dispute process, including records relating to the current conditions of treatment, co-existent conditions, or any other relevant information
- Your explanation as to why the adverse determination should be overturned

The Provider Dispute Resolution process is available for post-service requests only. Disputes related to pre-service and concurrent service requests are subject to the Appeals process previously described. To initiate a Provider Dispute Review, you must request a review of an adverse determination within 180 calendar days from the date you received the adverse determination letter from UBH. Disputes received outside of this timeframe will not be processed. UBH will notify you or your authorized representative of the dispute resolution in writing within 30 calendar days of the receipt of your request unless otherwise required by law.

When allowed by law, you or your authorized representative may dispute the adverse determination a second time if you are dissatisfied with the outcome of the first level dispute. The second level request must be made in writing within 60 calendar days of the date you received notification of the outcome of your first level dispute from UBH. You may initiate a second level dispute by contacting UBH at the address listed on the first level dispute notification.

MANUAL UPDATES AND GOVERNING LAW

Manual Updates

This manual may be updated periodically as procedures are modified and enhanced. Providers will be notified a minimum of thirty (30) calendar days prior to any material change to the manual unless otherwise required by regulatory or accreditation bodies. The current version of the manual is always available at ubhonline. You can view the manual online or download a complete copy from your computer. If you do not have internet access or printing capabilities, you may request a paper copy by contacting Network Management.

Governing Law and Contract

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual differs from the terms and conditions outlined in your Agreement, the subject matter shall first be read together to the extent possible; otherwise and to the extent permitted by, in accordance with, and subject to applicable law, statutes or regulations, the Agreement shall govern.

MEMBER RIGHTS AND RESPONSIBILITIES

In the course of care, a Member has both rights and responsibilities.

Member Rights

UBH believes and supports the proposition that every Member has the right to:

- Be treated with respect and recognition of his or her dignity and right to personal privacy
- Confidentiality of information
- Receive care that is considerate and respectful of his or her personal values and belief system
- Reasonable access to care in a timely manner, regardless of race, religion, gender, sexual orientation, ethnicity, age, disability or communication needs
- Receive information about UBH and its services, practitioners and Providers, clinical guidelines, quality improvement program, Member rights and responsibilities and any other rules or guidelines utilized to make coverage and payment decisions
- Be informed of rules and regulations concerning his or her own conduct
- Be informed, along with his or her family, of his or her UBH rights in a language they understand
- Participate with his or her practitioners or providers in an informed way in making decisions about his or her health care
- A candid discussion with his or her treating professionals about appropriate or medically necessary treatment options and alternatives for his or her condition regardless of cost or benefit coverage
- Participate in treatment planning, if over the age of 12, and/or to have family members participate in treatment planning
- Designate a surrogate decision maker if he or she is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care
- Consent to or refuse treatment and to be informed of potential consequences that may be associated with choosing not to comply with recommended treatment
- Receive information regarding medications, (e.g., what they are, how to use them and possible side effects)
- Receive reasonable continuity of care, including information about continuing health care requirements following discharge from an inpatient facility
- Individualized treatment, including:
 - Adequate and humane services regardless of the source(s) of financial support
 - Provision of services within the least restrictive environment possible
 - An individualized treatment plan that is periodically reviewed and updated

- An adequate number of competent, qualified and experienced professional clinical staff to supervise and carry out the treatment plan
- Participate in the consideration of ethical issues that may arise in the provision of care and services, including:
 - Resolving conflicts including those related to proposed or provided treatment
 - Developing an Advance Directive to include the decision to withdraw or withhold resuscitative or other life prolonging or sustaining services
- Participating in investigational studies or clinical trials, and the member's right to refuse to participate in such research projects
- Voice complaints or appeals about his or her provider of care or decisions made by UBH which could include treatment authorization, claims payment, or benefit interpretation issues without risk of subsequent discrimination
- Make recommendations regarding UBH's rights and responsibilities policies
- Be informed of the reason for any utilization management adverse determination, including the specific utilization review criteria or benefits provision used in the determination
- Have utilization management decisions based on appropriateness of care; UBH does not reward providers or other individuals conducting utilization review for issuing adverse determinations for coverage or service
- Protection from unauthorized or inappropriate use of Personal Health Information (PHI) in all settings
- Receive a copy of the [UBH Privacy Notice](#) including information regarding UBH privacy practices.
- Request to obtain and inspect a copy of his or her PHI, to amend or restrict the use of his or her PHI and to receive an accounting of non-routine disclosures of the Member's PHI
- Request confidential communications of PHI be sent to an alternate address or by an alternate means
- Voice complaints regarding use or disclosure of PHI
- Be informed that routine consent is given upon enrollment in the plan for UBH to use PHI as needed for UBH operations, such as: treatment, coordination of care, measurement and survey data collection, utilization review, billing and fraud detection

Member Responsibilities

In addition to the rights listed above, every Member has the responsibility to:

- Learn and understand his or her rights
- Know his or her Plan Benefits and abide by Plan policies and procedures
- Understand his or her health problems and participate in developing with his or her treating practitioner or provider mutually agreed upon treatment goals to the degree possible
- Follow plans and instructions for care that they have agreed upon with his or her treating practitioner

- Review information regarding covered services, exclusions, limitations, and policies and procedures as stated in Member materials and his or her Certificate of Coverage
- Pay any required deductibles, co-payments and/or co-insurance at the time services are rendered
- Provide to his or her treating practitioner(s), to the extent possible, information necessary in order to receive appropriate care