I. General Information

Overview

Welcome to the North Texas Behavioral Health Authority (NTBHA) network of participating providers. This handbook (aka Provider Manual or Manual) is an extension of the provider agreement. It will answer questions about services funded by NTBHA and explains how we manage the delivery of mental health and substance use disorder (SUD) care to consumers. It describes NTBHA’s policies and procedures from referrals and authorizations to claims submission and problem resolution. Adherence to these guidelines will assist in obtaining timely service authorizations and claims reimbursement. Included is a glossary of frequently used terms.

About NTBHA

Based upon an interlocal agreement authorized by commissioners courts from each participating county, the Texas Health and Human Services Commission (HHSC) designated North Texas Behavioral Health Authority as the Local Behavioral Health Authority to plan, coordinate, develop policy, allocate resources, supervise, and ensure the provision of community-based mental health and SUD services for qualified indigent residents of Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall Counties.

Our Mission

North Texas Behavioral Health Authority seeks to create a well-managed, integrated, and high-quality delivery system of behavioral health services available to eligible consumers residing in our catchment area.

The Role of NTBHA, the Local Behavioral Health Authority

Function, Role, and Structure

NTBHA manages a system of care for both mental health services and SUD treatment. NTBHA is charged with developing mechanisms that ensure the concerns of consumers, family members, advocates, and taxpayers from each participating county are fairly and equitably represented. These mechanisms also ensure that persons who are knowledgeable and experienced in mental health and SUD issues advise NTBHA to identify challenges as well as opportunities for system growth and improvement. State delegated functions to NTBHA include the following:

Policy Development

Since NTBHA is a local entity, it is in a unique position to understand the regional context in which services are delivered and rapidly identify, analyze, and respond to local issues affecting access and service delivery. NTBHA serves as an advisory to the State in matters of policy and relays matters of community concern directly to the State for action, but has no direct control over the business functions of the State.
NTBHA works with the State to identify problems of local concern and may propose solutions to the problems. When an issue of local concern arises, NTBHA will work with the State to identify the source of the problem. If the problem has its origin in existing policy, NTBHA will work in collaboration with the State to modify existing policy to correct the problem. If the problem has its origin in noncompliance, the State will take steps to ensure that NTBHA comes into compliance with existing policy.

Through an information-sharing arrangement, the State and NTBHA monitor the status of the service delivery system during each contracting cycle. Before each new contracting cycle, the State and NTBHA evaluates the performance of the participating Contractor to determine the need for modifications to existing policy and contract language. NTBHA has standing committees to advise it on various behavioral health issues. These committees will include such entities as local councils on mental health and substance use disorders, community management teams for the Children’s Mental Health Plan, and other specialty committees.

1. Cooperation in Problem Identification/Resolution
   NTBHA works closely and cooperatively with the State to identify problems of access and service delivery and to ensure continued compliance with all applicable laws, regulations, and contractual requirements.

2. Liaison to Contractors and Local Communities
   NTBHA provides a voice for the local community on matters pertaining to publicly funded managed behavioral healthcare. NTBHA serves as a liaison between citizens of local communities and the providers serving those communities. If a problem, complaint, or issue of concern is raised by a consumer, family member, or other interested party about access or services provided by a plan or provider, it will be resolved through the NTBHA internal complaint processes. However, either the complainant or NTBHA may contact HHSC to resolve the issue to the mutual satisfaction of all parties.

3. Coordination with Other Systems and Institutions
   NTBHA is well coordinated with other public systems and institutions in the community to ensure the early identification of need for services as well as the prompt delivery of services once need is identified. NTBHA performs:
   • Critical coordination activities to help assure continuity of care for all persons in need of services including networking with community leaders and the plan
   • Determine the most effective means of outreach and coordination of services
   • Work with NTBHA and community leaders to develop methods for the early identification of need and timely provision of services to vulnerable populations
   • Address concerns expressed by community-based agencies relating to access, efficiency, and effectiveness of the NTBHA service delivery system

   NTBHA works closely with the State to ensure that services are well coordinated with all local entities serving or having frequent contact with adults with Serious
Mental Illness (SMI), children with Serious Emotional Disturbance (SED), and individuals affected by a Substance Use Disorder (SUD).

4. Monitoring and Oversight
Consumers and family members who might be reticent to approach the State may respond more readily to local representatives who are empowered to address issues of access and service delivery. Local oversight can also facilitate early identification, and hence, early correction of problems that may arise in the service delivery system and provide customized, community-centered solutions to problems.

Although the State retains the primary responsibility of monitoring the system of care, NTBHA procures and holds contracts with the providers and conducts oversight activities. NTBHA has established an efficient mechanism for the resolution of consumer complaints which includes:

- Staffs a phone line to provide information to consumers, potential consumers, and providers and to identify problems with service access and delivery.
- Works with the State to measure consumer and stakeholder satisfaction.
- Measures the effectiveness of complaint resolution systems and efforts to

5. Single Portal Authority
The Texas Administrative Code specifies that all mental health commitments pursuant to the Texas Health and Safety Code, Chapter 574, shall be made to the Single Portal Authority (SPA) or to the mental health facility that serves an area. NTBHA will provide information as required by the SPA regarding the status, response to treatment and service utilization history of persons who are involuntarily committed to the SPA.

At its discretion, HHSC may designate NTBHA as the SPA for the service delivery area. In this role, NTBHA would be responsible for the coordination of involuntary commitments in the service delivery area. NTBHA may, at the direction of the State, subcontract certain SPA functions to a vendor contracted through the procurement process. NTBHA provides oversight to ensure that consumers who are involuntarily committed receive appropriate and cost-effective treatment.

6. Opportunities for Public Input
- NTBHA provides a variety of opportunities for consumers of public behavioral health services and their families to have meaningful involvement in the design, implementation, operation, and oversight of NTBHA. NTBHA conducts regularly scheduled consumer-focused meetings that provide opportunity for feedback and concerns regarding the system of care.
- Planning and Network Advisory Committee (PNAC) comprised of board appointed consumers, family members and other community stakeholders will collect insights
into the needs and preferences of consumers and their families concerning care and identify meaningful goals to improve the system.

7. Quality Improvement
   - NTBHA will provide quality management oversight to all providers in network. NTBHA will conduct surveys, needs assessments, focus groups and town hall meetings, as required by the State, with consumers in an effort to ensure qualitatively superior care is being administered. NTBHA uses this information in its quality improvement efforts. The State uses it in its regulatory oversight.

**Consumer Ombudsman Information**

The State recognizes that persons with mental illness or substance use disorders often have more difficulty engaging the service delivery and appeals systems than do individuals in the broader population. To facilitate ease of access to these systems, NTBHA will provide ombudsman services to our consumers.

NTBHA’s Ombudsman performs the following functions:
   - Provide information to consumers about managed care.
   - Assist consumers in filing grievances and appeals.
   - Assist in the resolution of consumer complaints.
   - Advocate for consumers’ interests and rights.

**North Texas Behavioral Health Authority**

9441 LBJ Freeway, Suite 350
Dallas, TX 75243
Phone: (214) 366-9407

If the consumer is experiencing an emergency medical or behavioral health condition necessitating immediate response, our clinician will stop the interview and assist the consumer in accessing emergency medical or behavioral health services.

If the consumer does not have indications of a behavioral health problem necessitating a clinical assessment, the caller will be referred to an external behavioral health resource (e.g., self-help group, etc.).

**Reporting Fraud, Waste, and Abuse**

Providers should report fraud, waste and abuse, or suspicious activity thereof, such as inappropriate billing practices (e.g., billing for services not rendered, use of CPT codes not documented in the treatment record). Reports and questions may be made in writing to NTBHA at the address below or by calling the Rights Protection Officer at (214) 366-9407.

North Texas Behavioral Health Authority
9441 LBJ Freeway, Suite 350
Treatment Record Standards and Guidelines

Consumer treatment records should be maintained in compliance with all applicable medical standards, laws, rules, and regulations as well as NTBHA’s policies and procedures and in a manner that is current, comprehensive, detailed, organized and legible to promote effective consumer care and quality review. NTBHA policies and procedures incorporate the requirements of applicable state and federal laws, rules, and regulations.

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

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

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

1. Each page in the treatment record contains the consumer’s name or identification number.

2. Each record includes the consumer’s address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.

3. All entries in the treatment record are dated and include the responsible clinician’s name, professional credentials and relevant identification number, if applicable.

4. The record is legible to someone other than the writer.

5. Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the consumer has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
6. Presenting problems, along with relevant psychological and social conditions affecting the consumer’s medical and psychiatric status and the results of a mental status exam, are documented.

7. Special status situations, when present, such as imminent risk of harm, suicidal ideation, or elopement potential are prominently noted, documented, and revised in compliance with written protocols.

8. Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.

9. A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic). For consumers 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit use of prescribed and over-the-counter drugs.

10. A DSM-IV-TR or DSM-V diagnosis is documented, consistent with the presenting problems, history, mental status examination and /or other assessment data.

11. Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution and include a preliminary discharge plan, if applicable. Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers, and health care institutions are included, as appropriate.

12. Informed consent for medication and the consumer’s understanding of the treatment plan are documented.

13. Progress notes describe the consumer’s strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives. Documented interventions include continuity and coordination of care activities, as appropriate. Dates of follow-up appointments or, as applicable, discharge plans are noted.

In addition to other requests for consumer treatment records included in this Manual and/or the provider agreement, consumer treatment records are subject to focused and random audits by NTBHA Quality Management Department or its designee, as well to audits by state, local and federal regulatory agencies, and accreditation entities to which NTBHA is or may be subject.

II. Consumer Eligibility and Services Provided

Services Provided
NTBHA has contracted to provide a vast array of ongoing and acute behavioral health services to both children, adolescents, and adults. At all times it is the primary goal of NTBHA to ensure access to care for all who qualify to the following available services:

- **Substance Use Disorder (SUD)**
  - Outpatient
  - Residential
  - Detoxification (residential and ambulatory)
  - Specialized Female/Women and Children
  - HIV specific services
- **Outpatient Mental Health (MH)** - a robust array of services are available with many of NTBHA contracted Comprehensive Mental Health Providers (CMHP)
- **Acute Psychiatric Stabilization**
  - Crisis Residential
  - Inpatient Stabilization
- **Mobile Crisis Outreach Team (MCOT)** - available to all residents in the NTBHA service delivery area

All NTBHA program eligible individuals who meet the clinically indicated criteria for SUD treatment will receive the appropriate level of care which may include any of the above listed levels of care. Those who meet residential and financial eligibility or have exhausted benefits in other existing plans (e.g., CHIP) are also eligible for mental health services. Contracted NTBHA providers will assist in completing the financial eligibility process.

**Mental Health Priority Definitions – Children and Adolescents**

Who is eligible for mental health services? Children and youth ages 3-17 who:

- Have a diagnosis of mental illness; and;
- Exhibit serious emotional, behavioral, or mental disorders; and
  - Have a serious functional impairment; or
  - Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
  - Are enrolled in a school system’s special education program because of serious emotional disturbance.

**Mental Health Target and Priority Population Definitions - Adults Initial Criteria**

Who is eligible for mental health services? Adults ages 18+ who:

Meet the criteria for Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, or severe major depression.
Adult Mental Health (MH) Priority Population - Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment. Services to individuals who do not meet the criteria for target population are reviewed on a case by case basis.

A standalone diagnosis of SUD and/or intellectual development disorder, development disorder (e.g., Autism), or other organic condition (e.g., head injury, dementia) does not meet the SMI standard.

**Prescription Benefits**

NTBHA covers prescription medications for qualified indigent consumers if prescribed by a NTBHA Network Provider. NTBHA consumers must meet the target population, and medications must be prescribed in accordance with the NTBHA Drug Formulary. In partnership with contracted CMHP’s, the Patient Assistance Program (PAP) is available to fund brand name medications that may not be available through the NTBHA formulary.

Any medications that require pre-authorization must be sent to [rx@ntbha.org](mailto:rx@ntbha.org) by the provider on the NTBHA created Prior Authorization form.

**Procedures for Providers to Verify Eligibility**

**Overview**

A consumer’s eligibility for NTBHA funded services begins after determining the consumer meets clinical and financial guidelines. The consumer’s eligibility may be terminated due to specific criteria. These criteria include the following:

- Consumer moves out of the NTBHA service delivery area.
- Consumer dies.
- Consumer’s Medicaid category changes, making them ineligible for NTBHA funded services.

It is the responsibility of all network providers to verify a consumer’s eligibility for NTBHA funded services prior to delivering non-emergency services. NTBHA reserves the right to recoup funds for services rendered to consumers that are later identified as being ineligible.

NTBHA is responsible for managing funds for indigent behavioral healthcare services in Dallas, Ellis, Kaufman, Rockwall, Hunt and Navarro Counties. A key component of the management of these funds is ensuring all members receiving services meet the minimum financial standards.
that qualify them for indigent funding. The following criteria must be met to meet minimum indigence standards to receive fully reimbursed behavioral health services:

1. Submit proof of income to determine Minimum Monthly Ability to Pay (for non psychiatric emergencies)
2. Ability to verify personal or household income
3. Ability to document residency in Dallas, Ellis, Kaufman, Rockwall, Hunt or Navarro Counties
4. Completed Head of Household form if individual receiving services is dependent on another person
5. No current behavioral healthcare coverage in an insurance plan; or
6. Exhausted benefits through another plan (with a copy of the denial notification or letter of attestation indicating as much)

**Documenting Eligibility**

Prior to requesting authorization for service, it is necessary to, at minimum, conduct a brief financial eligibility screening. It is the responsibility of contracted providers to obtain the above documentation and provide financial eligibility verification when prompted by NTBHA staff during routine QM functions. Comprehensive Mental Health Providers must document eligibility in the Provider Integration Gatherign Eligibility Online (PIGEON) system and Substance Use Disorder providers must maintain these records in CMBHS. Financial eligibility for mental health services remains with the consumer. The table below is to be used as a guide to develop a complete financial for consumers.
<table>
<thead>
<tr>
<th><strong>Outpatient Mental Health</strong></th>
<th><strong>SUD</strong></th>
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</thead>
<tbody>
<tr>
<td>• Due Annually</td>
<td>• Due every 180 days</td>
</tr>
<tr>
<td>• Calculated by the provider using the eligibility screen in PIGEON</td>
<td>• Calculated in CMBHS</td>
</tr>
<tr>
<td>• Documented in PIGEON</td>
<td>• Narrative documented in CMBHS</td>
</tr>
<tr>
<td>• Supporting documentation maintained by provider in consumer file</td>
<td>• Medicaid enrollment verification requested conducted in CMBHS</td>
</tr>
<tr>
<td>• Provider responsible for identifying initial date of financial and updating all subsequent financials</td>
<td>• Documents saved and uploaded into CMBHS</td>
</tr>
<tr>
<td>• File audits will include financial documentation</td>
<td>• NTBHA will review approximately 20% of all billed consumers to ensure complete financials present</td>
</tr>
</tbody>
</table>
| • Consumers with incomplete, missing, or inaccurate annual financials are subject to full recoupment of funds for services rendered | • Requirements of a complete financial:  
  o Explanation of current financial circumstance  
  o Some form of Identification (DL, State ID, SS Card, etc.)  
  o Verification of Residency (at least 1 bill in name of consumer or head of household)  
  o Last 2 paystubs (for spouse as well if married)  
  o Verification of Assistance form, if not working or living independently  
  o Client Attestation form (printed from CMBHS and signed by consumer)  
  o Explanation of circumstance if homeless |

| Requirements of a complete financial:  
  o Medicaid Eligibility Verification (MEV) must be completed on all consumers  
  • Consumers without MEV at time of intake and end up being on Medicaid, may be fully recouped  
  • It is recommended that MEV be conducted on a monthly basis for |
<table>
<thead>
<tr>
<th>consumer or head of household</th>
<th>consumers that remain in treatment for longer periods of time</th>
</tr>
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<tbody>
<tr>
<td>o Last 2 paystubs (for spouse as well if married)</td>
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<tr>
<td>o Explanation of circumstance if homeless</td>
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</table>

**Provider Responsibilities**

If the consumer’s current eligibility status is active, a provider should then follow the authorization procedures. A local case number (LCN) is created and stored for all consumers (mental health only) served by NTBHA in PIGEON. The LCN is a unique identifier to NTHBA consumers generated using the Provider Integration Gathering Eligibility Online (PIGEON). Providers will be authorized and generated access as needed by NTBHA staff. A consumer’s LCN must be used for all services, billing, and other interactions between NTBHA, the provider and the consumer.

NTBHA is considered the payor of last resort, however, there are circumstances when consumers have benefits that do not cover all services or benefits they cannot afford to access. Review the circumstances below for additional eligibility scenarios:

1. Medicare Coverage- ex. Medicare does not cover rehabilitation services
2. Medicare Part D- Consumer is currently in coverage gap for prescriptions and meets indigent standards
3. Medicaid
   a. Services available through NTBHA that are not covered by Medicaid. A thorough explanation is required for any consumer that has Medicaid, but NTBHA is funding services
4. Private Insurance- ex. Consumer unable to meet deductible due to financial hardship

In the event a consumer with other benefits is eligible for NTBHA covered services, a full financial update in PIGEON is required.

**Involuntary Termination of Eligibility**

NTBHA may request that a consumer’s eligibility be involuntarily terminated due to certain criteria. These criteria include the following:

- Severe disruptive behavior not caused by a behavioral health condition at a network provider’s office
• Non-compliance with the financial and/or clinical assessment forms.
• Resolution of an emergent condition for an out-of-area individual.
• Consumer no longer meets residential eligibility criteria.
• Consumer no longer meets financial eligibility criteria.
• Consumer no longer meets clinical eligibility criteria.

Consumers may appeal the involuntary termination of benefits through the Appeals, Complaints, and Grievance Procedures described in Section VI of this Manual.

III. Consumer Information

Consumer Rights

Each consumer receiving NTBHA funded services is a partner in his or her behavioral health care and each individual has certain rights. We feel that it is important that our Network Providers are aware of the rights NTBHA guarantees to its consumers while they are receiving services under the NTBHA program. Under the NTBHA Program, consumers have the right to the following:

1. Dignity, privacy, confidentiality, and non-discrimination. This includes the right to:
   • Be treated fairly and with respect.
   • Know that their medical records and discussions with their providers will be kept private and confidential and not shared without their written permission.

2. Ability to choose a mental health or SUD provider from the NTBHA network and a reasonable opportunity to change providers if they choose to do so. This includes the right to be informed about how to choose or change providers.

3. The opportunity to ask questions and get answers about anything they don’t understand. This includes the right to:
   • Have their provider explain their behavioral healthcare needs to them and talk to them about the different ways their behavioral healthcare problems can be treated.
   • Be told why care or services were denied and not given when requested by the consumer or their provider, or why services were modified from those requested by the consumer or their provider.

4. The ability to consent to or refuse treatment and to actively participate in treatment decisions. This includes the right to:
   • Be treated in the least restrictive, clinically appropriate setting.
   • Give permission for their family members or guardians to be involved in the planning of their treatment.
   • Work as part of a team with their provider in deciding what behavioral healthcare is best for them.
   • Give consent to the care recommended by their provider.
5. The utilization of each available complaint process through NTBHA and/or the State, including receiving a timely response to complaints. This includes the right to:
   • Make a complaint to NTBHA or to the State about their behavioral healthcare or behavioral health provider.
   • Get a timely answer to their complaint.

6. Timely access to care that does not have any communication or physical access barriers. This includes the right to:
   • Have telephone access to a behavioral health professional 24 hours a day 7 days a week to obtain any needed emergency or urgent care.
   • Get behavioral healthcare in a timely manner.
   • Be able to get in and out of a behavioral health provider’s office, including barrier-free access for persons with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act.
   • Have interpreters, if needed, during appointments with their providers and when talking about their plan. Interpreters include people who can speak in the consumer’s native language or those with Level III interpretive sign language services for the hearing impaired, those who assist with a disability or help the consumer understand the information provided.
   • Be given an explanation they can understand about their behavioral health plan rules, including the services they can get and how to get them.

Consumer Responsibilities

Just as consumers have rights, they also have responsibilities as partners in their recovery. Consumer responsibilities include:

1. Learn and understand, to the best of their ability, each right they have under the NTBHA program. This includes the responsibility to:
   a. Ask questions if they don’t understand their rights.
   b. Make any changes in their behavioral health provider in the ways established by NTBHA and approved by the State.
   c. Keep their scheduled appointments.
   d. Cancel appointments in advance when they can’t keep them.
   e. Use a NTBHA provider for all but emergency room care in an emergency or life threatening situation.
   f. Understand when it is appropriate to go to an emergency room and when it is not.
g. Always contact their behavioral health provider first, or NTBHA if they do not have a behavioral health provider assigned, to locate a NTBHA provider for their non-emergency behavioral health needs.

h. Abide by the NTBHA policies and procedures, and obtain an explanation of these, if they are not understood, from their provider or NTBHA.

2. Share information relating to their behavioral health status with their behavioral health provider and become fully informed about behavioral health service and treatment options. This includes the responsibility to:
   a. Tell their behavioral health provider about their behavioral health.
   b. Talk to their behavioral health provider about their behavioral healthcare needs and ask questions about the different ways their behavioral healthcare problems can be treated.
   c. Help their behavioral health provider obtain their medical records.

3. Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their behavioral health. This includes the responsibility to:
   a. Work as a team with their behavioral health provider in deciding what behavioral healthcare is best for them.
   b. Understand how the things, they do can affect their behavioral health.
   c. Do the best they can to stay healthy.
   d. Treat behavioral health providers and staff with respect.

**Consumer Access to Services**

1. *Emergency, Urgent, and Routine Appointment Standards*

The State's standards for appointments for NTBHA consumers are as follows:

- **Emergency:** Immediately
- **Urgent:** Within 24 hours of request, including transfer between levels of care during an SUD episode.

- **Routine:** Within 14 calendar days of request
The State also requires NTBHA to ensure that their Network Providers complete a behavioral health assessment and treatment plan within three (3) days of a routine outpatient visit and within 48 hours of an emergency or urgent inpatient or residential placement.

2. Schedule for Outpatient Appointment after Hospital Discharge

Per State requirements, outpatient services must be scheduled prior to a consumer’s discharge from an inpatient (or other 24-hour) setting. Consumers must be seen within seven (7) days of discharge for mental health follow-up care and within five (5) days for SUD follow-up care.

3. Appointments, Missed Appointments, and Follow-up

Providers are not permitted to bill patients for missed appointments.

Consumer Special Needs Affecting Access to and Delivery of Services

Cultural and Linguistic Sensitivity, Including Use of Interpreters

The State is particularly concerned that each consumer who needs culturally appropriate services receive services from a provider who is sensitive to his/her cultural background, values, and perspective. Because of this, NTBHA will:

• Coordinate services with community advocates and agencies that assist non-English and limited-English speaking individuals and/or provide other culturally appropriate services.

• Ensure that all of our marketing and eligibility materials are written at the 4th through 6th grade reading levels and are available in alternative formats for the blind and disabled and in the language of any population group that comprises more than ten percent of our consumers.

• Ensure providers offer 24-hour access to interpreter services for consumers to access emergency behavioral health services within our network.

In keeping with both the State’s requirements and its own mission, NTBHA must also make certain that its Network providers take the following steps:

• Provide interpreter services for consumers as necessary to ensure effective communication – including translated written/video materials, e.g., documents, forms and information pamphlets regarding behavioral health prevention services (assessment, treatment, or education)
• Use trained, professional interpreters when behavioral health treatment information is to be discussed. Family members or friends are discouraged from being used as interpreters in behavioral health treatment.

• Have an identified staff member to assist consumers who are deaf or hard-of-hearing.

• Maintain a current list of interpreters who are "on-call" to provide interpreter services and make a copy of the list readily available to NTBHA (for submission to the State) upon request. This list will include individuals that can competently translate Spanish and provide Level III interpretive sign language services.

• Comply with Title III of the Americans with Disabilities Act and have TDDs in offices where the primary means of offering goods and services is by telephone.

If you have any difficulty in understanding the above requirements, or if you need further information, please contact NTBHA at (214) 366-9407.

IV. CMHP Policies and Procedures

NTBHA’s Criteria for CMHP Providers

The following established criteria is used for selection of potential CMHP providers:

• Previous experience and demonstrated ability to provide necessary services to target populations.

• Ability to coordinate care and maintain accountability for service provision to SMI/SED consumers, including:
  
  o Established referral relationships and written coordination agreements with behavioral health providers to ensure that consumers can access medically necessary covered services in a timely manner.

  o Referral relationships and written coordination agreements with local human service agencies to ensure that necessary support services are available and accessible for eligible consumers.

  o Ability to provide all services outlined in the Texas Resiliency and Recovery (TRR) model (http://www.dshs.texas.gov/mhsa/trr/)

  o Complete and maintain trainings and competencies identified in Texas Administrative Code (TAC) 412.316

• Policies and procedures to ensure coordination between behavioral and physical health Providers.
• In addition to providing all core CMHP services identified above, must be able to provide or arrange for all coordinated CMHP services.

• Policies, procedures, and sufficient staff to provide plan of care oversight, coordination of care, and case management services.

• Ability to accept referrals and ensure access to care within required time frames for routine, urgent, and emergent care.

• Policies, procedures, and staff necessary to assist NTBHA in managing the mental health commitment process.

• Sufficient numbers of qualified staff to provide clinical assessments within required time frames for all eligible consumers.

• Functional Quality Management program, including policies and procedures for utilization review/utilization management.

• Ability to maintain and report data, including consumer and encounter data, within required time frames in a format acceptable to NTBHA.

• Provide accurate charting as required by NTBHA quality standards and those required to make a disability determination by application of SSI/SSDI benefits.

Selection Process for NTBHA’s CMHP Network

CMHP providers who meet the requirements of the CMHP RFA during each open enrollment period will be eligible to contract with NTBHA to provide services. Criteria will include the providers ability to offer a comprehensive array of services established by the State and to utilize Texas Resilience and Recovery (TRR) guidelines. After careful review of an application, NTBHA may ask additional questions or schedule an on-site review of the facility. NTBHA uses State-approved selection criteria.

NTBHA will continuously monitor and assess whether the network is adequate. If the decision is made to expand the CMHP network, NTBHA will solicit applications for this service through an open enrollment or competitive proposal process.

Services to be Provided Directly by NTBHA’s CMHPs

The services that we look to our CMHPs to provide directly include the following:

• Financial assessment

• Availability of licensed clinical and psychiatric staff to assist consumers and potential consumers with urgent and emergent needs

• Clinical assessment and coordination of care including case management, wraparound, and ACT team or other intensive community support services for eligible consumers
• Outreach and support services to individuals who are homeless or who are residing in local jails or juvenile detention centers
• Rehabilitation services as defined by the Texas Resilience and Recovery Guidelines
• Psychiatric evaluation and medication monitoring

Services to be Provided or Coordinated by NTBHA’s CMHPs

CMHP providers must have referral relationships and written agreements for coordination to ensure that consumers can access the medically necessary covered services for which they are eligible if they do not directly provide a covered medically necessary service. Unless a service is made available system wide by NTBHA, the CMHP must secure access to these services. They should assist consumers in obtaining these services when medically needed:

• 24-hour mobile crisis intervention and assessment capability
• Acute inpatient stabilization
• Residential treatment, including intensive crisis residential services
• Therapeutic and treatment foster care
• Personal care homes/assisted living and adult foster care;
• Specialized rehabilitation services, including partial hospitalization, day treatment, and vocational services
• Supported housing
• Psychological evaluation
• Employment related services, including supported employment
• Needed SUD treatment services for CMHP consumers
• Early intervention services for children 3 – 5 years old

NTBHA’s CMHP Referral Process

At the time of initial referral for services, providers and NTBHA Quality Management Customer Service representatives perform a brief telephone screening to identify consumers who may qualify for CMHP assignment. These include individuals with histories or current signs and symptoms consistent with an SMI/SED designation, as well as other consumers whose functioning and service needs are like those of defined target populations. Based on the telephone screening, such individuals are referred to a CMHP provider for clinical and financial assessment. Individuals who do not appear to meet these criteria may be referred to either a CMHP provider or an alternative network provider for assessment, depending on the needs and wishes of the individual. If more than one CMHP provider is available in the geographic area in which the individual lives, the individual is referred to the CMHP provider most appropriate for his/her needs. If more than one CMHP provider can meet the consumer’s needs, the consumer is given a choice of providers.
Consumers who wish to change their assigned CMHP may do so at any time by contacting an in-network CMHP provider of their choice. Once the receiving CMHP provider has determined that they can meet the consumer’s needs, they will contact the consumer’s assigned CMHP to request a discharge of the consumer from their services.

Oversight and Assistance for CMHP Network Providers

CMHP Coordinating Meetings

NTBHA meets regularly with CMHP providers, usually monthly. Policy changes, programmatic issues and other topics are routinely covered. The CMHP providers are encouraged to actively participate in the meetings.

Daily CMHP Oversight

Administrative Services provides day-to-day oversight of the CMHP network, including monitoring of all CMHP performance against defined performance criteria. The Director of Administrative Services works closely with other senior management staff, including the Chief Clinical Officer, the Chief Operations Officer, the Quality Management Manager, the Chief Information Officer and the Director of Finance in performing this daily oversight and monitoring.

V. Clinical Policies and Procedures

Introduction

The role of NTBHA is to coordinate the delivery of clinical services. There are three parties to this care coordination process: the consumer, the provider(s), and the Utilization Management Department. Each party has a significant role to play to assure that care is coordinated, consumers receive medically necessary and needed services within the scope of their eligibility, and providers both deliver quality care and get reimbursed for the services they provide.

Roles of Consumers and Their Families in Treatment

NTBHA embraces the premise that to be maximally effective, behavioral health treatment needs to be an active process. This means that consumers and their families are expected and encouraged to be active participants in the treatment process to the full extent of their capabilities.

Roles of Providers

The provider's role is to provide timely access for assessment and treatment services for consumers receiving services funded by NTBHA. Providers are responsible to involve consumers and their families in the treatment process, for coordination of care with other
providers and human service agencies, for measuring treatment outcomes and satisfaction with care, and working collaboratively with NTBHA to meet the needs of consumers. Providers will have an organized system to screen, assess, refer, and follow-up with consumers with Co-Occurring Psychiatric and Substance use Disorders (COPSD). Assessment procedures used by providers will be sufficiently sensitive to detect substance use disorders among consumers with psychiatric disorders and mental illness symptoms. Providers who serve consumers with dual diagnosis will be trained per COPSD requirements in the Texas Administrative Code (Chapter 411.651-660).

Roles of NTBHA’s Utilization Managers

NTBHA Utilization Managers assist providers in assuring that consumers access the services they need at the most appropriate level and intensity of care, for the right amount of time. Utilization Managers work with providers to authorize the delivery of medically necessary services. Utilization Managers also assure that providers are performing comprehensive assessments, developing specific, individualized service plans, coordinating the delivery of care, and providing or referring consumers to additional services.

Referral Information

Access to Care

Access to care may occur through one of three processes:

- Various sources may make referrals directly to a provider or agency within the NTBHA network.
- Individuals or family members seeking help may contact the NTBHA provider directly.
- Referral sources may contact NTBHA to obtain a referral.

When consumers call NTBHA for entry into services funded by NTBHA, a brief screening to determine the clinical needs of the consumer and to confirm basic demographic information is conducted. Based on the information gathered from the consumer during this telephonic screening, the consumer is referred to an appropriate network provider for a clinical and financial assessment.

Treatment for Ineligible Individuals

Indigent individuals who do not meet the clinical and/or financial necessity criteria for fully or partially funded NTBHA services may be treated by providers with alternative funds or may be referred to other community services.

Authorization

Service Authorization Review
To better serve those in crisis, we request that routine calls to our Utilization Management Department at 469-299-9451 (i.e. those that are not urgent or emergencies) be made during business hours, Monday through Friday, 8:00 am to 5:00 pm CST. NTBHA’s Utilization Management Department provides authorization for all covered services. Requests for authorization of emergent or urgent levels of care is conducted telephonically when providers call the NTBHA Utilization Management Department to request authorization of services, present and discuss clinical information, and receive a decision regarding the request.

Authorizations for rehabilitative and supportive services which are delivered through the Comprehensive Mental Health Provider (CMHP) require an assessment in CMBHS which includes the CANS or ANSA. In addition, for LOC 4, a treatment plan must be submitted.

**Mental Health Outpatient Levels of Care - Review and Authorization**

Outpatient services are authorized by NTBHA in accordance with the HHSC Texas Resilience and Recovery (TRR) UM guidelines and in a way that does not inappropriately deny persons’ access to services. In some instances, if additional information is required to make an authorization determination, the NTBHA Utilization Manager may request submission of the complete treatment plan from the consumer's medical record.

**Utilization Management Review/Utilization Management (UM) Program**

The NTBHA Utilization Management (UM) program encompasses management of care from the point of entry through discharge using objective, standardized, and widely-distributed clinical protocols, and enhanced outpatient care management interventions. Intensive utilization management activities may apply for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk. Participating providers are required to comply with utilization management policies and procedures and associated review processes. Examples of review activities included in UM program are determinations of medical necessity, preauthorization, certification, notification, concurrent review, retrospective review, care/case management, discharge planning and coordination of care.

The UM program includes processes to address:

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

Objective, evidence based clinical criteria and treatment guidelines, in the context of provider or member supplied clinical information, guide the utilization management processes.
The overall purpose of the utilization management process at NTBHA is to ensure that consumers receive quality, cost effective services in the most appropriate treatment setting, and in a timely manner. The Utilization Management (UM) Department manages the utilization of clinical resources by monitoring patterns of over-utilization, under-utilization, inefficient scheduling or provision of services, and any other identified problems that compromise care. The UM Department strives to achieve a balance between the needs and well-being of the persons in need of behavioral health services and the demand for services and availability of resources. UM is a critical component to the Texas Health and Human Services Commission State Health Services (HHSC) Mental Health (MH) initiative.

NTBHA maintains an infrastructure which supports the implementation and maintenance of key UM processes and functions, incorporating UM data and information into management decisions. Key UM processes include the facilitation of access and referral to services, promotion of the most effective use of resources, and the ongoing exchange of clinical information between NTBHA and providers.

NTBHA maintains a comprehensive UM Program Plan, provides an adequate number of qualified UM staff to implement it, and supports the activities of a UM Committee. To be effective, the UM program:

- Recognizes the evolutionary nature of Utilization Management.
- Acknowledges the efficiencies that will be gained as managers improve their ability to use data and providers gain trust in UM as a process to facilitate access to care rather than create barriers to care.
- Uses data to identify patterns of utilization, working with clinicians to determine if the patterns and variations are desirable or not; and working with providers to make needed improvements.
- Ensures that clinically qualified persons make decisions throughout the authorization process.
- Limits the use of prior authorization to only the highest risk, highest cost services where the need for prior authorization has been demonstrated.
- Reduces prior authorization and concurrent review requirements for providers who demonstrate a consistent ability to follow the UM Guidelines and submit appropriate documentation.
- Capitalizes on information management technology and oversight activities which will allow Automatic Authorization for some services based on provider submission of appropriate clinical data.
- Conducts retrospective reviews in conjunction with other local authority functions such as Quality Management (QM), Claims Management and Data Verification to maximize the use of staff resources.
• Integrates utilization data into various local authority functions to include strategic and local planning.

Utilization Management is a dynamic process that provides timely, accurate and relevant information to facilitate fact-based decision making by NTBHA and results in positive outcomes for persons receiving services and improved provider practice. UM staff and the UM Committee recommend and participate in interventions to make utilization of services more effective, efficient, and consistent with contractual requirements and the local planning processes.

NTBHA UM responsibilities include:
• Developing, implementing, and improving the Utilization Management Program so that it meets the needs of people receiving services, the community, NTBHA and HHSC
• Conducting prospective, concurrent, and retrospective reviews to authorize services using the HHSC Utilization Management Guidelines and ensuring that people are receiving and benefiting from services
• Applying objective criteria when making adverse determinations
• Ensuring notification of adverse determinations to the person requesting or receiving services and his/her provider, including information on how to file an appeal
• Managing appeals in a timely manner per established procedures
• Implementing Utilization Care Management for persons with special circumstances and needs to ensure their access to needed services
• Collaborating with other functions such as Quality Management, Financial Services, and Network Management in the use of UM data and with providers in planning interventions to improve provider practice
• Coordinating and supporting the activities of the UM Committee

Participating at the state level with HHSC in the future development and evolution of the HHSC UM Guidelines.

NTBHA Service authorization requests in CMBHS are reviewed with the following guidelines:
• Determination made within two business days when all relevant information is provided.
• Notification of authorization is available to providers within two business days of making the determination.
• Authorizations are required on all consumers with corresponding encounters

Clinical Overrides and Exceptions

a. Overrides
NTBHA may authorize a clinical override to the TRR Guidelines, which may result in placement in an alternate level of care for the following reasons:

- **Consumer need**: A person has a medical need for services, evidenced by psychiatric inpatient admissions, which are included in a level of care other than the one recommended by the TRR.

- **Continuity of Care**: The TRR recommends a lower level of care but the person is maintained in the current level of care for clinical reasons such as ensuring that improvements are maintained.

- **Other**: A person presents for care and a clinician determines that an extenuating circumstance exists that requires the person to be served that is not captured in one of the other deviation reasons.

- **Consumer Choice**: A person chooses not to receive services in the TRR recommended level of care and wants to move to a lower level of care.

b. **Exceptions**

NTBHA may authorize an exception to the amounts of service within a level of care for the following reasons:

- **Consumer need**: A person in services and the clinician determine that an extenuating clinical circumstance exists that require the person to be served with an increased frequency or duration of services than is routinely authorized by NTBHA.

**Requests for Clinical Deviations**

If, when applying the TRR, the Licensed Professional of Healing Arts (LPHA) conducting the eligibility determination, identifies that one of the approved conditions exist for granting a clinical deviation, the LPHA will request an alternative LOC on the assessment and/or treatment plan.

The exception and clinical deviations processes are not intended as mechanisms for appeal. These mechanisms are to ensure that members have access to clinically appropriate services.

**Inpatient and Alternative Levels of Care**

a. **Pre-authorization**

NTBHA requires pre-authorization for all funding requests for crisis levels of care. Entry into crisis services can occur through several entry points; however, the below processes must be followed. If the below guidelines are not followed requests may be administratively denied. Provision of services not authorized in accordance with these requirements will not be reimbursed by NTBHA.
• Meet established clinical care criteria for admission into a psychiatric emergency level of care
• Facility transfers require prior authorization for all levels of psychiatric emergency care
• Failure to supply clinical and eligibility forms within 24 hours of admission at a psychiatric hospital may result in non-payment of services
• Discharge documentation required for all consumers admitted to any crisis level of care; discharge documentation from an inpatient psychiatric level of care must include an outpatient appointment date (within 7 days of the discharge) and must be provided to NTBHA within 2 days of the consumer’s discharge; discharge planning should include collaboration with NTBHA Care Coordinators. At a minimum discharge planning should include:
  o An outpatient appointment with 7 days
  o Case management services if indicated
  o Outpatient medications
  o A housing plan
• Weekday census updates must be sent to um@ntbha.org each day by 9:30 AM. A template will be provided to hospitals upon request. Updates should include:
  o Demographic/patient identifying information
  o Legal status and OPC county if applicable
  o Diagnosis, including F code
  o Admission date, expected discharge date, and discharge date
• Services provided by the pre-transfer facility after a transfer has been initiated, approved or arranged, will not be reimbursed if the treating facility fails to adequately coordinate the transfer, or fails to obtain pre-authorization for continued service

After performing the assessment and stabilization responsibilities, please follow these steps when requesting precertification to acute levels of care:

  o **Contact** the Utilization Management Department for pre-authorization of services for all eligible consumers for request of information consistent with continuity of care or coordination assistance for seeking a higher level of care.

  o **Required Clinical and Demographic Information:** When you contact the Utilization Management Department to request pre-authorization, please ensure the Eligibility and Clinical forms have already been faxed (469-420-5496) or emailed to NTBHA
o Capacity All authorization are based on capacity and authorizations will be prioritized based on acuity. If NTBHA is unable to authorize funding related to a crisis level of care due to capacity and the provider may contract NTBHA UM to request funding consideration every 24 hours. The provider should be able to provide information related to the consumer’s acuity within the last 24 hours, attempts to stabilize the patient, and attempts to obtain appropriate care for the consumer.

b. Inpatient Psychiatric Transfer Process
   o NTBHA authorized transfers will be facilitated by Bed Access (Transicare), with transportation by Transicare. Transfers occurring outside of the NTBHA authorized process may result in an administrative denial.
   o Contracted hospitals will make a good faith effort to accept transfer requests in collaboration with NTBHA and the originating facility into the dedicated capacity. If a contracted hospital is unwilling to accept a transfer, the denial reason must be conveyed and clearly within the hospital’s written exclusionary criteria. Hospitals will maintain a minimum 65% rate of bed days occurring by consumer’s transferring into the facility as calculated on a monthly basis.
   o Delays in access to the NTBHA dedicated capacity (e.g., unable to complete admission process timely due to pending discharge or lack of available appropriate bed) may result in reduced reimbursement; reduced capacity due to delays may be adjusted by added capacity within the month when authorized by NTBHA

c. Concurrent Review/Authorization Extensions

It is up to providers to contact the Utilization Management Department to request additional authorizations. Providers should contact NTBHA per the instructions provided by the Utilization Manager during the initial authorization. NTBHA does not initiate calls to providers for continued stays and concurrent reviews. Failure to follow the below guidelines may result in administrative denials. Adjustments to the below guidelines may be granted when appropriate, but must be documented by NTBHA staff in writing. Please follow these steps related to concurrent reviews or continued stay requests

   o Submit the Concurrent Review Checklist and/or other information requested by NTBHA staff. Documentation must be submitted by 1:00 PM on the last uncovered. The Concurrent Review Checklist has a companion document

(um@ntbha.org).
that is located in Appendix A. It is called the North Texas Behavioral Health Authority Guide to Concurrent Reviews. It is to be utilized as a reference for information that is to be submitted on the Concurrent Review Checklist. Information that is included on the Guide that is not on the Checklist may be returned or denied funding. Both the Checklist and Guide are documents that are updated periodically to ensure the most relevant information is documented and reviewed. New versions of both will be sent out accordingly.
Late submission of documentation and/or incomplete documentation may result in an administrative denial. Information can be submitted through fax (469-420-5496) or email (um@ntbha.org).

- A facility requesting continued stays must provide a contact to telephonically review continued stay requests at a scheduled time each weekday.

- Providers should utilize the NTBHA formulary when making decisions related to medications. If a facility intends to prescribe a medication which requires prior authorization, a prior authorization form should be submitted prior to administration of the medication for review regarding the ability for the medication to be continued on an outpatient basis.

- Concurrent reviews will support care by monitoring areas such as: need for ongoing inpatient stay, aggressiveness of psychiatric treatment, persistent of medication commitments when appropriate, submission of prior authorization forms when needed, continuity of care with prior treatment and/or outpatient provider, involvement of collateral supports when appropriate, discharge planning, and patient rights.

- NTBHA requires aggressive psychiatric treatment. To support providers in providing best care a peer consultation between the treating physician and the NTBHA Medical Director may be arranged for complex case staffings.

- NTBHA recognizes inpatient psychiatric admission as a high level of care. If an individual is stabilized and no longer in need of such a restrictive level of care, stepdown to another level of care (e.g., crisis residential) may be arranged. Stepdown to a lower level of care may be an element related to discharge planning; however, planning should extend beyond the transitional level of care and include an appointment with an outpatient provider within 7 days of discharge from the psychiatric admission.

- NTBHA requires notification of a held discharge as soon as possible, with the latest notification prior to 9:00 AM on the day after the expected discharge. For ongoing funding consideration NTBHA must be notified of the discharged timely and informed the reason of the discharge, the discharge plan, and the expected adjustment for successful discharge.
d. Appeals

- Request for emergent psychiatric services does not guarantee approval. Medical necessity criteria and available funding for services must be met and available at the time of request. NTBHA has an expedited appeal process when services are not authorized due to medical necessity criteria based on the immediacy of the condition. Denial of admission or continued stay for inpatient services requires an expedited appeal process. Within one hour of making the adverse decision, NTBHA notifies the individual requesting or receiving services, the individual’s LAR, anyone the individual designates to advocate for him/her, or the individual’s provider of the adverse decision.

- Once notified of a denial of inpatient services or continued stays for hospitalization, the individual requesting or receiving services, the individual’s LAR, anyone the individual designates to advocate for him/her, or the individual’s provider will have one business day to request an appeal through NTBHA’s UM Department. However, if notification of the denial is made at 5:00 PM or later, they will have until 8:30 AM the next business day to make the request.

- A NTBHA physician who was not involved in the original authorization decision reviews the appeal. The expedited appeal is completed based on the immediacy of the condition and no later than one calendar day from the date that all information necessary to complete the review is received by NTBHA.

- Within one calendar day of the decision, UM staff assigned to the case verbally, in person or telephone, as well as certified mail (Appeal Resolution letter), notifies the appellant and individual requesting or receiving services, if different, and his/her provider of the decision.

- At any time, the appellant and individual requesting or receiving services, or their LAR, may contact the DSHS Office of Individual Services and Rights Protection (1-800-252-8154) for further review of their concern about the appeal decision and any proposed action.

e. Discharge Planning

- **Begins at Admission:** Discharge planning begins at the time of admission as a collaborative effort between the Utilization Managers and the treating provider. The intensity of the Utilization Manager involvement in discharge planning will vary, depending upon the consumer’s needs and the level of care from which the consumer is being discharged.

- **Updating the Discharge Plan:** Discharge plans should be updated throughout a consumer’s stay, and should be updated and revised as necessary per the decisions reached in the concurrent review authorization process. Authorization for other levels of care will be based on clinical necessity, current
treatment plan, continuity-of-care issues, acuity, and capacity. Discharge planning should occur collaboration with NTBHA Care Coordinators. Discharge planning should address the drivers related to the current crisis and include at a minimum:

- An outpatient appointment with 7 days
- Case management services if indicated
- Outpatient medications
- A housing plan

  o *Follow up appointment*: A critical component of discharge planning is the scheduling of the follow-up appointment. Per State requirements, outpatient services must be scheduled prior to a consumer's discharge from an inpatient (or other 24-hour) setting. Consumers must be seen within seven (7) days of discharge for mental health and within five (5) days for SUD treatment.

**Information Required for Service Authorization**

NTBHA shares with providers the common goal of delivering care that is most appropriate given the severity of the illness and intensity of needed services. A review of current clinical data is required at all levels of care. The initial review should identify problems requiring treatment at the identified level of care, the treatment approach which will be used to resolve the current problem(s) and an identification of objectives by which to monitor progress, including length of stay. Further reviews should focus on a solution-oriented response to treatment, any revisions in the treatment plan and the discharge or follow-up plan. The provider should be prepared to discuss the following with a NTBHA Utilization Manager to facilitate the process. The clinical records should contain the same type of information to facilitate the review process.

After obtaining basic demographic information on the consumer (name, LCN, etc.) and the services requested, the following information, as relevant, will be gathered telephonically with as much detail as the provider can complete:

- Contact person
- Name/credentials of assessing/treating provider
- Date of Assessment
- Telephone number (contact person and/or assessment clinician)
- Date of Review
- Presenting problem
  - Detailed description of the problem, including severity of symptoms
  - Who prompted the call (e.g., family, consumer, etc.)
  - Evaluation of precipitants
  - Stressors
  - Social support
- Mental Status
• Evaluate orientation x3/reality testing/thought
  process/content/affect/mood
• Judgment/insight/intelligence/memory
• Suicidal ideation, plan, history of attempts-details-including specific
  thoughts and plans
• Homicidal ideation, plan, violence history – details

• Psychiatric History
  o Illness and previous treatment with outcomes

• SUD History
  o Consumer’s current use pattern (particularly in the last week)
  o Prior use and treatments, if any (persubstance)
  o Family history of SUD
  o Criminal history (currentstatus)
  o Special needs/special services consideration
  o Treatment readiness
  o Obstacles for treatment access

• Medical History
  o Date of most recent physical exam
  o Current medical problems
  o Any current medical treatment
  o Coordination of care with medical provider (Primary Care Physician
    [PCP])

• Medications
  o All current coordination of medications with PCP

• Family History (including pre-morbid functioning)
  o Include illness and treatment received by family consumers
  o Current family composition and any overt dysfunction

• Current Work Status of Consumer

• Work/School History and Status

• Social Functioning

• Community Support

• Risk Assessment
  o Ideation (Suicide/Homicide)
  o Plan (is there a current plan?)
  o Intent (will the eligible individual contract for safety?)
  o Means
  o Dates of previous attempts

• Diagnosis
  o Axis I (Clinical Disorders)
  o Axis II (Personality Disorders/MentalRetardation)
  o Axis III (General Medical Condition)
  o Axis IV (Psychosocial and EnvironmentalProblems)
  o Axis V (Global Assessment of Functioning –[GAF])

• Treatment Plan
  o Focus
  o Goals
  o Interventions
- Estimated Length of Stay and Target Dates for Improvement
  - Discharge
    - Discharge plan and anticipated discharge date
    - Transition Plan to the next level of care (who, where and when)
    - Placement, if relevant
    - Legal guardianship, if any
    - Resources needed to support compliance
    - Continuity related to established therapeutic relationships
    - Family/significant other involvement
  - Review Outcome (decision on the Level of Care and length of authorization)
  - Cite applicable Level of Care Criteria

**Peer Review and Medical Necessity Determination**

During an authorization review, the NTBHA Utilization Manager requests clinical information about the consumer’s condition and response to treatment to assure that the requested level of service meets medical necessity. At times, the Utilization Manager may indicate that he/she cannot authorize the requested level of care due to the apparent lack of medical necessity. In these instances, the Utilization Manager may discuss alternative levels of care or treatment plans that could be authorized. If the provider disagrees with these recommendations, and maintains that the requested level of care is the one that is required, the case will be referred to the Medical Director for Peer Review. Utilization Managers cannot deny level of care requests. Only the Medical Director (or other physician on staff) can issue such a denial.

If a peer-to-peer review was not completed prior to the adverse determination, then reconsideration may be requested within 3 days. NTBHA will perform a good faith effort to try to resolve any disagreements regarding non-authorization decisions in an expedient informal manner before proceeding to the appeals process. Please see the Appeals, Complaints, and Grievances section for a formal description of the State-approved NTBHA Appeal, Complaint, and Grievance policy.

**VI. Appeals, Complaints, and Grievances**

**Definition of Terms**

In compliance with State requirements, NTBHA defines the following terms related to consumer or provider concerns with the NTBHA program:

**Administrative Denial:** A denial of services, or claims payment for services, based on reasons other than a lack of medical necessity.

**Administrative Appeal:** a request by a consumer, consumer-designated representative, or provider to reconsider an administrative denial.

**Adverse Determination:** a determination that the health care services requested or proposed to be provided to a consumer are not medically necessary.
Clinical Appeal: a request by a consumer, consumer-designated representative, provider, or facility to review an adverse determination made in response to a request for services.

Complaint: any dissatisfaction expressed by a complainant orally or in writing to NTBHA with any aspect of NTBHA operation, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way decisions are made concerning how service is provided and decisions are made. Complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the consumer. It does not include a provider’s or consumer’s oral or written dissatisfaction or disagreement with an adverse determination.

Grievance: A verbal or written communication from a complainant of dissatisfaction with the outcome of a complaint resolution.

Inquiry: An oral or written communication from an external party seeking information or requesting an action or assistance (e.g., request to check eligibility, clarify benefits, explain a process, check on the status of a claim/invoice) that does not meet the definition of a “complaint” or an “appeal”.

Complaint Process

An important component of the NTBHA Quality Management Program is the complaint resolution process. There is a defined complaint process that meets State requirements. Complaints may be submitted orally or in writing by the complainant. Complainants include consumers, family members, other consumer representatives and providers. Complaints are acknowledged within five (5) business days from receipt of the complaint and resolved within thirty (30) calendar days. The complainant receives both an acknowledgement and a resolution letter within the timeframes specified above. The acknowledgement letter comes with a complaint form to provide additional complaint details when an oral complaint is made. The form may be completed and mailed or faxed back to the attention of the QM Department using the contact information provided in this section. Completion of this form is optional. The resolution letter is mailed to the complainant and provides a determination or details regarding what was specifically done to address the complaint. Additional complaint and appeal process options are attached to the resolution letter.

At no time, will NTBHA retaliate or take any discriminatory action against a consumer or provider due to filing a complaint, a grievance, or an appeal.

How to initiate a complaint

Contact NTBHA at (214) 366-9407 to speak directly to a QM Customer Service representative who will assist in documenting the nature of the complaint. The NTBHA Customer Service
Department is accessible to non-English speaking Consumers through a language translation service.

Mail written complaints directly to the attention of the:

NTBHA QM Department  
9441 LBJ Freeway, Suite 350  
Dallas, TX 75243

Fax complaints directly to NTBHA QM Department at (214) 366-9417 QM  
Department staff is available between 8:00 am and 5:00 pm central standard time.

A consumer may designate a representative to file complaints on their behalf. There are no time limits for the filing of a complaint.

Complaint Resolution

All complaints are investigated in coordination with the appropriate NTBHA department and handled by the QM Department staff. Written notification includes clinical or contractual rationale, if appropriate, for the outcome of the investigation.

NTBHA aggregates complaints by provider and complaint type in order to identify trends and quality of care concerns. Aggregate reports are presented at least annually to the Quality Management Committee (QMC).

Complaint resolution letters include the procedure for requesting the next level of review if the complainant is not satisfied with the resolution of their complaint.

Administrative Appeal

When a service is denied based on administrative determination, a Denial of Authorization Letter is mailed to the individual requesting or receiving services or the individual advocating on their behalf and the provider. The letter will include the reason for the decision as well as information relative to the right to make a complaint and the process.

Administrative appeals are handled in the same manner as complaints and must be filed within 60 calendar days from the administrative denial. Administrative appeals must be in writing by consumers or providers and are responded to within five (5) business days from receipt of the appeal and resolved within thirty (30) calendar days. The appellant receives both an acknowledgement and a resolution letter. The resolution letter provides an appeal determination (uphold or overturn initial decision) and a brief description of the rationale for the determination. Additional complaint and appeal process options are attached to the resolution letter.

A consumer may designate a representative to file an appeal on their behalf. Providers and Facilities may also file appeals related to claims and other administrative denials.
The appeal request must at least include the consumer’s name and NTBHA Local Case Number (LCN), and the dates of service for which a denial of services or claims payment and filed within the 60-day timeframe.

An administrative appeal can be sent to the attention of the Quality Management Department in writing to NTBHA at 9441 LBJ Suite 305 Dallas, TX 75243, faxed to 214-366-9417 or via encrypted email to QM@ntbha.org.

As part of the appeals process, a consumer, consumer representative, provider or facility rendering service is given the opportunity to submit written comments, documents, records, and other information relating to the appeal. NTBHA takes all submitted information into account in considering the appeal regardless of whether such information was submitted or considered in the initial decision.

**Administrative Appeal Resolution**

When an appeal request is received, designated staff will verify timeliness and that it is an administrative appeal (versus a clinical appeal). The appellant is informed of what additional information, if any, is required to conduct the appeal and the timeframes for submission of such information.

When an appeal is requested, but requested information is not received within the decision timeframe, the appeal decision is made based on whatever information is available and a decision is rendered within the appropriate timeframes. An administrative appeal will be reviewed by someone who did not previously have involvement with the decision making related to the original denial. Based on a review of all available information, the reviewer determines whether the original issues that led to the administrative denial have been resolved. If not, the original decision is upheld and appropriate notice issued within the applicable timeframe. Administrative appeals are resolved within 30 calendar days and a resolution letter is mailed to the appellant. Appeal resolution letters include the procedure for requesting the next level of review.

If the original administrative issues have been resolved in favor of the appellant and no further clinical review is required; the provider is notified that the initial administrative denial was overturned. Claims are reprocessed in order to complete the appeal process. The provider may be requested to submit corrected claims within a designated timeframe in order to reprocess the claim.

If the review determines that the original administrative issues have been resolved in favor of the appellant, but further clinical review is required, the provider is notified that the initial administrative denial was overturned and forwarded to clinical for a review of medical necessity in order to act on the original request for services. The appeal is forwarded to the appropriate clinical staff member for a medical necessity review and determination.

Consumers or providers may challenge the unsatisfactory disposition of a complaint or an
administrative decision. All complaint and administrative appeal resolution letters include information regarding obtaining additional review.

Clinical Adverse Determination Procedures

During an authorization review, the NTBHA Utilization Management Department requests clinical information about the consumer’s condition and response to treatment to assure that the requested level of service meets medical necessity. At times, the UM Department may indicate that she/he cannot authorize the requested level of care due to lack of medical necessity. In these instances, the UM Department may discuss alternative levels of care or treatment plans that can be authorized. If the provider does not feel that these alternative suggestions are clinically appropriate, and believes that the requested level of care is the one that is required, the case is referred to the Medical Director for a Peer Review.

The NTBHA Medical Director evaluates the case and attempts to discuss the care of the consumer with the treating provider by phone.

Notification of denials at all levels of care include:
- Reason for the adverse determination
- The clinical basis for the adverse determination
- The medical necessity criteria utilized in making the determination
- Instructions for filing an appeal

VII. Service Coordination

Working with the Department of Family and Protective Services (DFPS)

Contractual Requirements for Providing Services to DFPS Clients

The State's requirements for NTBHA regarding DFPS include the following:
- NTBHA must include information on working with DFPS in provider manuals and training materials.
- NTBHA must coordinate with DFPS when consumers are also clients of DFPS. Children who enter DFPS foster care placement may have services terminated by the State.
- NTBHA will provide all covered services to the child in foster care placement who does not have Medicaid, until the State terminates services.
- NTBHA must cooperate and coordinate with the State, HHSC and DFPS regional program staff and agents to ensure prompt delivery of services to children served by DFPS.
- NTBHA must designate a liaison to work with the regional DFPS staff to
develop written procedures to address:
  o How NTBHA and DFPS coordinate care and services for consumers
  o The process for exchanging behavioral health information of consumers
  o Reporting requirements from NTBHA to DFPS

• NTBHA cannot deny, reduce, or controvert the medical necessity of any behavioral health services included in an Order. Any modification or termination of ordered behavioral health services must be presented and approved by the court with jurisdiction over the matter for decision.

• The State’s requirements for the NTBHA Provider Network regarding DFPS are as follows:
  o Providers that serve consumers in DFPS custody must provide periodic written updates on treatment status for consumers under their care to DFPS as required by DFPS.
  o Providers must participate, when requested by DFPS, in planning to establish permanent homes for consumers in DFPS custody to ensure that behavioral health care needs are accurately and thoroughly addressed in the consumer’s permanency plan.
  o Children entering DFPS custody must have access, within 14 days of request by DFPS, to any medically necessary developmental evaluations and behavioral health evaluations to assess the child for out-of-home placement. If the NTBHA Provider Network is unable to provide routine care within the network, NTBHA must provide such care out of network, in accordance with the Contract.
  o Network Providers must comply with all provisions of a court order or DFPS service plan with respect to a child in the conservatorship of DFPS ("Order") entered by a court of continuing jurisdiction placing a child under the protective custody of DFPS that relates to the behavioral health services to be provided to a consumer.

Recognition of Abuse and Neglect

Upon request, NTBHA works with DFPS to provide additional training in the recognition of abuse and neglect to any of its Network Providers.

1. Referral of Suspected Abuse and Neglect to DFPS

Each provider shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to reporting suspected child abuse and the provisions of the Texas Health and Human Services Commission (HHSC) policy. Provider staff shall respond to disclosures or suspicions of abuse of minors by reporting to appropriate agencies as required by law.

The Texas Family Code states that child abuse and/or neglect will be reported by “a person having cause to believe that a child’s physical or mental health or welfare has been or may be adversely affected by abuse or neglect by any person.”
All forms of child abuse and neglect must be reported by the clinician within 48 hours to: Child Protective Services within the DFPS.

The provider must document in the consumer’s chart that DFPS was notified, the name of the person contacted and the date the call was made. Signs of abuse and relevant clinical information must be documented.

VIII. Quality Management

Overview

NTBHA is committed to providing a collaborative approach with our provider network to create and sustain an optimal system of care for the indigent population per the guidelines of our contract with HHSC. Quality management processes are used in oversight of contracted mental health and SUD service providers. The goal is to encourage providers to increase the efficiency and effectiveness of services through a continuous quality improvement process that includes monitoring and evaluating appropriateness of care, identifying opportunities for improving quality and access, establishing initiatives to accomplish agreed upon improvements and monitoring resolution of problem areas. We will work closely with our contracted providers to promote hope, support recovery and build resilience. Our efforts will be similar to what providers have been involved in throughout the NorthSTAR contract period.

NTBHA’s participating providers are informed about the Quality Management (QM) program through written and oral communications, provider meetings and in other various committees and/or sub-committees. Routine reporting of our Quality Management Program activities to our governing board, providers, other appropriate organizational staff members, and community stakeholders will take place.

A. Improving Patient Safety

NTBHA is committed to supporting high quality care provided in a safe and supportive environment and ensuring that we are in compliance with local, state, and federal regulatory requirements. To do this, we will collect meaningful comparative data, evaluate data to insist in the identification of high risk behaviors and trend/monitor information to ensure that effective correction actions are taken.

Data collection and activities to support our commitment to patient safety include:

1. **Adverse Incidents (AI)**

   AIs are occurrences that represent actual or potential risk of serious harm to well-being of the consumer or to others by the consumer while the consumer is in treatment. The types of incidents that should be reported to us and will be analyzed include:

   - Self-inflicted harm requiring medical treatment
   - Unexpected death occurring in any setting not related to the natural course of the consumer’s medical illness or underlying condition.
   - Violent and/or assaultive behavior with physical harm to self or others
• Sexual behavior with other consumers or staff, whether consensual or not, while in a treatment program
• Elopements from hospital or residential center where patient is considered a danger to self or others.
• Injuries either in a facility or a provider office that require medical treatment
• Property damage including fire setting while in a treatment setting
• Serious adverse reaction to treatment requiring medical treatment
• Medication error resulting in the need for medical intervention
• Human rights violations (e.g. neglect, exploitation)
• Other occurrences representing actual or potential serious harm to a consumer not listed above (e.g. staff misconduct, unexpected closure of a facility).

DEATH REVIEW
Contracted providers are required to have Preliminary, Administrative, and Clinical Death Review policies and procedures in place to conduct a complete death review in accordance with 25 TAC Chapter 405 Subchapter K. A reasonable effort to provide complete information regarding consumer deaths must be made by the provider (e.g., consumer’s emergency contact/next of kin is contacted to establish date of death, manner/cause of death, etc.) and all forms must be signed by the appropriate staff.

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accredited SUD providers may submit JCAHO required root cause analysis (RCA) in lieu of Administrative and Clinical Death Reviews.

Contracted providers should submit the following to QM@ntbha.org:
1. Death Report form (within 1 business day of notification of consumer death)
2. Preliminary Death Review (within 1 business day of notification of consumer death) with required signatures
3. Treatment records for 180 days prior to the date of death (within 5 business days of notification of consumer death)
4. Administrative and/or Clinical Review (within 14 calendar days or 45 days if an autopsy is conducted)

Preliminary Review of consumer deaths should be conducted in accordance with §405.269. Within one working day of the knowledge of death of a person receiving services at a NTBHA contracted provider, the contracted provider’s CEO is responsible for conducting a preliminary review to determine whether:
1. the death occurred on the premises of a provider;
2. the death occurred while the person was participating in provider program activities (e.g., the consumer drowns while on a psychosocial program outing);
3. other conditions indicate that the death may reasonably have been related to the consumer’s care or activities as part of the provider program (e.g., the consumer overdosed on a psychoactive drug; the consumer commits suicide); or
4. other conditions indicate that although the death is not reasonably related to the consumer’s care or activities as part of the provider program, an evaluation of policy is warranted (e.g., the individual dies of a chronic illness in a community hospital).

If none of the conditions described in this section is met, then the contracted provider may elect not to conduct an administrative death review. Documentation that this preliminary review was conducted must be included in the deceased's treatment record submitted to NTBHA.

If any of the conditions described in the Preliminary Review are met, an administrative death review must be conducted in compliance with this section. In addition, the need for a clinical death review must be determined as described in §405.274.

Clinical Review of consumer deaths should be conducted by a medical review committee of at least (but not limited to) three medical/nursing professionals in accordance with §405.274 when any of the following conditions are met:
1. possible need for review of clinical policies and procedures (e.g., the consumer overdosed on a psychoactive drug; the consumer commits suicide);
2. the opportunity for professional education (e.g., consumer reported being in crisis but §412.321 was not followed);
3. and/or the opportunity to improve patient care through medical practice.

Based on the review, the committee shall evaluate the quality of medical and nursing care given prior to death and shall formulate written recommendations, if appropriate, for changes in policy and procedures, professional education, operations, or patient care. Suspected abuse or neglect must be reported in accordance with the rules of the Texas Department of Protective and Regulatory Services.

Administrative Review of consumer deaths should be conducted by an administrative review committee in accordance with §405.275 when any of the following conditions are met:
1. review the information and recommendations provided by the clinical death review committee and/or from the preliminary investigation;
2. review operational policies and procedures and continuity of care issues which may have affected the care of the individual and formulate written recommendations for changes in policies and procedures, if appropriate; and
3. act upon the recommendations described in paragraphs (1) and (2) of this subsection.

If information presented during the administrative review indicates the need for a clinical death review or a re-review, then the administrative death review committee has the authority to request such review. Suspected abuse or neglect must be reported in accordance with the rules of the Texas Department of Protective and Regulatory Services.
Preliminary, clinical, and administrative outcomes and recommendations submitted by providers will be reviewed by NTBHA’s Medical Director, Chief Clinical Officer, and Quality Management Committee. If additional quality of care improvements are identified, corrective action plans may be required.

NTBHA will do an internal investigation that may include requesting treatment records, written responses and if indicated, corrective actions. Investigation outcomes will be reviewed by our Medical Director and our Quality of Care Committee will be responsible for reviewing and identifying quality of care opportunities from adverse incident tracking and reporting.

2. Quality of Care (QOC) Issues/Trends
Increasing the awareness of QOC issues decreases the chances of negative health outcomes. True quality of care complaints have to do with the treatment rendered. These can be identified by consumers about their own treatment, consumer representatives, providers, or identified by NTBHA staff. A QOC concern is any action or failure to act (a verified deviation from acceptable standard of practice or standard of care) on the part of the provider that has the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the consumer at risk. QOC concerns can be investigated as both an AI and a QOC concern. NTBHA has a defined process for identifying, investigating, resolution and monitoring of QOC concerns. If QOC concerns are validated or identified during the investigation process, they will be presented and reviewed in our monthly Quality of Care Committee meeting to determine what next steps will be taken or if a Correction Action Plan (CAP) is required.

3. Complaints
NTBHA has a process in place to address all complaints from consumers, consumer representatives, providers, and other stakeholders. The complaint process provides a tracking system for resolving concerns promptly and appropriately. Investigations will include contacting providers, requesting formal responses, and requesting records if indicated. If a complaint investigation or resolution need further review, they will be reviewed in the Quality of Care Committee for feedback. Complaint trends will be addressed with providers with the potential of requesting Correction Action Plans.

B. Contract Compliance
NTBHA will have mechanisms in place to monitor contract compliance.
   1. Provider Audits
      NTBHA’s designated staff will routinely perform provider audits based on specific review criteria, including treatment record reviews, utilization of evidenced based practices (EBPs), accuracy of assessments, person-directed recovery planning, compliance with key indicators of quality and performance, HR/credentialing, access/availability, continuity of care, and to assess fidelity to the treatment model as well as compliance with the Texas Resilience and Recovery (TRR) program requirements and treatment record/documentation
standards. The purpose of these audits is to determine compliance with contractual standards, the TAC/State requirements, and clinical guidelines. The method for communicating results that require improvement is determined by the severity of the deficiencies to be improved and the monitoring protocol through which the need is identified. At the time of the audit, some initial feedback will be provided with more formal follow up later in the form of a letter with detailed findings and recommendations for improvement. Feedback on compliance opportunities is communicated and if necessary, the letter can include an approximate time for a follow-up review and/or a request for a corrective action plan and documentation it has been implemented. Prior to the audit, the provider is given adequate notice regarding the date and time of the audit.

2. Clinical reviews

NTBHA staff may identify issues or concerns related to any of the stated areas and will forward these to the QM department for follow-up and tracking.

C. Quality Indicators

Another component of the quality management process is the identification of key domains and quality indicators, which have the greatest impact on overall quality of care. Quality of care indicators are closely linked to successful outcomes. Some key indicators include: High Risk - Aspects of care that pose a risk to the patient if the care is not provided correctly. This includes providing care that is not indicated and failing to provide care that is indicated. High Volume - Aspects of care that occur frequently or affect large numbers of patients. These can be problem-prone aspects of care, which in the past have tended to cause problems for patients. NTBHA will track these indicators and examine their relationship to factors such as re-admission and self-report of improved functioning.

D. Utilization Management Data

Utilization data in the form of reports or raw data is provided to the State on a quarterly basis. Reports cover utilization of multiple levels of care as well as readmission rates. Reports also generate identifying demographic characteristics of NTBHA’s indigent population (i.e., gender, age, sex, diagnosis). Information from these reports will be used internally at NTBHA to identify trends in utilization, problem areas for clinical intervention and quality improvement studies.

E. Member Rights and Responsibilities

Consumers should be informed of their rights and responsibilities when their treatment begins. Our expectation is that all consumers will be treated in a manner that respects their rights and dignity. QM promotes the following values:

- Person centered- the individual will be at the core of all plans and services.
- Respect- individuals, families, providers, and staff are treated with respect.
- Independence- the individual’s personal and economic independence will be promoted.
- Choice- individuals will have open options for services and supports
- Self-Determination- individuals will direct their own lives
• Living well- the individual’s services and supports will promote health and well-being.
• Contributing to the community- individuals who can work, volunteer, and participate in local communities.
• Cultural competencies- individuals can interact effectively with people of different cultures.
• Flexibility-individual needs will guide our actions.
• Effective and efficient-individual’s needs will be met in a timely and cost effective way.
• Collaboration – partnerships with families, communities, providers and other federal, state, and local organizations result in better services.

F. Confidentiality and HIPAA Compliance

NTBHA abides by all HIPAA Federal Regulations, Privacy Laws and Substance Abuse Confidentiality Regulations: 42 CFR Part 2 in all of our operations, including QM functions. NTBHA staff receive training on privacy and HIPAA standards upon hire. Annual re-training efforts reinforce the importance of confidentiality and adhering to HIPAA standards. All consumer information is kept strictly confidential. All NTBHA staff maintain the confidentiality of all consumer information they encounter and maintain the rule of only on a ‘need to know basis’ internally. All consumers and providers who participate on NTBHA committees must also demonstrate their understanding of confidentiality policies and procedures by signing confidentiality statements prior to committee participation. Participating provider contracts are explicit regarding HIPAA and privacy regulations including treatment record confidentiality requirements.

G. Cultural Competency

NTBHA is committed to exploring and incorporating concepts that ensure a system designed to provide care and services that are culturally competent and sensitive. Culturally sensitive care services are provided to all ethnic groups regardless of ethnocentric differences. NTBHA will incorporate the following cultural principles into its quality management program: importance of culture, assessment of cross-cultural relations, expansion of cultural knowledge and adaptation of services to meet the specific needs of our consumers.

H. Reporting to Department of Family & Protective Services (DFPS)

NTBHA will develop mechanisms to measure, assess, and reduce incidents of client abuse, neglect and exploitation and improving the client rights protection processes. Suspicion and incidents of abuse, neglect and exploitation of children, youth and adults must be reported to DFPS as required by law. In addition, an employee, agent, or contractor who suspects or has knowledge that an in addition, an employee, agent, or contractor who suspects or has knowledge that an individual being abused, neglected, or exploited shall make a written report to performance.contracts@HHSC.state.tx.us within
48 hours after suspicion or learning of incident allegedly perpetrated by an employee, agent, or contractor. In addition, an employee, agent, or contractor who suspects or has knowledge that an being abused, neglected, or exploited shall make a written report to performance.contracts@HHSC.state.tx.us within 48 hours after suspicion or learning of incident allegedly perpetrated by an employee, agent, or contractor.

I. Quality Management and Utilization Management
The integration of QM and UM is assured through representation on key committees. These structures support the integration of clinical and quality management activities, assuring that immediate access to exceptional care is provided to all members in a consistent way, utilizing evidence based protocols. Clinical indicators have been established to measure the effectiveness of practice guidelines, over and under-utilization, and the timeliness of utilization decision making.

J. Quality Management Committees
1. The Quality Management Committee (QMC) is comprised of representatives from key operational units within NTBHA, HHSC designated staff, and a participating provider representative. The QMC is responsible for ensuring the quality, continuous improvement of clinical care, utilization management, and other services delivered to members within NTBHA’s responsibilities.

2. Planning and Network Advisory Committee (PNAC)
Development of a board appointed committee of no less than 9 members comprised of at least 50% NTBHA consumers and/or family members with remaining members coming from community stakeholders such as advocacy agencies may eventually replace CFAC. PNAC will be charged with providing feedback into system design enhancement and review adequacy of the provider network. IT must be actively involved in the development of the Local Provider Network Development Plan.

3. As the Quality Management Program continues to develop, other committees will be considered based on the determination of needs to meet contract requirements and to maintain a collaborative approach to procedures and operations.

IX. Network Management

Network Participation
North Texas Behavioral Health Authority is the Texas Department of Health and Human Services Commission (HHSC) designated Local Behavioral Health Authority (LBHA). NTBHA believes in a strong and effective provider network that is capable of providing high quality behavioral healthcare to members in its’ catchment area. Developing and managing a qualified and innovative provider network capable of meeting the needs in the community is a primary role of NTBHA. It is our goal to maintain a network that allows choice of high quality service providers available to NTBHA consumers. On a yearly basis, NTBHA will review the needs of
the network and identify any areas of growth or change needed to ensure the above-mentioned goals are met.

All providers in network, or those that desire to be in network, must meet minimum state required licensing and accreditation standards for services provided.

**Procurement Process**

In compliance with TAC §412.58 and 412.761 as it relates to competitive procurement methods for community services, NTBHA will post all procurement documents. The procurement process will be carried out as follows:

1. Prospective providers will have at least twenty-one days to submit a complete and final response.
2. In some unique circumstances, or in the event of a Request for Information and not a complete procurement, the response time may be reduced to meet the needs of NTBHA.
3. Questions regarding the procurement documents will be accepted up until five business days prior to the due date of the procurement documents.
4. NTBHA will consolidate all questions and post official responses on the organizations website (ntbha.org) no less than three days prior to the close of the procurement period.
5. All submitted procurement documents will be reviewed within ten business days. Any requests for additional information will be sent to each provider prior to scoring submitted documents.
6. Upon completion of an initial scoring of submissions, the Executive Review Committee will evaluate the scored documents and adopt recommendations for the Board of Directors.
7. Recommendations for award will be placed on the agenda as an action for the next scheduled Board of Directors meeting.
8. Upon Board of Director approval, written notice of award will be sent to the provider(s).
9. Providers that are not chosen will be provided with the following information:
   a. Reason(s) for lack of award
   b. Steps to appeal the decision

**Procurement Appeals Process**

Applicants that desire to appeal NTBHA decisions on Request for Application (RFA) and/or Request for Proposal (RFP) awards must submit a written appeal within 7 days of receipt notification of rejection. All notifications will be sent via email to the individual identified in application as the point of contact.

The appeal must be received by the NTBHA Contracts Coordinator by certified mail within the allocated time frame. Failure to comply with the time restriction in the appeals process is a forfeiture of the right to appeal. If extenuating circumstances prevent timely submission, the NTBHA CEO may waive the certified mail requirement and allow for electronic submission of an appeal.
Once the appeal has been received, and validated, the Contracts Coordinator shall forward the appeal to the Board of Directors within 4 business days. If the appeal is received, and validated, by the Thursday prior to the next regularly scheduled NTBHA Board of Directors’ meeting, the appeal request shall be added to the meeting agenda for discussion.

An appeal shall be determined valid if the following criteria are met:
1. Received by NTBHA in the amount of time allotted
2. Does not include new information previously requested by NTBHA staff during the procurement period that was not provided at that time
3. Based on reasoning of incorrect/unfair scoring of bids
4. Proclaims an issue with procurement process itself (unclear steps, requirements, etc.) that may adversely affect potential outcome of scoring

An appeal shall be determined to be invalid if the following components exist:
1. Based on information requested in RFP and subsequent follow up requests that was not provided at that time
2. Not received in the amount of time allotted
3. No basis to investigate and/or recommend a follow up hearing with the Board of Directors

If an appeal is invalidated, the provider may request from the Board of Directors, that the procurement process be reopened to submit a new, updated, and complete application. If this request is approved, the application must be resubmitted within three business days. Upon closing of the procurement, all established time frames will be followed.

Any and all denied applicants for the identified service may resubmit applications at this time as well. If the appeal or request to reopen the procurement is denied, the provider must wait until procurement is opened for the identified service at a later date and time. No further appeals/requests will be heard on the matter after the Board of Directors votes on an appeal or request to reopen procurement. Written notification of the Board of Directors decision will be provided to each provider that is party to an appeal or request in no more than three business days from the date of the board meeting.

Sanctions, Appeals, and Contract Termination
1. NTBHA shall take punitive recourse for actions that pose a hazard to consumers or potentially violate services guidelines.

2. Penalties/Sanctions. The failure of the Provider to perform any responsibility set forth in this manual, the signed provider contract, its exhibits or attachments, or any law, regulation, rule, or requirement incorporated by reference may result in any one or more of the following to be imposed or taken by the NTBHA, subject to notice as provided herein:
   a. Submission of a Plan of Correction to NTBHA;
   b. Return of funds to NTBHA
i. For serving unauthorized persons with funds subject to the Provider Agreement

ii. For using funds for unauthorized purposes, and

iii. For overlapping billings

c. Withholding by NTBHA, in whole or in part, any payments due and owing to the Provider until the Provider has cured the breach of contract to the satisfaction of NTBHA;

d. Legal action to protect or remove consumers when the life, health, welfare, or safety of the consumer is endangered, or could be endangered or if NTBHA has a reasonable belief that the Provider has engaged in the misuse of state or federal funds, fraud, or illegal acts;

e. If NTBHA is able to demonstrate a direct link between a sanction or penalty imposed upon NTBHA by any State Agency due to Provider’s performance, Provider will refund/reimburse/remit to NTBHA those portions of the sanction/penalty assessed to NTBHA. Examples of such instances would be documentation chart audits, CARE accuracy, failure to report accurate and timely information/data, and etc.

f. Suspension or withholding of additional funds until performance deficiency or breach is cured to the satisfaction of NTBHA; and/or

g. Termination of Provider Network Agreement.

3. **Imposition of Penalties.** Providers should refer to their contract regarding the imposition of penalties.

4. **Appeals.** Any Provider receiving a notice of penalties may appeal decisions for adverse determinations other than utilization management and/or resource allocation. These decisions include credentialing/re-credentialing, privileging, eligibility determination and claims/billing issues. Providers may file an appeal within fifteen (15) days of the date of receipt of the decision following the Local Authority’s appeal process.

5. **Provider Termination.**

a. **Voluntary.** If a Provider chooses to voluntarily terminate their contract, a written request should be submitted to Contract Services thirty (30) days prior to termination to:

   Contract Services
   North Texas Behavioral Health Authority
   9441 LBJ Fwy. Suite 350
   Dallas, Texas 75243

b. **Involuntary.** Non-adherence to performance standards or criteria may result in termination. Critical areas which may be monitored to demonstrate non-adherence include:
• Adherence to contract stipulations
• Professional liability claims/disposition involving direct care.
• Patterns of practice contrary to procedural standards
• Patterns of service delivery
• Billing fraud
• Unsatisfactory Records Compliance Audit
• Refusal of accepting referrals
• Inability to service Individuals within specified time lines

If performance standards are questioned, the Provider will be contacted by phone or by certified mail to alert the Provider to the issue(s) and review the appropriate documentation in compliance with due process/fundamental fairness procedures. If the contract/agreement is terminated, Provider is expected to cooperate with NTBHA in the transfer of Individuals to other providers.

X. Claim and Billing Information

Claims Submission Requirements

Time Limit for Filing Claims

All encounter data for Mental Health (MH) covered services must be submitted by the 10th calendar day of the following month to be considered for reimbursement. Substance Use Disorder (SUD) claims for covered services must be submitted by no later than ninety (90) days of the date of service to be considered for reimbursement. Those SUD claims submitted beyond the ninety (90) day time limit will be denied in writing by the NTBHA Finance staff payment voucher.

Incomplete Claims

Claims are not paid or included in the reconciliation process by NTBHA in the case of incorrect or incompleteterequired data elements.

NTBHA notifies the provider, via the provider summary voucher, of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in the provider’s individual contracts and also on the NTBHA website at www.ntbha.org.

Claims Submission Policy

NTBHA accepts monthly FTP file encounter data from Mental Health (MH) providers electronically via the NTBHA FTP website no later than the 10th day of the following month. The FTP file information shall be uploaded to the Texas DSHS-HHSC MBOW system. The EDI Documentation FTP submission file format and supplemental information is located at www.ntbha.org. Please note that Texas DSHS-HHSC will not
allow corrections to MBOW system after the 15th day of the following month. For more details on MH FTP encounter submissions, please contact NTBHA’s IT Department at (214) 366-9407.

*NTBHA SUD providers* will submit electronic claims via the Texas DSHS-HHSC CMBHS website. For more details on CMBHS access, please contact NTBHA’s IT Department at (214) 366-9407.

The provider agreement details the covered services that have been contracted for and the definition of services included in the provider’s negotiated contract rates and/or DSHS-HHSC fee for service rates.

Claims must be submitted with the NTBHA Local Case (LCN) Number. Failure to use this permanent ID number results in the denial of the claim on the provider summary voucher.

Claims must be submitted with the provider’s NPI National Provider Identifier number.

Claims must be submitted with a complete and valid DSHS-HHSC diagnosis codes for service dates beginning on or after January 1, 2017. Providers should refer to their contracts regarding approved diagnosis codes. Claims submitted with any other diagnosis code will be denied on the NTBHA provider summary voucher.

*NTBHA* is committed to continuing communication with network providers regarding changes and updates to billing policies and procedures. Future communications are provided as needed through online news and education articles.

*Electronic Media Claim Submission Requirements, Filing and Status Inquiries*

Questions on billings and anticipated payments may be directed to the NTBHA Finance Staff at AP@ntbha.org or via phone at (214)366-9417.

*State Requirements for Claims Turnaround Time*

NTBHA shall plan to pay 100% of clean claims (error-free claims) submitted by providers within 5 business days of receiving reimbursement from Texas DSHS-HHSC. For specific payment schedules, providers should refer to their individual contracts. Providers shall be notified in writing of any potential delays in payment.

**Claims Appeal Process**

You have the right to request reconsideration or appeal of a claims payment. A claim appeal is managed through the administrative appeal process.

Your request for reconsideration of a claim should include a cover letter detailing the reasons that you are requesting an appeal, a copy of the original claim, and a copy of the corresponding remittance advice.

*NTBHA* must receive your request for reconsideration within thirty (30) days from the date the claim appears on your *NTBHA* payment remittance letter.
Claims/Administrative appeals should be mailed to:

**NTBHA**  
Attn: Claims Appeals Coordinator  
9441 LBJ Freeway, Suite 350  
Dallas, TX 75243

*NTBHA* has thirty (30) days to respond to your request.

**Adjustment/Reversal Requests**

Claims requiring reconsideration of payment amounts for any reason must be resubmitted to *NTBHA* via one of the methods below:

- Submission of an adjustment request, detailed information regarding the reason for reconsideration (i.e.; specific claims info by patient name, date(s) served, etc.) within thirty (30) days from the date of the *NTBHA* Payment Remittance letter.
- Resubmitted by electronic spreadsheet within thirty (30) days from the date of the Payment Remittance letter.

Please email completed spreadsheets to: AP@NTBHA.org or via mail at NTBHA, Attn: Finance Department, 9441 LBJ Freeway, Suite 350, Dallas, TX 75243.

**Re-Submissions**

Claims not paid by *NTBHA* due to incorrect or incomplete required data elements must be resubmitted for payment consideration within thirty (30) days from the date on the Payment Remittance Letter.

Providers may resubmit claims electronically or by mail.

**Incomplete Claims**

Claims are not paid by *NTBHA* in the case of incorrect or incomplete required data elements. *NTBHA* notifies the provider via the Provider Remittance Letter, of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in provider’s individual contracts.

**XI. Definitions/Glossary**

**Access (medical)** - A consumer's ability to obtain medical care determined by factors such as the availability of medical services, the location of practitioners, facilities, transportation, hours of operation, and cost of care.

**Active NTBHA Consumer**: A consumer who is currently receiving services from a NTBHA provider, having been deemed eligible for services at the point in time services are rendered.
**Administrative Appeal:** A request by a member, member-designated representative, or provider to reconsider an administrative adverse determination.

**Administrative Denial:** A denial of services, or claims payment for services, based on reasons other than a lack of medical necessity.

**Admission:** The formal acceptance of a consumer who is to receive mental health and/or SUD services at all levels of care, excluding outpatient.

**Adverse Determination:** A determination that the healthcare services furnished by or proposed to be furnished to a consumer is not medically necessary.

**Alternative Level of Care (ALOC):** If clinically appropriate, consumers can receive care in less intensive/restrictive environments in lieu of acute inpatient care.

**Assertive Community Treatment (ACT):** A self-contained program merging treatment, rehabilitative and support services in a mobile service delivery system for Consumers with SMI (Serious Mental Illness) who have a history of multiple hospitalizations, involvement with the judicial system, homeless shelters, or community residential homes.

**Assessment:** The clinical process of looking at a person’s mental health and/or substance use disorder and medical history, plus his or her functioning, relationships, and development to determine their need for treatment.

**Authorization:** Approval for a specific service to be reimbursed by NTBHA. It represents an agreement that the service is clinically necessary under the NTBHA Level of Care Criteria.

**Behavioral Health Services:** Prevention, treatment, and support services which address consumers’ mental health and/or substance use disorders.

**Benefit:** The specific type and number of services a specific eligible individual may receive through NTBHA funding, as a result of specific eligibility factors, state/federal policies, or funding priorities.

**Board Certified:** A physician who has passed examinations given by a medical specialty group who has, as a result, been certified as a specialist in an area of practice. Board Certification generally denotes a degree of competency across a national standard that is higher than the minimal standards to practice as defined by individual state licensure.

**Chemical dependency:** The psychological or physical dependence on, or the addiction to, alcohol or a controlled substance, corresponding to the DSM IV (see definition) criteria for chemical dependency disorders. Also known as Substance Use Disorder (SUD).
Chemical dependency counselor (LCDC): A person licensed by the Texas Commission on Alcohol and Drug Abuse (see TCADA definitions under rules of counselor licensure 150.3) to provide counseling to chemically-dependent individuals.

Chronic or complex condition: A physical, behavioral health, or developmental condition that may be treatable but has no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated.

Claim Adjudication: The process of determining whether a procedure is covered by the consumer's benefit plan and calculating the payment amount for that procedure.

Claims Billing Audit – The process to verify the documentation supports the services/claim billed.

Clean Claim: A claim that can be adjudicated without additional information from the provider of the service or from a third party and contains accurate and complete information in all fields required for the adjudication of the claim on appropriate forms.

Clinical Appeal: A request by a member, member-designated representative, or provider to review an adverse medical necessity determination made in response to a request for services.

Clinical Management for Behavioral Health Services (CMBHS): a web-based clinical record keeping system for state-contracted community mental health and SUD providers

Community Resource Coordination Groups (CRCGs): A statewide system of local interagency groups, including both public and private providers, which coordinate services for “multi problem” children and adults. CRCGs develop individual service plans for children and adults whose needs can be met only through interagency cooperation. CRCGs address complex needs in a model that promotes local decision-making and ensures that children receive the integrated combination of social, medical and other services needed to address their individual problems.

Complaint: Any dissatisfaction expressed by a complainant orally or in writing, with any aspect of NTBHA’s operation or that of our providers, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction or termination of a service for reasons not related to medical necessity; the way service is provided or eligibility decisions are made. Complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing-up the misunderstanding or supplying the appropriate information to the satisfaction of the consumer. It does not include a provider’s or consumer’s oral or written dissatisfaction or disagreement with an adverse determination.
Comprehensive Mental Health Provider (CMHP): CMHPs are designated provider agencies which deliver specialized rehabilitation services and coordination of care to priority populations.

Concurrent Review: Determining the medical necessity of care by case review while the patient is in treatment (as opposed to retrospective review).

Consumer: An individual who has received or is currently receiving NTBHA funded services.

Continuity of Care: The coordination of services that ensures a consumer an efficient entrance into the managed care network, appropriate transitioning or adjustment of services to meet consumer’s changing needs during the episode of care that is inclusive of a multidisciplinary team approach or communication between physical and behavioral healthcare providers, and a smooth transition out of the network in the event the consumer loses or changes membership eligibility. This may involve the sharing of documentation, necessary verbal information exchanges and follow-up by the incumbent care provider.

Controlled substance: A toxic inhalant or a substance designated as a controlled substance under the Health and Safety Code.

Course of Treatment: The uninterrupted provision of medical treatment to a patient for the resolution or stabilization of specific symptoms or disorders. The course of treatment is initiated at the point of access for treatment and may span multiple episodes of care at different levels of care until resolution or stabilization of the medical condition occurs.

Covered Services: Mental health and substance use disorder services within the scope of the benefit plan.

Crisis Stabilization: A short-term, intensive and aiding process offered to consumers in the event of a crisis. It involves individual assessment, follow-up and possibly referral to long-term treatment.

Cultural competency: The ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the people and protects and preserves their dignity.

Date of Service (DOS): The date on which behavioral healthcare services were provided to a consumer.

Detoxification: Medical regiment to reduce the amount of toxic agents in a patient's body. Provides reasonable control of active withdrawal and averts life-threatening medical crisis.

Diagnosis: Descriptors for mental health and substance use disorders.
DSM-IV: Diagnostic and Statistical manual, 4th edition. A manual that provides diagnostic criteria, classification and descriptions of mental disorder diagnoses. All official DSM-IV codes are included in the ICD-9-CM.

DSM-V: Diagnostic and Statistical manual, 5th edition. A manual that provides diagnostic criteria, classification and descriptions of mental disorder diagnoses. All official DSM-V codes are included in the ICD-9-CM and cross reference with many on the ICD-10-CM.

Dual Diagnosis: A co-occurring major mental illness and substance use disorder.

Early Intervention: Specialized services including child/family assessment, play therapy, parent counseling, and parent educational training.

Effective Date: Date that an individual becomes eligible for NTBHA funded services, or a provider begins participating in the NTBHA network.

Eligible individual: A person who can get behavioral health services if they meet the established financial and behavioral health criteria.

Emergency behavioral health services: Inpatient or outpatient behavioral health services needed to evaluate or stabilize an emergency behavioral health condition.

Episode of Chemical Dependency Care: A planned, structured, and organized program to promote a chemical-free status that may include different facilities or modalities lasting up to a year. A treatment episode is complete when the individual is discharged on medical advice from a level of care or a series of levels without a lapse in treatment. A treatment episode is determined by the treating professional who is a psychiatrist, a physician with experience in addiction medicine, or the primary counselor (qualified credentialed counselor). In the medical and social-medical programs, an episode is physician-determined; counselors may determine the episode of chemical dependency care in social model programs.

Formulary: A list of medications pre-approved for reimbursement.

Grievance: A verbal or written communication from a complainant of dissatisfaction with the outcome of a complaint resolution.

Health and Human Services Commission (HHSC): The state mental health authority that utilizes state, federal, and local funds to offer a range of intensive community-based services and inpatient hospitalization for adults with SMI (Serious Mental Illness) and children with SED (Serious Emotional Disturbance) through contracts with community mental health centers, state-operated community services in rural areas, and psychiatric hospitals. HHSC serves both medically indigent and Medicaid eligible individuals.
**Inpatient Services:** Twenty-four hour services which provide medical intervention for mental health diagnosis, or both. Hospital based detoxification is not a reimbursable service under NTBHA.

**Inquiry:** An oral or written communication from an external party seeking information or requesting an action or assistance (e.g., request to check eligibility, clarify benefits, explain a process, check on the status of a claim/invoice) that does not meet the definition of a “complaint” or an “appeal”.

**Length of Stay (LOS):** The number of days that a consumer stays in any level of care.

**Level of Care:** The intensity of care required to achieve treatment for an individual.

**Licensed Clinical Social Worker (LCSW):** An individual licensed as a professional Clinical Social Worker.

**Licensed Master Social Worker (LMSW):** An individual licensed as a professional Master Social Worker.

**Licensed Professional Counselor (LPC):** An individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors.

**Local case number (LCN):** A unique number assigned to an individual receiving NTBHA funded services.

**Medicaid Eligible:** A person who is determined to be eligible for Medicaid services.

**Medicaid:** A federal program administered and operated individually by participating state and territorial governments which provide medical benefits to eligible low-income persons needing healthcare. The costs of the program are shared by the federal and state governments.

**Medically necessary behavioral health services:** Behavioral health services which:

- Are reasonably necessary for the diagnosis or treatment of a mental health or substance use disorder or to improve, maintain or prevent deterioration of functioning resulting from such a disorder.
- Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral healthcare.
- Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- Are the most appropriate level or supply of service which can safely be provided.
- Could not have been omitted without adversely affecting the individual’s mental and/or physical health or the quality of care rendered.

**Mental health priority population:** HHSC serves individuals who meet the definition of the priority population. The priority population for mental health services is defined as:
• Youth under the age of twenty-one who have a diagnosis of mental illness and exhibit severe emotional or social disabilities that are life-threatening or require prolonged intervention.
• Adults who have severe mental illnesses such as schizophrenia, major depression, manic depressive disorder, or other severely disabling mental disorders that require crisis resolution or ongoing and long-term support and treatment.

North Texas Behavioral Health Authority (NTBHA): The local behavioral health authority for Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall Counties. NTBHA is responsible for planning, policy development, coordination and oversight of mental health and SUD services with in service delivery area.

Out of Area Care: The behavioral health services consumers receive when they are out of the NTBHA Service Delivery Area (SDA).

Outpatient Services: Mental health and SUD services provided in an ambulatory care setting, such as a mental health or SUD clinic, hospital outpatient department, community health center, or Provider’s office.

Physician: An individual who is licensed by the Texas State Board of Medical Examiners.

Peer Review: Evaluation by practicing physicians of the quality and efficiency of services provided by other practicing physicians.

Per Diem Rate: A negotiated daily rate to cover costs for an inpatient, RTC, and partial hospitalization program. Per Diem rates typically include most ancillary charges. Physician fees may or may not be included.

Provider Integration Gathering Eligibility Online (PIGEON)- NTBHA online eligibility feed for pharmacy benefits and crisis service authorization numbers.

Prior Authorization: A determination made by NTBHA to prospectively approve or deny payment for a service or course of treatment of a specific duration and scope to a member prior to the provider's initiating provision of the requested service.

Procurement: The review process Network Management performs to approve a practitioner, group practice, program, or facility that has applied to become a NTBHA provider.

Provider: An entity that delivers direct behavioral health services to a consumer.

Psychiatrist: An individual licensed as a psychiatrist by the Texas State Board of Medical Examiners to practice medicine in Texas and specializes in diagnosis, treatment, and prevention of mental illnesses and substance use disorders.

Psychologist: An individual licensed as a psychologist by the Texas State Board of Examiners of Psychologists.
**Referral:** The sending of an individual either to a provider or from one care setting or service to another to obtain community based resources and/or covered mental health or SUD care.

**Release of Information:** The legal form signed by a member allowing NTBHA to share specific information regarding the member to a specific person.

**Residential Treatment Center (RTC):** A facility such as a hospital or healthcare organization which provides psychiatric, drug abuse or alcoholism services in a less structured environment than that of an acute inpatient program.

**Retrospective Review:** The process of determining the medical necessity and the quality of care provided after treatment has been completed without authorization.

**Serious Emotional Disturbance (SED):** Youth seventeen and under who have a diagnosis of mental illness that exhibit severe emotional or social disabilities (SED) that are life-threatening or require prolonged intervention.

**Serious Mental Illness (SMI):** Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the DSM V: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); and schizoaffective disorders (bipolar or depressive) that require crisis resolution or ongoing and long-term support and treatment.

**Service Delivery Area:** The NTBHA Service Delivery Area (aka Service Area) includes Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall Counties.

**State Hospital:** Any one of seven hospitals owned and operated by HHSC providing both acute and sub-acute inpatient services to persons in the mental health priority populations.

**Substance Use Disorder (SUD) treatment center:** A facility that provides a program for the treatment of a SUD pursuant to a written treatment plan approved and monitored by a physician or qualified credentialed counselor and that is also:
- Affiliated with a hospital under a contractual agreement with an established system for patient referral
- Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse
- as a chemical dependency treatment program or center by any other State agency having legal authority to so license

**Utilization Management Department:** The department responsible for providing authorizations for mental health and substance use disorder treatment

**Utilization Manager:** NTBHA staff that assist providers in ensuring that all aspects of the consumer’s care are being appropriately addressed and services within various levels of care
are coordinated to meet the continuing needs of the consumer. They work with providers to assure the consumer receives the appropriate care in the least restrictive environment possible. It is important to note that our Utilization Managers are only able to authorize treatment, but can never *deny* authorization for services. Any denial of authorizations is handled by our Medical Director and the appeal process for Providers and Consumers is detailed in a Section VI (Appeals, Complaints and Grievances) in this Manual.

**Utilization review:** A system for concurrent and/or retrospective review of the appropriateness of behavioral healthcare services being provided.

**Appendix A: NTBHA Guide to Concurrent Reviews**