THE HOLMAN GROUP

Managed Behavioral Health Care Services

Provider Manual

The Holman Group

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The Holman Philosophy

The Holman Group is dedicated to providing the most appropriate and intensive treatment, in the least restrictive setting. We believe that this approach has a sound therapeutic foundation as well as an economic one. Through this intensive treatment approach we strive to create, establish and provide short-term treatment plans which promote client independence and encourage participation in community based programs for support and maintenance.

We believe that people recover from their problems most quickly when they are treated in surroundings that most closely resemble their normal daily lives: among family, at home, at work and at play. Helping people resolve their problems is Holman's highest priority. The Holman Group takes pride in the quality services our providers offer and looks forward to developing a mutually beneficial and satisfying working relationship.

Introduction

Welcome to The Holman Group family of health care professionals. The Holman Group's Employee Assistance Program (EAP) and Membership Aid Plan (MAP) are composed of a nationwide network of behavioral healthcare professionals who offer a comprehensive program of mental health and chemical dependency assessment, referral and treatment services.

In addition to EAP/MAP services, The Holman Group also serves as a managed mental health/chemical dependency plan for many of its clients. As a managed care organization we offer treatment authorization, care management and utilization review for the following treatment modalities:

- Information and Referral Services
- Group Therapy Services
- Individual Outpatient Services
- Intensive Outpatient Therapy
- Psychological Testing
- Psychiatric Evaluation/Medication Management
- Day Treatment
- Residential Treatment
- Alcohol/Drug Rehabilitation
- Detoxification
- Hospitalization

This Provider Manual outlines those procedures which will enable you to function effectively as a Holman contracted provider. Additionally, the Provider Relations Department is available to assist you with any questions or concerns. The Provider Relations Department can be contacted by calling (818) 704-1444 or (800) 321-2843 (nationwide) Monday through Friday from 8:00 a.m. to 5:00 p.m. P.S.T. Below is a description of the activities and services of the various departments within The Holman Group.

Note: Client denotes Enrollee and/or Eligible Dependent.

The Holman Group's Departments

Below is a description of the activities and services of the various departments within The Holman Group.

Care Access Department:

- Receives calls from clients requesting treatment.
- Gathers demographic information.
- Refers clients to individual contracted providers.
- The Care Access Specialist authorizes the initial EAP/MAP and/or insurance treatment sessions, coordinates all incoming crisis calls and verifies client's eligibility to receive benefits. Records provider's diagnostic information and conveys it to the Care Manager who will authorize, if appropriate, additional EAP/MAP and/or insurance treatment sessions.
- CONTACT STAFF: Care Access Manager, Care Access Specialists

Provider Relations Department:

- Contracts with and credentials individual providers and facilities nationwide for mental health and chemical dependency treatment services.
- Provides information and referral services (e.g., community resources, self-help groups and adjunctive therapies).
- Responds to provider inquiries and concerns regarding Holman policies and procedures.
- Provides The Holman Group forms required for use as a contracted provider. These include billing forms, client information forms, clinical assessment forms, progress notes and discharge summaries.
- Supervises and monitors over the Provider Dispute Resolution Committee
  CONTACT STAFF: Provider Relations Supervisor; Provider Relations Specialists; and Credentialing Coordinator.

You may contact each of these departments by calling (818) 704-1444 or (800) 321-2843 (nationwide) Monday through Friday from 8:00 a.m. to 5:00 p.m. (PST)

Inpatient Care Management:

- Makes all treatment authorization decisions on inpatient and higher level of care cases.
- Carefully monitors all inpatient and higher level of care cases (residential, day treatment, sober living and intensive outpatient).
- Maintains regular contact with provider to ensure treatment goals are being met.
- Coordinates and makes discharge plans from one level of care to another (i.e. hospital to residential).
- Interprets and explains patient benefits to providers and patients.
- CONTACT STAFF: Critical Healthcare Advisor

Outpatient Care Management:

- Makes all treatment authorization decisions on outpatient cases.
- Carefully monitors outpatient cases including the review of clinical assessments and requests for continued authorizations (renewals).
- Coordinates assignments of patients to psychiatrists.
- Interprets and explains patient benefits to providers and patients.
- Provides supervision, remediation and education to providers when necessary.
- CONTACT STAFF: Outpatient Behavioral Healthcare Advisor

Quality Management:

- Monitors integration of Quality Management Plan into day-to-day operations.
- Facilitates analysis of data obtained through Quality Improvement monitoring.
- Interprets Provider/Client Satisfaction Survey findings in the interest of identifying areas in need of improvement.
- CONTACT STAFF: Quality Improvement Manager

Compliance Department:

- Oversees the patient Grievance Process.

You may contact each of these departments by calling (818) 704-1444 or (800) 321-2843 (nationwide) Monday through Friday from 8:00 a.m. to 5:00 p.m. (PST)

The Holman Group's Departments (continued)

Utilization Review Department:

- Creates and maintains patient files.
- Processes requests for authorization extensions for individual treatment sessions.
- Mails out all written verification of authorization to providers.
- Provides the Request for Treatment Authorization (Renewal) forms to providers.
- CONTACT STAFF: Utilization Review Specialist, Utilization Review Staff

Claims/Accounting Department:

- Reimburses providers for services rendered to Holman referred clients.
- CONTACT STAFF: Claims Supervisor, Claims Coordinators

Sales and Client Services:

- Maintains smooth functioning of corporate/labor accounts.
- Consults with client account management/personnel on issues related to employees' mental health and job functioning.
- Monitors Formal Management Referrals.
- Marketing Department - Markets The Holman Group HMO/EAP/MAP plans to potential corporate/labor accounts.
- CONTACT STAFF: Account Executives and Client Services Representative

Additional Departments:

- MIS (Management Information Systems) - Data processing, Web development
- Administration (includes Desk Top Publishing)

You may contact each of these departments by calling (818) 704-1444 or (800) 321-2843 (nationwide) Monday through Friday from 8:00 a.m. to 5:00 p.m. (PST)

Behavioral Health and EAP Access and Availability Standards

The Holman Group has established access standards for face-to-face services as required by the Department of Managed Health Care (DMHC).

A. Providers must be able to offer a member an appointment with five (5) business days for routine cases, 48 hours for Urgent cases, or within 6 hours for non- life threatening emergent cases. All other life threatening cases need to be directed to 911 or the nearest Hospital. Providers shall cooperate and comply, as set forth in the Provider Manual.

The access standard can be changed if the referring or treating licensed care provider assesses a different standard is acceptable and within recognized standards of practice. Any deviation from the standard needs to be documented in the member's record indicating that the longer waiting time will not have an adverse effect on the member's well-being.

B. It is the provider's responsibility to be in compliance with the following standards: Disclose hours of operations to clients (new and established), by including this information on a pre-recorded telephone message or any other effective and verifiable means; provide coverage for your practice when not available, including , but not limited to having an answering service with emergency contact information; inform members of how to proceed should they need services after business hours, including but not limited to providing a pre-recorded telephone message with directions for the callers or clients to call 911 or go to nearest emergency room, in case of an emergency; inform members as to when they can expect a return call after leaving a message (and to call an alternate number or 911 if assistance is needed sooner); and respond to telephone messages in a timely manner.

Provider shall inform the Enrollees/Members that language assistance services are available and provided to them at no charge by the Plan. If an Enrollee is in need of the Language Assistance Program, please have he/she contact The Holman Group at 1-800-321-2843.

C. In addition providers are also responsible for the following:

- Providers shall notify the Plan if a situation arises in which language assistance is needed for a Limited English Proficient member.
- Providers shall notify the Plan within one business day of any requests for translation or interpretation of vital documents.
- Provider shall ensure that their office staff members who are in contact with members are trained to work effectively with in-person and telephone interpreters.
- The Providers shall submit an attestation in regards to their availability, either through themselves or an employee, to provide services in a language other than English.
- Provider is required to submit and update any changes that have occurred to its language assistance capabilities by contacting the Provider Relations Department.

D. Office appointment wait times should be less than 30 minutes after the members scheduled appointment with the provider.

1. **Initial call to Care Access**

   The client calls the Holman Care Access Department to be assigned to a Holman Contracted Provider. A Care Access Specialist will obtain information from the client regarding the presenting problem and statistical information, (i.e., name, address, phone number, client account, etc.). Subsequent to verification of the client's eligibility, the Care Access Specialist contacts a Holman Contracted Provider within 15 miles and/or 30 minutes from the client's geographic area with expertise in the presenting problem(s).

2. **Referral to Provider**

   When making a referral to a provider, the Care Access Specialist will:

   A. Call the provider with a referral or leave a message for the provider to call The Holman Group within the same business day. If the Care Access Specialist identifies the case as emergent or urgent, a return call from the provider is expected as soon as the message is received.

   B. Authorize depending on various factors including Client Company, benefit schedule, etc.

   C. Provide the client's benefit schedule, including copayment and applicable deductible information.

   D. If applicable, specify a time frame in which to complete the authorized sessions (i.e., five weeks for five sessions).

   E. Inform the provider whether to contact the client at home or at the place of employment.

   F. Inform the provider of the appropriate procedures to follow (see 3A and 3B below) after the patient is seen for the first session.

3. What To Do After Accepting a Referral:

A. For a routine referral, once the provider accepts the case from a Care Access Specialist, he/she must call the client within 24 business hours and make every effort to set up the initial session within five business days. If the client is identified by the Care Access Specialist as being in crisis (that is, needs to be seen on emergent [within six hours] basis or urgent [within 48 hours] basis), please call immediately. On-Call clinicians are available twenty-hour (24) hours per day to assist clients in crisis. The nationwide number is (800) 321-2843.

It is imperative to maintain Confidentiality. When leaving a message for a client, never indicate that you are calling from The Holman Group. The provider should give only his/her name and phone number. If the provider is unable to reach the client and/or schedule an acceptable appointment, he/she must notify the Care Access Department immediately. This allows The Holman Group to either attempt to reach the patient, and/or make a note in the patient's file that they were unreachable after requesting initial services.

B. If the provider is unable to accept a case, he/she must immediately inform the Care Access Department. Unavailability for a case will not adversely affect the provider's status as a Contracted Provider.

C. It is never permissible for the client to be seen by anyone other than the authorized provider. The use of interns practicing under the supervision of an authorized provider is strictly prohibited. If the provider is unable to accept a case please contact the Care Access Department.

D. Schedule an appointment at the earliest mutually convenient time. If the earliest mutually agreed upon time is more than five (5) business days, the provider must notify the Care Access Department. Additionally, it is the provider's responsibility to inform the client of The Holman Group's **24-HOUR CANCELLATION POLICY.** The Holman Group is not currently authorized to reimburse for late cancellation or missed appointments for Medi-Cal enrollees

E. Commercial Product

A client may cancel an appointment if 24 hours advanced notice is given. Late cancellations and/or no-shows may result in the client's loss of an authorized session. The Provider may bill The Holman Group for no-shows or late cancellations that occur during authorized EAP or free HMO/ASO carve out sessions. This amount shall not exceed thirty-five dollars ($35.00). A late cancellation refers to a client who fails to cancel with at least 24 hours advanced notice. The Holman Group will pay for up to two (2) no-show/late cancellation occurrences per benefit year, per enrollee. For no-show/late cancellations after the maximum (2 per benefit year), the provider may charge the enrollee directly for such an event. If a copayment is required an enrollee may be charged the applicable copayment or the sum of thirty-five dollars ($35.00).

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Medi-Cal Product (not applicable to facility providers)

The Holman Group is not currently authorized to reimburse for late cancellation or missed appointments for Medi-Cal enrollees. In the event of a late cancellation or missed appointment, Holman should be contacted so that enrollee education may take place.

PLEASE NOTE: The no-show/late cancellation policy may differ for each client company. The Care Access Specialists can provide you with the applicable no-show/late cancellation policy. Please refer to your Provider Contract for more details on the no-show/late cancellation policy as it pertains to our different product lines.

4. What To do After Seeing the Client for the First Session:

Following the first date seen, the provider will forward (either by fax at [818] 704-4252 or mail) to Care Management a completed copy of the Clinical Assessment form. This form needs to be on file before applicable claims can be paid.

For those cases which allow for additional sessions and require additional treatment, the provider will complete a Request for Treatment Authorization Renewal (RTA) form and forward either by fax (818) 704-4252 or by mail to the Utilization Review Department ten days prior to the authorization expiration date. Health Care Advisors will review all RTA forms for completeness and clinical appropriateness. The provider will receive written notification of the treatment authorization outcome. Authorization decisions made by Health Care Advisors are based on Holman's Clinical Review Guidelines. Health Care Advisors disclose or provide for the disclosure to providers of the process used to authorize or deny services under the benefits provided by The Holman Group. Health Care Advisors will also disclose those processes to enrollees or persons designated by an enrollee upon request.

5. What About Management Referrals:

For a management referral, once the provider accepts the case from a Care Access Specialist, he/she will be transferred to a Senior Account Executive who will provide an orientation to the case and discuss the management referral policies and procedures. The Account Manager communicates with the client's employer regarding treatment compliance information.

Following the first date seen, the provider will forward (either by fax at (818) 704-4252 or mail) to the Senior Account Executive completed copies of the Clinical Assessment form. This form needs to be on file before applicable claims can be paid.

If the provider feels that an additional assessment session is needed to further diagnose or recommends adjunctive, additional or a different form of therapy (i.e., medication evaluation), the provider should make those requests to the Outpatient Department. If the client is in a crisis,

contact the Outpatient Department, immediately to discuss the case. The Outpatient Health Care Advisor may verbally authorize additional sessions within a specific period of time, if appropriate.

The provider will receive written authorization for all approved treatment sessions. The written authorizations will confirm your verbal authorization for treatment sessions. The Health Care Advisor will note the number of sessions authorized and the time frame to complete these sessions. An RTA form may also be sent to the provider. If additional sessions are needed, please complete and return this form to Holman ten days prior to the treatment authorization expiration date.

Note: IT IS ABSOLUTELY CRITICAL THAT CONFIDENTIALITY BE MAINTAINED AT ALL TIMES. DO NOT CONTACT, OR RELEASE ANY INFORMATION TO ANY REPRESENTATIVES OF THE CLIENT'S EMPLOYER, SUCH AS SUPERVISORS OR HUMAN RESOURCE PERSONNEL. THE HOLMAN ACCOUNT EXCUTIVE SHOULD BE CONTACTED IMMEDIATELY IF THE PROVIDER RECEIVES A CALL FROM A REPRESENTATIVE OF THE CLIENT'S EMPLOYER.

6. What If The Client Has A Deductible?

There are certain clients who may have a deductible. All deductible and copayment information will be given to the provider at the time of referral. If a client disagrees with the deductible amount, then the provider should require the client to bring in an Explanation of Benefits form (EOB) from his/her insurance carrier to determine if any applicable deductible has been satisfied. It is the provider's responsibility to collect any outstanding deductible for authorized insurance treatment sessions.*

In addition to the EOB, the client must bring a signed insurance claim form obtained from his/her benefit department. (Holman HMO clients have no deductibles or insurance claim forms for their mental health/chemical dependency services.)

All financial obligations, including applicable deductibles and copayments, must be discussed with the client during the first session.

If the client is unable or unwilling to meet the deductible or copayment, please call The Holman Group IMMEDIATELY after the initial session.

*The deductible amount must be collected by the provider and used towards payment. The Holman Group will deduct any deductibles due from provider reimbursement.

Once You Have Received A Referral, Have You . . . ?:

- Contacted client within 24 hours to set an appointment to take place within five (5) business days.
- Met with client within five (5) business days for first Holman referred session.
- Notified Holman's Care Access Department by the next business day if client was a "no-show" or "late cancellation".
- Discussed with client his/her financial obligations, (i.e., applicable deductible and/or copayments).
- Obtained client's signature on the A**uthorization for Release of Information form** found on the reverse side of the **EAP Billing Form.**
- Obtained authorization for additional EAP/MAP and/or insurance treatment sessions from the Health Care Advisors. **ALL TREATMENT MUST BE PRE-AUTHORIZED.**
- Collected a signed claim form from the client's insurance carrier, if the client is NOT covered by The Holman Group HMO. Holman HMO referred clients have no deductibles.
- If applicable, received copy of the **Explanation of Benefits (EOB)** as proof that the client's deductible has been fully or partially satisfied.
- Collected any outstanding deductible from client.
- **PROVIDERS WILL NOT BE REIMBURSED IF CLIENT'S DEDUCTIBLE HAS NOT BEEN SATISFIED.**
- Collected applicable copayments from clients. Please Note: Copayments are kept by the provider and deducted from your contracted rate.
- Requested additional authorized treatment sessions by completing and forwarding to Holman a **Request for Treatment Authorization (RTA)** ten (10) days prior to the expiration date of your current authorization.
- Established the client's file with a copy of each form, including **Clinical Assessment form, Progress Notes form, Client Information form, and Authorization for Release of Information form.**

The Plan will not restrict a health care professional, acting within their lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient regarding:

- Patient's health status, medical/mental health care, or treatment options (including alternative treatments), including provision of information to provide the patient an opportunity to decide among relevant treatment options;
- The risks, benefits and consequences of treatment or non-treatment,
- The opportunity for the individual to refuse treatment, and
- The opportunity for the individual to express preferences about future treatment decisions.

Reporting Adverse or Sentinel Events

The provider must report immediately any Adverse or Sentinel Events to The Holman Group.

Adverse or Sentinel Events include:

- Successful and attempted suicides
- Behavior exhibiting danger to self (other than suicidal behavior)
- Behavior exhibiting danger to others
- Patient injury during the course of treatment
- Tarasoff Interventions
- Ethical/ Legal misconduct

Call 1-800-321-2843, during business hours (7:30 a.m. — 6:30 p.m. P.S.T.) and speak to an Outpatient Health Care Advisor, after hours speak to the On-Call therapist and report the incident.

If the provider is unsure whether an incident can be considered an Adverse or Sentinel Event he/she should contact the Holman Group and confirm.

Grievance Mechanism

Enclosed in your original provider packet is a copy of The Holman Groups Grievance/Complaint Form. Please have these forms available for Holman Clients that express any form of dissatisfaction in regards to The Holman Group or their services. These forms are also available on our website.

By definition, a grievance from an **enrollee** is an oral or written expression of dissatisfaction regarding the Holman Group and/or a provider including quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by an **enrollee** or the **enrollee's** representative.

The Holman Group systematically investigates all grievances.

FILING GRIEVANCES:

All enrollees will have reasonable access to the filing of a complaint. Complaints may be reported to any Holman staff member in person, by telephone, or in writing who will then immediately direct the complaint to the Compliance Specialist. An enrollee may voice a grievance by contacting The Holman Group at (800) 321-2843 or submit it in writing to The Holman Group, 9451 Corbin Avenue, Suite 100. Northridge, CA 91324 or via the Internet through **www.HolmanGroup.com**. If a member needs assistance with filing a grievance, Holman Client Services Personnel will assist them. Call (800) 321-2843 for assistance.

If you have any questions regarding the Grievance Mechanism please contact the Provider Relations Department (800) 321-2843 and speak to the Provider Relations Supervisor.

The following is the DMHC notification regarding the Grievance Process and Independent Medical Review (IMR):

> "**The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."**

Treatment Referrals

Please remember that each client's benefit plan has specific program options and limitations.

Should the provider feel that a different treatment modality such as hospitalization, residential treatment, day treatment, and intensive outpatient services, psychiatric or medication evaluation is indicated for a Holman referred client, the provider **MUST** contact the Inpatient Care Management Department **TO REQUEST SUCH REFERRAL.**

To recommend a different course of treatment for a Holman client who has only seen you for an assessment session, contact the Care Access Department. To recommend a different course of treatment for a Holman referred client who is in ongoing treatment, contact the Care Management Department.

PLEASE NOTE: It is crucial that we are able to reach the provider at all times. Please keep the Provider Relations Department current on all telephone, pager and address information. Additionally, the Provider Relations Department must receive and have on file a copy of the providers' current license as well as liability/malpractice insurance information. We are unable to assign cases to any provider whose license and/or liability/malpractice insurance has lapsed. Please notify the Provider Relations Department in advance of any absence, vacation or change in availability. The Provider Relations Department may be reached on weekdays from 8:00 a.m. to 5:00 p.m. (PST) at (818) 704-1444, Nationwide at (800) 321-2843.

Behavioral Health Treatment

Behavioral Health Treatment (BHT) and Applied Behavioral Analysis (ABA) are professional services and treatment programs that are evidenced based services that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder (PDD) or Autism Spectrum Disorder (ASD).

Please be aware not all benefit plans provide coverage for BHT. Eligibility/coverage for BHT benefits can be verified by contacting a Behavioral Health Care Advisor.

Treatment:

These disorders require interventions early and often for significant periods of time with multiple modalities. ABA is a highly tested treatment modality, which is often effective in helping children develop increased prosocial behaviors such as communication, and reduced behaviors that may be harmful or interfere with the development and maintenance of social interactions or behaviors that may be harmful to self or others. Treating providers must have special expertise and training in these areas in order to provide effective care. Holman is committed to providing the ABA services that are needed for this group of patients.

The following ABA therapy services will be available to eligible children/adolescents with ASD.

- **ABA Assessment/Reassessment:** During the assessment and reassessment there is an evaluation of the participant's current level of functioning, skill deficits, and maladaptive behaviors using validated instruments; a treatment plan is also developed. The assessments and reassessments are administered to a child/adolescent by an ABA provider.).
- **ABA Treatment Planning:** ABA treatment planning is an ongoing indirect service performed by a psychologist, BCBA-D or BCBA. A maximum of 4 hours per month may be requested. ABA treatment planning may consist of:
  - Development and revision of the treatment plan and goals;
  - Data analysis; and
  - Real-time, direct communication and coordination with the participant's other service providers.

- **ABA Therapy:** ABA therapy is the utilization of behavioral interventions designed in advance by the psychologist, BCBA-D or BCBA, who will provide supervision during a portion of the treatment. ABA therapy is most often administered by the BCaBA, RBT, or BT. ABA therapy may be delivered as:
  - Individual therapy administered face to face to a child/adolescent by an ABA provider (Psychologist, BCBA-D, BCBA, BCaBA, RBT, or BT);
  - Group therapy administered to multiple children/adolescents by an ABA provider (Psychologist, BCBA-D, BCBA, BCaBA, RBT, or BT); or
  - Social skills group therapy administered to multiple children/adolescents by an ABA provider (Psychologist, BCBA-D or BCBA).

- **ABA Supervision:** ABA supervision is the monitoring, direction, and oversight of a BCaBA, RBT or BT, delivered by a psychologist, BCBA-D or BCBA, while the

BCaBA, RBT or BT is delivering direct ABA therapy. Guidelines require the amount of supervision be equal to at least 10 percent of the total amount of hours that direct ABA therapy is delivered. ABA supervision can be provided directly or remotely. If approved to provide remote supervision, at least 25 percent of the supervision must be delivered in-person. When delivering remote supervision, providers must secure access to HIPAA compliant technology which provides an auditory and visual connection between the above mentioned provider types.

- **ABA Parent Training:** ABA parent training is behavior treatment guidance that is provided in-person with a participant's parent or caregiver, with or without the presence of the participant. During parent training there is an identification of maladaptive behaviors and skill deficits followed by instructions to the parent or caregiver on how to utilize ABA treatments to reduce maladaptive behaviors and skill deficits. ABA parent training may be delivered as:
    - o Individual parent training administered by an ABA provider (Psychologist, BCBA-D, BCBA or BCaBA); or
    - o Multiple-family group training administered by an ABA provider (Psychologist, BCBA-D or BCBA).

SERVICE RULES

Applied Behavior Analysis

Clinical information that outlines medical necessity is required to support the need for initial and continuing ABA services, including:

- ASD diagnosis confirmation documented by ONE of the following:
    - o A comprehensive diagnostic evaluation (CDE) completed within the last 3 years confirming an ASD diagnosis and a referral outlining the need for ABA services written within the last 6 months by one of the following qualified health care professionals (QHCP):
        - Pediatricians
        - Developmental Pediatricians
        - Pediatric Neurologists
        - Child Psychiatrists
        - Clinical Psychologists
        - Nurse Practitioners
        - Neuropsychologists

Authorizations:

In order for Holman to authorize initial ABA Treatment all of the following criteria must be met:

1. The FBA must contain Member's information (e.g., name, DOB, Identification number, home address, phone number, parent/guardian name, and spoken language;
2. Referral information (e.g., date, presenting concerns);
3. Background Information (e.g., family living, school, health and medical, services and activities, intervention history, and availability), which will require a review of the Member's medical, psychiatric, educational records;
4. A structured clinical interview with parent/guardian;

5. Administration of validated developmental and adaptive skills assessment to establish baseline functioning;
6. Administration of Preference Assessment;
7. A minimum of 2 Member observations across all relevant settings (e.g., home, school, community);
8. An evaluation of the purpose of maladaptive behaviors using a validated assessment tool;
9. Structured data collection of the identified behaviors and analysis of antecedents and consequences;
10. Target Behaviors that warrant clinical attention should be operationally defined, have a clear onset/offset, course of behavior, history and recent changes, baseline levels and severity. Each behavior will need a statement on the social significance.
11. A detailed description of behavior reduction goals with clear definition, antecedent, baseline, and mastery criteria for needed skills development;
12. A detailed description of replacement behavior and skill acquisition goal selection based on reported behaviors and developmental evaluations scores;
13. Caregiver training goals and a plan to provide necessary support and training to caregivers as a plan to evaluate their acquisition of these skills.
14. A Behavior Plan that Includes Ecological/Antecedent Strategies, Reactive/Consequence Strategies, Teaching Procedures for Replacement Behaviors;
15. A detailed proposal for the intensity and duration of services, as well as the locations where these services; and
16. A clear plan with objective milestones for the systematic reduction of care and the criteria for DISCHARGE FROM SERVICES.
17. Evidence of consultation with school to include school and overview of school services.

InterQual

For Applied Behavioral Analysis, all decisions (authorization, denial, delay, or modification) are made with the assistance of the McKesson InterQual Clinical Decision Support Criteria and Software. If Member does not meet medical necessity as determined by InterQual, the Associate Medical Director or Licensed Psychologist will conduct a secondary review.

Qualified Providers

The treatment must be provided under a treatment plan prescribed by a qualified autism provider and administered by one of the following:

a. a qualified autism provider

b. a qualified autism professional supervised and employed by a qualified autism provider

c. a qualified autism paraprofessional supervised and employed by a qualified autism provider

The treatment plan should be modified and updated as needed (no less than once every six months) to ensure patient continues to meet criteria for services. Progress should be documented and reviewed for effectiveness of services. In addition, coordination of care with relevant treating providers, e.g. medical professionals (including primary care physicians), other behavioral health care clinicians such as psychiatrists, etc. should be clearly documented.

All BHT services require pre-authorization by Holman and are subject to medical necessity review.

Services for the following will not be authorized by Holman:

- Educational services
- Vocational rehab
- Respite or day care
- Orientation and mobility
- Reimbursing a parent for participation in the treatment program
- Activities that are solely recreational, social or for general fitness, such as gym and/or dancing classes.

Please note: although Holman is not responsible for providing enrollees with physical, occupational, and speech therapies, we recognize the importance of these therapies in conjunction with BHT and request every effort to facilitate coordination of care of all recommended treatment be made. In addition to providing a Coordination of Care form (which allows for the exchange/release of information regarding an individual's behavioral health condition to the enrollee's primary care physician or other treating providers), individual ongoing review of treatment (case management) allows our Behavioral Health Care Advisor to work closely with the treating provider to assure coordination of care of all recommended treatment.

Billing for BHT services

All services must be pre-authorized. Services must be billed using the codes included in your contract as follows:

H0031	Direct services for assessment/treatment plan conducted by licensed practitioner or BCBA/BCBA-D.
H2012/H0046	Direct BHT services by licensed practitioner or BCBA/BCBA-D.
H2019	Direct BHT services by paraprofessional.
H0032	Supervision of professional/paraprofessional conducted by licensed practitioner or BCBA/BCBA-D.
G9012	Parent training rendered by qualified autism provider or professional.
H2014	Social skills development group activity conducted by licensed practitioner or BCBA/BCBA-D.

Credentialing Requirements for Behavioral Health Treatment Providers

Qualified autism service provider means either of the following:

A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, or a person licensed pursuant to Division 2 (commencing with Section 500) of the business and Professions Code who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified (1374.73(c)(3).

Individual qualified autism providers:

- Licensed practitioner (Psychologist, LCSW, MFT or LPCC) with adequate experience and training in the treatment of Autism Spectrum Disorders.
- BCBA or BCBA-D with active certification and adequate experience and training in the treatment of Autism Spectrum Disorders.
- Minimum malpractice insurance of $1 million per occurrence/$1 million aggregate.
- Services must be provided by the qualified autism service provider to the member.
- Qualified Autism Agencies:

- Employs a qualified autism provider that is a licensed clinician or a BCBA with adequate experience and training that conducts assessments, treatment plans and provides direct supervision and training of qualified autism service professionals and paraprofessionals. qualified autism service has evidence of a minimum two (2) years relevant work history.
- Minimum malpractice insurance of 1 million per occurrence /3 million aggregated.
- Employs qualified autism service professionals under the supervision of the qualified autism service provider to conduct treatment as designed by the qualified autism service Provider. The qualified autism service professional as defined in Section 54342 of Title 17 of the California Code of Regulations and has training pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code. (1374.73(c)(4).
- Employs qualified autism service paraprofessionals which are unlicensed or uncertified individuals that are supervised directly by the qualified autism service provider and conduct treatment as designed by the qualified autism service Provider. All qualified autism service paraprofessionals must meet the criteria set forth in the regulations adopted pursuant to Section 4686.3/17 CCR 54342(b) of the Welfare and Institutions Code. (1374.73(c)(5).

- Services must be provided by a qualified autism service professionals and/or paraprofessionals under the supervision of a BCBA or licensed clinician. Services will also include supervision hours.

Formal Management (Work Performance) Referrals

A Formal Management Referral is a referral made by the client's employer for work performance problems. In order for The Holman Group to report the client's status to the employer, we must collect the following information:

1. Client's attendance in treatment
2. Client's compliance with treatment plan
3. Client's leave status, if any, from job (pertains to authorized medical leaves)
4. Client's prognosis

If a client is a Formal Management Referral, the Care Access Specialist will apprise the provider of this status when assigning the case. All communication with the client's employer will go through the Account Executive.

It is imperative that the provider have a Formal Management referred client sign the **Authorization for Release of Information form, Formal Management Referrals section.** The original is to be sent to The Holman Group, Attention: Account Executive. One copy must be given to the client, and one copy must be retained by the provider.

The provider will follow the appropriate procedure (see Page #11, #5) after the initial assessment session unless directed otherwise by the Account Executive in charge of the referred case.

If a Formal Management referred client is non-compliant or misses a session for any reason, the provider must notify the Account Executive at The Holman Group **immediately**. Please do **NOT** contact the client's supervisor!

Since Formal Management Referrals may result in job actions (e.g., retention, suspension, discharge), it is important to keep current and complete records on all such cases.

IT IS ABSOLUTELY CRITICAL THAT CONFIDENTIALITY BE MAINTAINED AT ALL TIMES. DO NOT CONTACT, OR RELEASE ANY INFORMATION TO ANY REPRESENTATIVES OF THE CLIENT'S EMPLOYER, SUCH AS SUPERVISORS OR HUMAN RESOURCE PERSONNEL. THE SENIOR ACCOUNT EXECUTIVE SHOULD BE CONTACTED IMMEDIATELY IF THE PROVIDER RECEIVES A CALL FROM A REPRESENTATIVE OF THE CLIENT'S EMPLOYER.

Summary of Utilization Management Process, Guidelines and Criteria

The materials provided to you are guidelines used by this plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

The Holman Group is committed to providing high quality mental health services, and strives toward excellence in customer service. It is our desire to help the client to reduce functional impairments and to improve daily functioning quickly. It is also our goal to deliver quality and cost effective mental health services through the effective use of resources while measuring outcomes and satisfaction via continuous quality improvement methodologies.

The function of Utilization Management is to facilitate the provision of quality, efficient mental health services to clients and providers through monitoring, evaluating and influencing the processes and behaviors, which impact the delivery of services. Managing the treatment patterns of the delivery systems for maximum efficiency is the overall goal of Utilization Management.

Accessing Services and Making Referrals

The Holman Group benefits, (inpatient, detoxification, alternative care and outpatient services), require pre-authorization, except for services provided on an emergency basis. In the case of emergency treatment, it is required that the facility, provider, enrollee, or a member of the enrollee's family contact The Holman Group on the following business day to notify Care Management of the emergency services rendered.

Urgently needed and emergency services can be authorized either by a Care Manager, if during business hours, or by an on-call crisis clinician, if after hours. The enrollee, the enrollee's representative or the provider can contact The Holman Group; the situation is assessed over the phone by the Care Manager or on-call clinician, and if appropriate, the enrollee is referred to and authorized for the necessary services at that time.

Providers seeing patients who need to make additional referrals for that patient (such as a MFT provider referring a patient to a psychiatrist) must contact The Holman Group Care Advisors for that patient, giving justification for the referral request. If the referral is determined as appropriate, the Health Care Advisor will make the assignment to the

new/additional provider, relaying pertinent information about the patient, and will ensure that the appropriate authorization is given.

Summary of Utilization Management Process, Guidelines and Criteria (Continued)

Authorizations Decisions: Initial and Concurrent Review

Initial, concurrent and retroactive authorization decisions are made by Health Care Advisors. Initial treatment authorization decisions are made at the time that the assessment and treatment plan are reviewed with the provider. Providers are verbally notified at that time of the initial authorization and will also be notified by mail in the form of a Notification of Authorization.

Client treatment progress and requests for continuing treatment authorizations are reviewed concurrently. Renewal requests are reviewed by Care Management staff for client progress, the continuing presence of impairments in functioning and crisis situations, and adherence to the treatment plan.

Retroactive Reviews

Most services received through The Holman Group require pre-authorization. However, on occasions a retroactive treatment authorization will be appropriate and necessary. When retroactive requests are received, they are reviewed for authorization by a Senior Health Care Advisor or the Medical Director.

When clients are treated for emergency situations (such as being admitted through an emergency room for suicidal ideation with intent and plan), which are treated without authorization, the facility or the client's representative should contact Care Management no later than the following business day. Services will be authorized if these benefits are contracted for by the employer or contracting agency, and if the functional impairments and severity of risk factors justify the level of treatment.

Processes and Criteria Used to Authorize or Deny Services

The clinical review guidelines and McKesson criteria utilized by the Holman Group are based on national standards for mental health professional practice. These fields include: Psychiatry, Clinical Psychology, Clinical Social Work, Marriage, Family and Child Counseling, and Psychiatric Nursing. These guidelines were developed using clinical resources from (but not limited to) the American Psychiatric Association, American Medical Association, American Abuse and Alcoholism, and the National Institute of Drug Abuse.

These guidelines define the general criteria used to determine the level of care and type of treatment needed for each case. The criteria include medical necessity,

impairment of functioning, severity of risk factors, and level of care required to effectively treat the patient's problem. Authorization decisions are also influenced by the unique characteristics of each individual benefit package (which determine the available benefit), and the specific limitations of each plan.

Summary of Utilization Management Process, Guidelines and Criteria (Continued)

Implicit in these guidelines is The Holman Group's goal to provide the most effective, appropriate level of care in the least restrictive (intensive) environment, and within the benefit package purchased by the client organization. This also requires that all patients have ready access to the covered services they need and that they receive quality treatment.

Medical Necessity

The central consideration in all The Holman Group clinical review decisions and authorizations is the determination of the most appropriate and medically necessary level of care. Clinical information gathered by The Holman Group's care management staff is aimed at satisfying this consideration.

The following conditions must be present in order to meet the criteria for medical necessity:

- Services are adequate and essential for the evaluation and treatment of a disease, condition or illness, as defined by standard diagnostic nomenclatures (DSM-IV, ICD-1 0);
- Treatment can be reasonably expected to improve an individual's condition or level of functioning;
- Evaluation and treatment methods are in keeping with national standards of mental health professional practice, using methods of treatment or evaluation for which there is an adequate basis in research;
- Are provided at the most cost effective level of care that is appropriate to the clinical needs of the patient.

To maintain authorization of benefits, all four elements of medical necessity must be present throughout the course of treatment.

Coordination of Care

The Holman Group encourages all of our providers to coordinate care with any other provider treating the enrollee.

Notification of Authorizations and Denials to Providers and Enrollees

Providers receive written notification of authorizations for all services authorized. Providers receive a written Notification of Authorization describing the services, number of units (sessions, days, etc.) and the time period authorized.

Summary of Utilization Management Process, Guidelines and Criteria (Continued)

For enrollees receiving higher levels of care, authorizations and denials are communicated to the provider via phone, and are followed by a written Notification of Authorization. When appropriate, these decisions are communicated to the enrollee directly by the Health Care Advisor; when not appropriate, the provider informs the enrollee of the authorization decision.

Initial outpatient authorization decisions are communicated verbally to the provider over the phone and are confirmed with a written Notification of Authorization. Subsequent authorization decisions are communicated via mail, unless the situation is urgent and requires immediate communication. Enrollees are notified by the provider of the authorization decisions regarding outpatient treatment.

Authorization decisions are sent to providers, in writing, as a Notification of Authorization. A copy of these decisions will also be sent to the enrollee upon request, or to anyone designated by the enrollee.

Denial of Authorization and Appellate Process

Benefits may be denied for a number of reasons, all of which are defined in the evidence of coverage information provided to the enrollee. Possible denials of authorization are reviewed by individual Health Care advisors, care management supervisors, or the Utilization Management Committee (UMC).

All denials for higher levels of care (acute hospitalization, partial hospitalization/day treatment or residential treatment) are reviewed by the supervisor of Inpatient Care Management with the final decision being made by The Holman Group Medical Director. Inpatient care management conferences cases regularly in order to provide peer review/consultation on cases requiring higher levels of care.

Outpatient authorization denials may be made by the staff, who is a licensed psychiatrist or by the UMC, which is chaired by a licensed psychologist. Note that the UMC reviews outpatient cases that have accumulated 15 or more sessions during the current course of treatment. It may also review, for the purpose of peer consultation, any difficult or

challenging cases that a health care advisor presents to the forum. Outpatient authorization denials to physicians will only be made by a Holman Psychiatrist.

Summary of Utilization Management Process, Guidelines and Criteria (Continued)

The following are some of the more frequent reasons that denials of authorizations are made:

- The patient meets one or more of the exclusionary criteria mentioned above (both contractual and operational);
- The patient does not meet inclusionary criteria;
- Treatment at the requested level of care is not justified as medically necessary;
- There has been an improvement in functional impairment, severity of illness and risk factors such that the patient does not require treatment at the requested level of care;
- There has been an improvement in functional impairment such that the patient can resume a reasonable level of functioning in most areas of his/her life, maintaining ongoing support through community resources;
- The treatment plan indicated is not appropriate to the treatment of the original problem(s) identified, or is not indicative of solution-focused, brief therapy;
- Following an adequate period of treatment, it does not appear that further treatment will produce significant improvement in the level of functional impairment;
- The patient is repeatedly non-compliant with one or more aspects of the treatment plan, thus impairing the progress and stability of treatment;
- The patient's benefit is exhausted.

Disclosure to Providers and Enrollees of Criteria Used Justifying Treatment Authorization Decisions

All denial decisions are justified to the provider, either verbally or in writing, at the time of the decision. Criteria supporting specific authorization decisions will be disclosed, upon request, to both the enrollee and the provider by a health care advisor. To inquire about authorization decisions, the enrollee or provider should call or write to the care manager directly requesting justification for the decision.

Summary of Utilization Management Process, Guidelines and Criteria (Continued)

Appeals to Authorization Decisions — Outpatient Care Management

Any provider, patient or subscriber has the right to appeal a care management authorization decision. The request may be made verbally or in writing, although it is strongly suggested that verbal requests be followed by a written request documenting the petitioner's justification for appeal. Depending on the level at which the original decision was made, the following is the hierarchy of review:

- Outpatient Health Care Advisor
- Outpatient Senior Health Care Advisor
- Utilization Management Committee
- Utilization Management Committee with consultation of staff psychiatrist

Available documentation will be reviewed; additional documentation from the provider may be required. A decision regarding the appeal will be made within five working days of the receipt of all requested documentation; the petitioner will be notified both verbally and in writing of the appeals decision.

Appeals to Authorization Denials — Higher Levels of Care

The process for appeals review of inpatient/higher levels of care (all levels of care other than Outpatient Expanded and Intensive) will be reviewed by the Supervisor of Inpatient Care Management and the final decision is made by The Holman Group's Medical Director. This review is initiated verbally or in writing by the Facility's attending psychiatrist. This is forwarded to the Inpatient Care Manager who may require that patient records and documents be submitted for review. It is at this point that the actual appeal process is begun.

The case in question is submitted to the Supervisor of the Inpatient Care Management Department along with a request for medical review and subsequently will be forwarded to the Medical Director for final determination. Once the final decision has been made, the Critical Health Care Advisor contacts the Facility's staff physician verbally and in writing.

If a satisfactory decision is not reached, our letter will always document the option of a second appeal by an outside board-certified psychiatrist. Once again, a complete copy of the patient's record along with a cover letter from the Facility, and The Holman Group's Request for Medical Review will be submitted and reviewed by the second psychiatrist. The

decisions made at this level of appeal shall be considered final. The Facility/psychiatrist will be notified both verbally and in writing of this decision.

A complete copy of the appeals policy and procedure can be made available upon request.

Billing/Provider Checklist

Please review this section carefully to facilitate the billing process.

All billing is between The Holman Group and the provider. DO NOT ask your client to call Holman regarding billing procedures. Do not bill the client or the insurance carrier for services rendered.

Authorized EAP/MAP sessions and authorized insurance treatment sessions are billed on a universal billing form.

The Holman Group must have on file copies of the provider's current licensure and liability coverage (to include expiration date) in order to adjudicate claims and reimburse providers.

NOTE: All services must be pre-authorized. THERE IS NO SUCH THING AS A WALK-IN CLIENT! Clients with benefits through The Holman Group should be encouraged to access their EAP/MAP program by calling the Care Access Department. Unauthorized services will not be reimbursed.

The Holman Group will not reimburse a provider for double sessions or more than one session on the same date unless specifically pre-authorized.

TO BILL FOR AUTHORIZED EAP/MAP SESSIONS:

Submit billing for dates of service for authorized EAP/MAP treatment sessions on a universal Billing form. It is essential that all information requested be complete including employee and/or client data. Providers are to bill on a timely basis. Claims received beyond ninety (90) days after date(s) of service may not be considered for processing.

NO-SHOW/LATE CANCELLATION:

The Provider may bill The Holman Group for no-shows or late cancellations that occur during authorized EAP or free HMO/ ASO carve-out sessions. This amount shall not exceed thirty-five dollars ($35.00). A late cancellation refers to a client who fails to cancel with at least 24 hours advanced notice. The Holman Group will pay for up to two (2) no-show/late cancellation occurrences per benefit year, per enrollee.

Medi-Cal Product (not applicable to facility providers)

The Holman Group is not currently authorized to reimburse for late cancellation or missed appointments for Medi-Cal enrollees. In the event of a late cancellation or missed appointment, Holman should be contacted so that enrollee education may take place. Please refer to your Provider Contract for more details on the no-show/late cancellation policy as it pertains to our different product lines.

FOR REIMBURSEMENT FOR AUTHORIZED EAP/MAP SESSIONS:

Submit the following completed claim forms to The Holman Group, attention Claims Department:

- Universal Billing form (HCFA1500/CMS1500 or CMS1450/UB04)
- Signed Authorization for Release of Information form or indicate signature on file.

Incomplete and/or inaccurate forms will be returned and reimbursement will be delayed.

NOTE: A Clinical Assessment Form must be on file with The Holman Group for any claims to be paid.

TO BILL FOR AUTHORIZED INSURANCE TREATMENT SESSIONS:

Submit billing for dates of service for authorized HMO treatment sessions on the HCFA or a universal billing form. It is essential that all information be complete including employee and/or patient data. Claims received beyond ninety (90) days after date(s) of service may not be considered for processing.

For reimbursement for authorized HMO treatment sessions, submit the following forms to The Holman Group, attention Claims Department:

a. Universal Billing Form (HCFA1500/CMS1500 or CMS1450/UB04).

b. Signed Authorization for Release of Information form or indicate signature on file.

NOTE: The Clinical Assessment Form must be on file with The Holman Group for claims to be paid.

CALIFORNIA LAW PROVIDES THAT ENROLLEES ARE NOT LIABLE FOR ANY AMOUNT OWED BY HOLMAN TO ANY CONTRACTED PROVIDER IN THE EVENT HOLMAN DOES NOT PAY FOR PRE-AUTHORIZED SERVICES AND THAT NO PROVIDER MAY TAKE LEGAL ACTION AGAINST AN ENROLLEE TO COLLECT SUMS OWED BY THE PLAN

COPAYMENTS:

It is the responsibility of the provider to collect applicable copayments from the client. Copayments are payable to the provider and are deducted from the contracted rates. The provider will not be reimbursed for uncollected copayments.

In the event that the applicable copayment exceeds the provider's contracted rate, the provider must remit the copayment in full to The Holman Group. The Holman Group will then reimburse the provider at his/her contracted rate.

PROVIDER REIMBURSEMENT SCHEDULE:

All bills must be submitted in a timely manner. EAP/MAP and HMO provider billings are stamped when received by the Claims Department and will be reimbursed to the provider of service within 30 working days or within the time frame specified by agreement or by law.

UR provider billings are forwarded by The Holman Group to the client's primary insurance carrier for reimbursement. After payment is received by The Holman Group from the insurance carrier, The Holman Group will reimburse the provider for billed authorized services at the provider's contracted rate less any applicable copayments. Please note: Any outstanding deductible must be satisfied before the provider will be reimbursed for authorized and rendered insurance treatment sessions.

EAP/MAP and Holman HMO provider billings will be paid by The Holman Group within thirty (30) working days following receipt of any acceptable, undisputed claim form. Again, any outstanding copayments will be deducted from the provider's contracted rate.

To avoid delays in reimbursement, be sure that billing materials are filled out accurately. The insured's name, social security number and employer must be clearly identified on the Billing Forms. Complete the requested data on the authorized client as well.

CHECKLIST FOR BILLING PROCEDURES:

To avoid delays in reimbursement for EAP/MAP services rendered to authorize Holman referred clients:

1. Make sure The Holman Group has on file copies of your **current licensure and liability coverage** with expiration dates. We will be unable to pay claims or assign cases without this information.

2. Complete the **Universal Billing Form (HCFA1500/CMS1500 or CMS1450/UB04)** for the client's sessions.

3. Bill only authorized EAP/MAP sessions. Dates of service must occur within the authorized time period. Do not exceed the number of authorized sessions in a particular authorized time period.

4. Bill only for authorized client(s).

5. Make sure the client (or legal guardian) signs and dates the **Authorization for Release of Information form.**

Submit the above mentioned forms in a timely manner to:

The Holman Group
9451 Corbin Avenue, Suite 100 Northridge, CA 91324
Attention: Claims

To receive reimbursement for insurance treatment sessions rendered to authorize Holman referred clients:

1. Complete the Universal Billing Form (HCFA1500/CMS1500 or CMS1450/UB04).

2. Bill for authorized client(s) and dates of service only.

3. Make sure the client (or legal guardian) signs and dates the following (if client had not done so already during his/her EAP/MAP sessions[s]): Authorization for Release of Information form.

4. Collect from the client any applicable deductible. Again, an EOB from the client's insurance carrier is the only reliable proof that the deductible, or a portion thereof, has been satisfied.

5. Collect and keep copayments and deductibles.

6. Submit the above mentioned forms, if applicable, in a timely manner to:

The Holman Group

9451 Corbin Avenue, Suite 100 Northridge, CA 91324

Attention: Claims

FRAUD, WASTE, AND ABUSE INVESTIGATION

Fraud is knowingly and willfully executing, or attempting to execute, a scheme to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. These may include:

- Knowingly billing for services not furnished or supplies not provided,
- Billing for non-existent prescriptions; and
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Waste includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally considered to be caused by the misuse of resources. Examples of actions that may constitute Medicare **waste** include:

- Conducting excessive office visits or writing excessive prescriptions;
- Prescribing more medications than necessary for the treatment of a specific condition; and
- Ordering excessive laboratory tests.

Abuse includes actions that may result in unnecessary costs to the Medicare Program. Examples of actions that may constitute Medicare **abuse** include:

- Billing for unnecessary medical services;
- Billing for brand name drugs when generics are dispensed; and
- Charging excessively for services or supplies.

If a Provider knows or suspects illegal or wrongful billing practices by an Enrollee or a Provider, the Provider should notify The Holman Group immediately. Any information provided will be treated with strict confidentiality. Call 1(800)321-2843, and speak with the Holman Group's Finance Manager. Reports can also be made to the HHS Office of inspector General at 1-800-HHS-TIPS or the CMS Hotline at 1-800-MEDICARE. For reports related to Medicare Parts C and D, call 1-877-772-3379.

The Holman Group's commitment to quality care places great emphasis on the quality of its provider network. As a member of The Holman Group's provider network, each provider is considered to be an integral part of the Quality Management program and is expected to participate in quality improvement activities. These activities may include, but are not limited to the following:

- ✓ Evaluation of quality of care through:
  - clinical assessment and treatment plan reviews
  - chart audits
  - complaint/grievance reviews
  - site visits, where applicable
  - credentialing and re-credentialing reviews
  - quality improvement studies
- ✓ Outcomes of care through:
  - discharge summary reviews
  - client satisfaction surveys
  - specific outcome studies
- ✓ Administrative procedures through;
  - review of compliance with program credentialing, quality and utilization standards
  - adherence to service standards, e.g., client access to care
  - review of compliance with Holman policies and procedures

The Holman Group believes that communication between individual providers and the organization will enhance the quality of the service it provides to clients. Therefore, providers are encouraged to share their comments and suggestions regarding ways to improve the delivery of care either in writing to or by calling the Provider Relations department.

CREDENTIALING

The credentialing of the provider network is an important aspect of The Holman Group's Quality Management Program. All providers are required to participate in the credentialing process which is under the auspices of the Provider Relations Department.

Each applicant is required to complete a provider application and submit the following documents:

- copies of license(s)
- copies of certifications
- evidence of malpractice insurance
- resume/vitae
- taxpayer identification (W-9) form
- afterhours access information
- Language Capability Attestation (Disclosure)

The completed application file is reviewed by the Peer Review and Credentialing Committee (PRCC) which makes the final determination for inclusion in the provider network. A site visit may be conducted, if applicable. Once an applicant has been approved, the Provider Relations Department will send provider contracts.

RECREDENTIALING

Providers are required to submit current copies of licenses and malpractice insurance coverage's in order to continue to participate in the provider network. Recredentialing occurs every three years and includes a review and update of provider documents as well as a review of the provider's experience with The Holman Group. The PRCC will review the following in its evaluation process:

- chart audit results
- clinical and administrative Provider Evaluation forms
- client satisfaction surveys
- salutary comments
- complaints/grievances

- updated credentialing information
- site visit results, as applicable
- afterhours access information

Provider Rights:

If any information obtained during the credentialing process varies substantially from information received from the provider, Provider Relations staff will call the provider to notify him/her of any discrepancies. The provider has the right to review all information submitted and to request the status of their credentialing/re-credentialing upon written request. The provider will have two (2) weeks to contact the Provider Relations Department to request a review of the material in question. A record of the call to the provider will be made.

The provider will remit to Provider Relations, in writing or by fax, any changes or corrections within two (2) weeks from the time the provider was presented with the material in question. Receipt of the changes or corrections will be noted in the provider file.

PROVIDER UPDATES

In addition to participating in the credentialing and re-credentialing processes, providers are required to notify The Holman Group's Provider Relations Department, within 5 business days, when changes occur in any of the following:

- licensure
- certification(s)
- malpractice coverage
- malpractice actions
- hospital privileges
- address(es) and/or phone number(s)
- tax identification number
- change in appointment availability
- Language Capability Attestation (Disclosure)

In an effort to maintain current and valid data, provider information will be verified bi-annually by the Provider Relations Department and requires an affirmative response from the affected provider within 30 days of inquiry. Failure to respond to requests for regular updates could result in the removal of the provider from The Holman Group's provider directory and/or delay in payment until the provider's information can be verified.

SITE VISIT ASSESSMENTS

All high volume individual providers will receive site visits at their main office to ensure compliance with the organization's standards.

The representative conducting the onsite review will make contact with the provider at least 2 weeks prior to the targeted site visit date and carry a picture ID with his/her full name and The Holman Group logo when conducting site visits. The representative will utilize a standard Site Visit Form (available upon request) to ensure provider's office meets the following requirements:

- Physical accessibility to the building, treatment rooms, and bathrooms including accommodations for the handicapped.
- Physical appearance to provide a safe clean environment for patients, visitors and staff
- Adequacy of waiting room space to accommodate the average number of patients seen per provider per hour
- Adequacy of treatment room space including provisions for privacy during sessions
- Availability of appointments, if applicable
- Adequacy of medical/treatment record-keeping

A medical record-keeping assessment will be reviewed to address the extent to which medical record-keeping practices support the following:

- Confidentiality of the record
- Consistent organization of the record

Where applicable, The Holman Group will conduct a Site Visit for provider Re-Credentialing that, in addition to the onsite criteria outlined above, will include an onsite Chart Audit of five (5) patient files. The Chart Audit process and scoring tool will be used to ensure compliance with professional standards of documentation by the provider and will follow the Chart Audit process and criteria as described below.

Upon request of the provider, the Providers Relations department will supply a summary of the site visit review standards and process.

CHART AUDITS

As part of The Holman Group's ongoing quality improvement procedures and as regulated by the Department of Managed Care, random chart audits will be conducted and compliance is mandatory. During this procedure, The Homan Group will randomly select a patient's file to review. If any additional information is needed the reviewer will contact you. Failure to comply may result in provider being placed on "Hold" status and/or may lead to termination. For your convenience, The Holman Group has made available to you several forms that when filled out, would guarantee compliance with The Holman Group Chart Audit standards. One of the most important of these forms, "The Clinical Assessment Form," when completed provides virtually all of the information that you need to provide in order to pass an audit of your patient records.

The Quality Management Department has adopted standards for documentation which are in keeping with various regulatory and accreditation entities. This review will ensure that all essential components of the client's chart are present and that overall documentation is of a quality nature.

All forms and documentation should be thorough, legible, labeled with the client's name, and dated and signed by the provider. All forms submitted, such as Client Information or the Initial Clinical Assessment forms, should be complete, with "N/A" indicated when the item is not applicable for this particular patient. The state of California requires a listing of the patient's primary care physician, the date of the last medical examination, and a listing of the prescribed medications with the dosage and frequency as well as the name of the prescribing physician. Our expectation is that each chart submitted will contain the following:

Psychotherapist

Background Information: Relevant medical, mental health, substance abuse, and treatment histories; presenting problems, risks and symptoms; and a bio-psychosocial history, which includes a regard for the cultural/religious background of the client; and current or past stressors affecting the patient's current functioning.

Diagnostic Information: A completed Mental Status Examination; and documented DSM-IV (all Axes) or ICD.9, which shows consistency with the listed symptoms

Treatment Plan: Goals and measurable objectives which are concordant with the presenting problems and symptoms; an outline of the level of care, number of sessions anticipated, and duration of treatment;

adaptation of the plan in accordance with the patient's strengths and weaknesses; interventions used as well as the patient's response to treatment; and documentation of appropriate referrals

Termination Procedures: If the patient has been terminated from treatment, the reason for the termination, and a completed Discharge Summary.

Record Keeping and Documentation: Dates of contact with the patient and the patient's signature in the appropriate places (Release of Information, Treatment Plan, etc.)

Please be aware that process/progress notes need not be submitted, but much of the information requested may be provided through a combination of forms (e.g. Clinical Summary, Intake information, Clinical Assessment, Request for Treatment Authorization, Discharge Summary, etc.)

Physicians

Background Information: Relevant medical, mental health, substance abuse, and treatment histories; presenting problems and symptoms; and current or past stressors affecting the patient's current functioning

Diagnostic Information: A completed Mental Status Examination; and documented DSM-IV (all Axes) or ICD.9, which shows consistency with the listed symptoms

Treatment Plan: Documentation of medications prescribed, including dosage and frequency; allergies to medications; and interventions which are concordant with the presenting symptoms and diagnosis

Referrals: Documentation of appropriate referrals.

Record Keeping and Documentation: Dates of contact with the patient; your signature on the records; evidence of informed consent for medication; and the patient's signature in the appropriate places (Release of Information, Treatment Plan, Informed Consent, etc.)

Please be aware that progress/process notes need not be submitted, but much of the information requested may be provided through a combination of forms (e.g.: Clinical Summary, Request for Treatment Authorization, Discharge Summary).

Upon reviewing his/her file, any adult patient of a provider has the right to provide to that provider a written addendum to his/her patient file regarding any item or statement in the file which the patient believes to be incomplete or incorrect. The addendum must be limited to 250 words per alleged incomplete or incorrect item in the patient's record and must clearly indicate in writing that the patient wants the addendum made a part of his/her patient file. The provider must then attach the addendum

to the patient's records and must include that addendum whenever the health care provider makes a disclosure of the file to any party.

INQUIRY AND REVIEW

The Holman Group is committed to developing and maintaining a quality provider network. The Quality Management Program is responsible for identifying, reviewing and acting upon serious administrative and/or quality of care issues regarding a provider's performance. Such concerns can be identified through:

- client complaints/grievances
- client satisfaction surveys
- quality Improvement activities (e.g. chart audits, site visits, Provider Evaluations)
- referral and treatment review
- credentialing and recredentialing activities
- regulatory, professional or legal entities (e.g. state licensing boards)

In an instance where there is a specific concern about a provider regarding a quality of care issue and/or a serious administrative infraction, the Provider Relations Department will contact the provider, either by telephone or in writing, to discuss the matter and request clarifying information. Many cases can be resolved at this point. Those issues requiring additional investigation and follow-up are referred to the Peer Review and Credentialing Committee (PRCC) for review. The provider is expected to participate fully in the resolution process as a condition of continued participation in the provider network.

A resolution plan is developed which can range from additional telephone remediation or a site visit to a change in the provider's network participation status, including termination. The provider is notified in writing, with an explanation of the appeals process, of any action taken regarding a change in his/her network status.

Any provider with three (3) or more Provider Evaluations within a twenty-four (24) month period will be referred to PRCC for review. In instances where a trend has been identified, the PRCC may recommend a Corrective Action Plan (CAP). The Provider Relations Department will notify the provider in writing, and request a written CAP to be submitted within forty-five (45) business days. The provider is expected to participate fully in the resolution process as a condition of continued participation in the provider network.

In all cases, Providers affected by a corrective action plan will be sent notification letters addressing:

- description of the identified deficiencies
- The rationale for the corrective action
- The name/number of the person authorized to respond to provider concerns regarding the Plan's corrective action.

Contractual Agreement

Provider's Non-Discrimination Agreement:

Provider shall provide Mental Health Services to Members in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate or discriminate against any Member as a result of his/her enrollment in a Plan or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for health services, status as a Medicare or Medicaid beneficiary, sexual orientation, or any other basis prohibited by law. Provider shall not be required to provide any type or kind of Health Service to Members that it does not customarily provide to others.

Termination of Contract:
To terminate a contract, a provider must give sixty (60) days prior written notice to the Provider Relations Department.

Please refer to your Holman Professional Counseling Centers and Holman Family Counseling contracts for termination agreements.

NOTE: Any clients who were assigned to the provider on or before the date of termination must be handled under the terms of the original agreement. When reassignment is indicated, a Holman Care Manager will review all active cases with the terminating provider and work to assure a smooth transition and continuity of care. It is expected that the resigning therapist will work in a professional manner with The Holman Group and the new provider throughout the transition period.

Critical Incident Stress Debriefing (CISD/CISM)

The CISD/CISM program is a special group counseling plan to help police officers, paramedics, emergency medical technicians, emergency service personnel, bank personnel, and others to deal with excessive distress caused by incidents which are particularly traumatic. This program provides licensed counselors who are available 24-hours a day, seven days a week to meet with employees on site or in the counselor's office to help the employees debrief and distress following a traumatic incident.

Guidelines When Conducting Onsite Services/CISM:

Should read guidelines for provider when conducting On-site services/CISM

Accepting an Onsite Assignment:

1. Verify that you have contact persons' name and phone number.
2. Verify correct address to On-site location.
3. Verify times and dates you have agreed to.
4. Check for any additional information you think you might need with the Account Executive at Holman.

Preparing for an On-Site:

Dress Code:

Business Attire required-

Men should wear a suit with matching coat and pants, appropriate shirt and tie. Women should wear matching jacket with skirt or pants and appropriate top.

Relaxed Professional-

Men should wear suite pants, with appropriate shirt and either a sweater or tie and sport coat. Women should wear dress skirt or dress pants with appropriate top or sweater.

Punctuality and Time:

A. It is very important for the intervention to start on time. You should allow enough time to get to On-Site location, park, deal with any security measures, and be able to identify your contact person upon arrival.

Critical Incident Stress Debriefing (CISD/CISM) (Continued)

B. If for any reason you expect to be late or unable to keep your schedule time, contact The Holman Group **immediately (800) 321-2843** and speak with client services or the Account Executive.

C. If you are asked to remain at an On-Site passed your schedule time please notify The Holman Group, and identify the person requesting the extended stay.

Communication:

It is important that you communicate to The Holman Group any changes in your availability or any schedule changes requested of you by the account representative as soon as possible. Call (800) 321-2843 and speak with client services or the Account Executive.

Suicide/Homicide/Detoxification Checklists

Please review the following checklists/guidelines available on our website www. Holmangroup.com:

- Detoxification Checklist
- Homicidal Intent Checklist
- Suicidal Intent Checklist
- Holman Acute Hospitalization Protocol
- Suicide/Homicide Assessment Guidelines
- Indicators of Dangerousness To Self
- Indicators of Dangerous Toward Others

Dispute Resolution Mechanism for Non-Clinical Issues

If a provider has a dispute regarding non-clinical issues (e.g. claims, contractual, credentialing, termination), s/he may submit the issue by e-mail, U.S. Postal Service, or fax to the Provider Relations Supervisor in the Provider Relations Department at 9451 Corbin Avenue, Suite 100, Northridge, CA 91324 The fax number is (818) 346-3753 or e-mail the Provider Relations Department by using the contact list through www.HolmanGroup.com. If the Provider is unable to submit a dispute in writing, the Provider Relations Supervisor may assist; call (800)321-2843.

Disputes must contain at minimum: Provider's name, provider's identification number, provider's contact information and If regarding claims or billing; a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider is disputing. If regarding other issues; a clear explanation of the issue and the provider's position on such issue. If the dispute involves a member, it must also include the name and identification number(s) of the member(s). If submitting similar multiple disputes in a bundle, the dispute must also include the following:

(i) Sort provider dispute by similar issues

(ii) Provide cover sheet for each batch

(iii) Number each cover sheet

(iv) Provide a cover letter for the entire submission describing each dispute submitted.

Disputes regarding a claim must be submitted within 365 days from action that led to dispute. The Holman Group will acknowledge receipt of the disputes within two (2) working days if it is filed electronically and within fifteen (15) working days if the dispute is paper filed. A written determination will be rendered within forty-five (45) working days of receipt of the dispute.

Glossary of Terms

Acute Care: Short-term hospitalization for detoxification and/or psychiatric stabilization when a client presents an imminent danger to self, others, or is gravely disabled.

Applied Behavioral Analysis (ABA): the design implementation and evaluation of environmental modifications to produce socially significant improvement in human behavior.

Behavioral Health Treatment: Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Care Management: Individual ongoing review of treatment. The Care Manager will work closely with the provider to assure coordination of all treatment.

Critical Incident Stress Debriefing/Critical Incident Stress Management (CISD/CISM): A special program provided for certain clients including emergency service workers and bank personnel. (For more information see CISD/CISM Section of this manual.)

Client: The insured/enrollee and/or covered dependent.

Coordination of Care: Information sharing across providers, patients, types and levels of service to ensure that a patient's needs are met and that care is efficient and of high quality.

EAP (Employee Assistance Program): A program provided directly by the employer for its employees to provide assessment, referral and short-term counseling where necessary. EAPs address problems that affect work performance such as substance abuse, family and relationship problems and crisis issues.

EAP Session: An authorized session that is used for assessment and/or short-term therapy and is generally free to the client.

Emergent: Indicating emergency care, that is, a client is provided an appointment within six hours of triage decision.

EPO (Exclusive Provider Organization): A network of providers who have contracted with a health care organization to render treatment services on a fee-for-service basis to eligible employees and their covered dependents. EPO contracted providers receive client referrals from the contracting organization.

Formal Management Referral: Recommendation by patient's employer (usually his/her manager) for assessment and treatment of client for behavioral problems that interfere with client's attendance and/or productivity at work. Employee will be asked to sign a limited release of information form during the first session to allow the Holman Account Manager to be appraised of the employee's participation in treatment.

Grievance Committee: A committee comprised of at least one member from each of

the Holman Departments. This committee meets as needed to discuss complaints filed by a client or a client representative.

Glossary of Terms (Continued)

Halfway House/Group Home: Alternative living situations which provide clients with a sober or safe environment while attending work or school. Participation in community based support groups is expected. The client may also participate in outpatient, day treatment or partial hospitalization programs

HMO (Health Maintenance Organization): A prepaid health plan purchased by an employer for its employees and their covered dependents. HMO clients are only referred to HMO contracted providers.

Holman Account: A corporation or labor union that has purchased an EAP/MAP/HMO for its employees.

Insurance Treatment Session: An authorized session that is used for ongoing treatment and is charged to insurance. Deductibles and copayments may apply.

Language Assistance Program (LAP): Enrollee/ members are able to request language assistance services upon request at no charge.

MAP (Membership Assistance Program): An EAP for labor union accounts.

Partial Hospitalization/Day Treatment: Treatment in either an acute or sub-acute setting in which the client participates in the full range of programming but does not remain overnight. Such programs are usually between six and twelve hours in length and meet several times per week.

Provider: A person licensed as a psychiatrist, psychologist, clinical social worker, marriage and family therapist, nurse, other licensed health care professional or qualified autism service provider, professional or paraprofessional with appropriate training and experience in behavioral health services, working individually or within a corporation, clinic, or group practice, who is employed or under contract with Holman to deliver behavioral health services to enrollees.

Qualified Autism Service Provider: A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, or a person licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified (1374.73(c)(3)).

Qualified Autism Service Professional: An individual who provides behavioral health treatment, is employed and supervised by a qualified autism service provider, provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider, is a behavioral service provider approved as a vendor by a

California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Program, and has training and experience in providing services for PDD/A, as specified.

Glossary of Terms (Continued)

Qualified Autism Service Paraprofessional: An unlicensed and uncertified individual who is supervised and employed by a qualified autism service provider, provides treatment and implements services pursuant to a treatment plan, meets the criteria set forth in regulations, as specified, and has adequate education, training and experience, as certified by a qualified autism service provider.

Quality Management: Program designed to assess the overall quality of service delivered to patients and client organizations. Managed by committee which meets at least quarterly.

Residential Care: Sub-acute, inpatient treatment usually based on a non-medical model.

Resourcing: Searching for treatment options, community based, for a specific need. Contact the Provider Relations Department.

Self-Help Group: Peer-based program of recovery from addictive and/or psychological behaviors often based on a twelve step model.

12-Step: Spiritual/peer based program of recovery from addictive behaviors/emotional problems (AA: Alcoholics Anonymous, NA: Narcotics Anonymous, CA: Cocaine Anonymous, ALANON for significant others of alcoholics, etc., GA: Gamblers Anonymous).

Urgent: Indicating urgent care, that is, a client is provided an appointment within 48 business hours of triage decision.

Explanation of Forms:

The following section provides an explanation for each Holman form.

- **Authorization for Release of Information Form**

  This form is found on the reverse side of the EAP/MAP and Holman's Insurance Billing forms. This form must be completed and signed by the client during his/her first session. If the client is a Formal Management Referral (see Page 18, Section titled "Formal Management Referrals"), he/she must complete and sign the bottom of the form as well.

- **Clinical Assessment Form**

  This form must be completed in full for all Holman clients. Send or fax at (818) 704-4252 the signed and dated copy to The Holman Group no later than 1 week following the first date seen. Keep the original for your records.

PLEASE NOTE: Payment will not be made for any session for which a Clinical Assessment form is not on file with The Holman Group.

- **Client Information Form**

  This form must be completed in full for all Holman clients. Send or fax at (818) 704-4252 the signed and dated copy to The Holman Group immediately following the first date seen. Keep the original for your records.

- **Coordination of Care Form**

  This form is used to coordinate care with other Health Care Practitioners. This form gives the provider consent to release confidential Information to any other provider treating the patient.

- **Request for Treatment Authorization (Renewal) Form.**

  If you feel that the client needs additional treatment session(s) beyond the initial treatment sessions authorized, you must complete this form and submit it to our Utilization Review Department for review by Care Management.

- **EAP Billing Form**

  This form is used to bill all authorized EAP/MAP sessions.

- **Language Capability Attestation (Disclosure) Form**

  This form is used for providers to report language capabilities by self or office staff.

- **Insurance Billing Form**

  This form is used to bill all sessions beyond the client's free EAP/MAP sessions. This form will come to you along with the initial "Request for Treatment Authorization" form.

- **Progress Notes Form**

  This form should contain significant data regarding progress toward stated treatment goals, significant observations about appearance and/or behaviors, documented attendance at support groups and any changes in the treatment plan. Notes must be dated and signed. A note should be made for each session. These records must be maintained in the client's file.

- **Discharge Summary Form**

  This form is used for termination of treatment. This form should be completed at the termination of treatment. If two or more months have elapsed since the client was seen for a session, the case should be considered closed unless part of an approved treatment plan. Please retain the original form in your chart and forward a copy to The Holman Group, Attention: Utilization Review Department.

- **Grievance Form**

  This form is for the client to use to file a formal grievance. This form is in your Holman HMO, EPO and PLHSO contracts. Additional forms are available by contacting our Provider Relations Department.

- **Client Contact Record form.**

  Clinical records **MUST** be maintained for seven (7) years. All laws, regulations and ethics governing confidentiality and release of information apply. Any provider who violates confidentiality laws, regulations or professional ethics will be subject to immediate contractual termination.