



# PROVIDER MANUAL



Texas Panhandle Centers  
Behavioral and Developmental Health  
Quick Reference Guide (806) 358-1681

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HIPAA	<a href="http://www.hipaadvisory.com/">www.hipaadvisory.com/</a>
Texas Administrative Code {(TAC) Click on TAC Viewer; Title 25 part 2}	<a href="http://www.sos.state.tx.us/tac/">www.sos.state.tx.us/tac/</a>
Texas Panhandle Centers ( <b>Provider Manual</b> )	<a href="http://texaspanhandlecenters.org">texaspanhandlecenters.org</a>

**Claims Submission: TPC: Accounts Payable: P.O. Box 3250: Amarillo, TX 79116**

## **IMPORTANT NOTICE**

This Provider Manual, in conjunction with the Provider Contract, outlines the procedures and guidelines that providers must follow to participate in the Texas Panhandle Centers Behavioral and Developmental Health's (Texas Panhandle Centers, or TPC) Community Behavioral Health Provider Network. Texas Panhandle Centers reserves the right to interpret any term or provision in this manual and to amend it at any time to the extent that there is an inconsistency between the manual and the provider contract. Texas Panhandle Centers reserves the right to interpret inconsistency(ies) and said interpretation shall be binding and final.

### **Introduction**

Texas Panhandle Centers has developed this Provider Manual to be better prepared to work with our external network of service providers. As a network provider you are a stakeholder with Texas Panhandle Centers and the individuals served in the successful service delivery of Behavioral Health Services to the residents of the upper 21 counties of the Texas Panhandle. We must work together in a cooperative manner to provide optimal care while being fiscally responsible.

This Provider Manual is an effort to develop the basis for a coordinated and consistent working relationship. As Texas Panhandle Centers moves into the role of payor for and manager of the delivery of services we wish to establish clear expectations and reasonable guidelines for working together.

In the age of managed care and financial constraints it is more important than ever to develop a competent and qualified provider network, credentialed to properly serve our Consumers. We view this Provider Manual as one small step in that direction.

### ***Strategic Direction Statements***

#### **Mission...**

To respond to the behavioral and developmental health needs of individuals by creating an accessible system of care that supports individual choice and results in lives of dignity and independence.

#### **Vision...**

Texas Panhandle Centers pursues its vision of "Making Lives Better" by providing quality services, informing the community about mental illness and intellectual and developmental disabilities, celebrating the accomplishments of individuals, and promoting the general well-being of area citizens.

#### **Values...**

- ***Individual Worth*** - We affirm that the individuals we serve share with us common human needs, rights, desires and strengths. We appreciate our cultural diversity and individual uniqueness and commit ourselves to support and enable each person's choices and preferences.
- ***Quality*** - We commit ourselves to the pursuit of excellence in everything we do.
- ***Integrity*** - We believe that our personal and professional integrity is the basis for public trust.

- ***Dedication*** - We take pride in our commitment to public service and to the care of the people we are privileged to serve.
- ***Innovation*** - We are committed to developing an environment which inspires and promotes innovation, fosters dynamic leadership and rewards creativity among our staff, volunteers, and the people we serve.
- ***Teamwork*** - We believe that teamwork is essential for providing comprehensive and professional services. Teamwork relates to our clients and staff, as well as collaboration with other service agencies, family members, etc.
- ***Accountability*** - We believe in being accountable to the public, our payers, and those we are responsible to serve. This accountability encompasses fiscal, contractual and system of care performance.

## **CHARACTERISTICS OF A SUCCESSFUL HEALTHCARE ORGANIZATION**

Texas Panhandle Centers recognizes the presence of powerful forces which are impacting today's healthcare and human service environment: realities that must be addressed in shaping the way we conduct business. Success, perhaps even survival, will be established by Providers demonstrating all of the following characteristics:

- An understanding that excellence in the delivery of service must consistently be provided: excellence, that is, as defined by all stakeholders - the individual served, the payor of service, as well as the provider.
- A recognition that the individual served and the payor drive the system.
- An understanding that individuals served /payors expect outcomes and value, not just good intent and hard work.
- A realization that being customer sensitive in all dimensions of organizational operations is an uncompromising necessity.
- A belief that progressive healthcare and human service organizations must focus on fostering customer empowerment and less on "controlling" persons with healthcare and other social/economic conditions.
- An unrelenting commitment to practice in concert with sound principles of business, while recognizing that adhering to an organization's mission, vision and values is likewise essential.
- A recognition that progressive organizational performance requires good information systems; that is, the capacity for all organizational stakeholders to know in a timely, unobtrusive and user-friendly manner what is and is not occurring as the result of operations.
- An organizational environment which empowers its human resources to realize the potential that exists in everyone.
- An organizational culture that fosters continuous quality improvement at all levels of the organization.

## **BUSINESS CODE OF CONDUCT SUMMARY**

Texas Panhandle Centers' Business Code of Conduct is for staff of Texas Panhandle Centers, vendors and its Provider Network and has been adopted to promote and maintain the highest standards of personal conduct and professional standards among its members. Providers must promote this code, thereby assuring public confidence in the integrity and service of Texas Panhandle Centers and the Providers within its Network.

As a member of the Texas Panhandle Centers' Provider Network, you pledge yourself, your staff and/or your organization to:

- Maintain and deliver services in an environment with the highest ethical, legal, and professional standards and personal conduct.
- Support the organizational Mission and Values.
- Improve public understanding of Community Behavioral Health services.
- Strive for personal growth in the field of Community Behavioral Health.
- Comply with all laws and regulations pertaining to Community Behavioral Health services, accounting and reporting, and third party billing.
- Maintain the confidentiality of privileged information.
- Instill in those served, and the community, a sense of confidence about the conduct and intentions of the organization.
- Maintain loyalty to the organization and pursue its objectives in ways that are consistent with the public interest.
- Refrain from using ones position to secure special privilege, gain, or benefits for self.
- Treat individuals served in a manner that preserves their dignity, respect, autonomy, self-esteem and civil rights.
- Report any suspected ethics, rights, and/or compliance issues appropriately.

IF YOU HAVE ANY QUESTIONS REGARDING THE BUSINESS CODE OF CONDUCT OR IF YOU FEEL THAT A STAFF OR CONTRACTED PROVIDER \HAS COMMITTED AN ETHICAL, RIGHTS, OR COMPLIANCE VIOLATION, PLEASE CALL THE TEXAS PANHANDLE CENTERS CORPORATE COMPLIANCE OFFICER VIA ONE OF THE FOLLOWING METHODS:

PHONE: (806) 351-3284

FAX: 806-351-3327

EMAIL: [donald.newsome@txpan.org](mailto:donald.newsome@txpan.org)

US MAIL: P.O. Box 3250, Amarillo, Texas 79116

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## INTRODUCTION

The Provider Manual has been developed to provide a general introduction to Texas Panhandle Centers' Community Behavioral Health system and to provide specific information regarding access to care and care management of available Behavioral health services.

As a Provider for Texas Panhandle Centers, you join a team of professionals dedicated to the management and delivery of medically necessary services. Our mutual goal is to ensure that Consumers have timely access to the most clinically appropriate and least restrictive care possible in the most caring, sensitive and confidential manner possible.

After reviewing the Handbook, please call Contracts Management (806) 351-3206 if you have any additional questions or informational needs.

### **I. Network Participation**

Texas Panhandle Centers is the Texas Health and Human Services Commission's (HHSC) designated Behavioral health local authority established to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of community based Behavioral health services for the residents of upper 21 counties of the Texas panhandle. The HHSC Performance Contract requires Texas Panhandle Centers to develop a network of Providers to ensure choice, when appropriate, for individuals receiving services and also requires a spectrum of behavioral health services under Texas Resilience and Recovery. Texas Panhandle Centers contracts with licensed psychiatrists, psychologists, advanced practice registered nurses, registered nurses, social workers, qualified behavioral health professionals and other specialty clinicians. Our goal is to create a collaborative relationship with the behavioral health care professional community. Texas Panhandle Centers believes that the key to quality care and satisfaction is a very informed, high-quality network. To accomplish this, we credential clinicians who are independently licensed and well trained in their particular area of expertise.

#### **1. Credentialing/re-credentialing of individual behavioral health care professionals**

A Provider must be credentialed before joining the network. Thereafter, health care professionals are credentialed every two to three years. Our credentialing program is a systematic process of assessing, reassessing and validating the qualifications and practice history of a health care professional against defined participation criteria.

The minimum criteria to become a credentialed provider are as follows:

1. Graduation from an accredited professional school applicable to the applicant's degree, discipline and licensure.
2. For physicians: completion of residency training in psychiatry and board certification.
3. For providers of peer support service: high school diploma or GED, at least one cumulative year of receiving mental health services for a disorder that is treated in the target population for Texas, and is able to be certified as a peer support specialist within one year from contract start.
4. Malpractice insurance in amounts specified in the Network Agreement.

5. Submission of an application containing all applicable attestations, necessary documentation and signatures.
6. Current unrestricted license.
7. Absence of current debarment or suspension from state or federal programs.

## **2. Site visits and monitoring**

Site visits may be required for monitoring purposes for certain projects (ex: Section 1115 (a) Medicaid Waiver projects). Site visits may also be required for those Providers for whom we receive complaints. Results will be shared with the Provider, along with any applicable requests for corrective action plans. Licensing boards shall be monitored monthly, complaints and adverse incidents will be continually monitored to track and trend the events and to determine if further investigation is needed. When action needs to be taken, the Planning and Network Advisory Committee (PNAC) will make any determination of changes in network participation status. At the time of re-credentialing, any complaints and quality-of-care concerns will be forwarded to the PNAC for consideration.

## **3. Notification of status changes**

Providers are required to notify Texas Panhandle Centers in writing within 14 days of any changes related to the following circumstances:

- Change in professional liability insurance.
- Change of practice location, billing location, telephone number or fax number.
- Status change of professional licensure, such as suspension, restriction, revocation, probation, termination, reprimand, inactive status or any other adverse situation.
- Change in tax ID number used for claims filing.
- Malpractice event.

Correspondence regarding changes may be faxed to: 806-351-3344

## **II. Provider Choice**

1. Texas Panhandle Centers, as the local Behavioral health Authority strives to provide our consumers choice in quality mental health services. Where applicable, consumers will have the choice of 2 or more providers to select from as a service provider.
  - a. At the time of intake, the Consumer shall be assessed and offered a list of Providers for his/her Provider of choice. A Consumer has 2 business days to make the selection and may contact potential providers with questions prior to selecting.
  - b. Follow-up appointment will be made with TPC staff
    - a. Texas Panhandle Centers and Provider process and responsibilities shall be explained to Consumer
    - b. MD appointment is made with “chosen” Provider
  - c. Case Manager shall meet with the consumer as needed per the LOC or as clinically indicated:
    - a. Assessment completion



- b. Consumer given the choice to switch to another Provider in the Network if desired. Provider choice is offered at each assessment
- c. Documentation for requests for overrides/exceptions and and-on services must include documentation of medical necessity and is documented in the comments section of the Uniform Assessment by the case manager when entering the assessment into designated data/reporting system.
- d. Texas Panhandle Centers shall authorize the level of care:
  - a. Approves/denies requests for adjuncted services in the comments section of the authorization portion of the Uniform Assessment.
  - b. The authorization is entered per HHSC UM Guidelines
- e. The Provider will be given a copy of the authorized uniform assessment including the signature on statement of medical necessity of services.
- f. The treatment plan is developed by the Provider per HHSC UM Guidelines including approved adjuncted services if applicable.

Questions regarding authorized services shall be directed to the Provider's designated Texas Panhandle Centers Case Manager or to Network Development Services.

- 2. Contracts Management may be contacted at: Phone: (806) 351-3206 and Fax (806) 351-3346.

Contracts Management Representatives and Texas Panhandle Centers Intake Staff are available Monday through Friday from 8:00 a.m. until 5:00 p.m. (CST) and are responsible for:

- Screening for Intake assignment
- Follow up services, education, and prevention
- Pre-certification for all applicable services
- Authorization and Reauthorization of all covered services
- Concurrent utilization management
- Verification of covered person's eligibility
- Verification of covered person's authorization status
- Provider applications
- Network monitoring/management
- Provider relations/education
- Consultation with Providers
- Claims inquiries
- Written inquiries
- Benefit explanations
- Contractual negotiation
- Coordination with other providers,
- Coordination of appeals; and,
- Exception authorizations for non-network providers.

### **III. Texas Resilience and Recovery**

“Hope, Resilience, and Recovery for Everyone” is the vision statement of the Mental Health and Substance Abuse Division (MHSA) of the Department of State Health Services (HHSC). This vision is aligned with the national movement to incorporate resilience and recovery oriented services, supports, practices, and beliefs into publicly funded mental health service delivery systems. In September 2012, to further reflect a commitment to these principles, the name of Texas’ mental health system was changed from Resiliency and Disease Management (RDM) to “Texas Resilience and Recovery” (TRR). MHSA acknowledges that children and youth affected by mental illness and severe emotional disturbance (SED) are on a continuum of mental health and have natural supports and strengths which should be built upon to foster resilience and recovery. Through the promotion of mental health, early intervention, and the provision of quality mental health services, providers have the opportunity to support children and youth to achieve not only mental health but also their individual potential.

In 2010 MHSA began its review of the RDM service delivery system, implemented in 2004. This review included feedback/input from frontline staff/providers and a review of research on best practices in serving children and youth with mental health needs. In response to this review, the Children’s Mental Health (CMH) System has been re-designed. Resilience and recovery are fundamental principles of the CMH system and have been incorporated throughout the new design and considered in the selection of available services.

The modern framework of the new system design utilizes an intensity-based approach to service delivery. Within this model, the intensity of services responds to where the child/youth is on the continuum of mental health. Levels of Care (LOCs) have been designed to make services available that correspond to the intensity and complexity of the child/youth’s identified needs. An expanded array of evidence based and promising practices (EBPs) can be individualized to meet these needs and build upon the unique strengths of each child or youth. Through the use of EBPs, the services and supports provided within the CMH system will result in measurable outcomes and ultimately the resilience, recovery, and achievement of mental health of children/youth.

The Substance Abuse and Mental Health Services Administration (SAMSHA) defines Recovery in the following way: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*

While the concept of recovery is often applied primarily to adults, the term is being used more and more in child-serving systems with the understanding that recovery supports extend to caregivers as well as the child/youth.

Historically, CMH service delivery systems have focused on building resiliency in children and youth. SAMSHA defines Resilience in the following way: *The ability to adapt well over time to life-changing situations and stressful conditions.*

In other words, resilience is the ability of a child/youth to achieve positive developmental outcomes in spite of personal and environmental risk factors. Resilience-based systems seek to

reduce risk factors and increase protective factors at the individual, family, and environmental levels.

In addition to resilience and recovery, the design of the intensity model of service delivery was heavily influenced by Systems of Care values and principles. Broadly speaking, the system of care approach involves collaboration across child-serving agencies, families, and youth in order to improve access to community-based services and supports for children/youth with SED and their families. Additionally, this approach places emphasis on the use of evidence-based practices to help children/youth and families function better at home in school, in the community, and throughout life. The goal of the new Texas CMH system is to incorporate systems of care principles to build meaningful partnerships with families, children, and youth. It is through these partnerships that resilience is fostered and recovery is supported.

It is important that clinicians and providers understand the principles and values that provide the foundation for the new system. In order for individuals receiving services to experience and benefit from these principles being put into practice; these values should be reflected in the services, supports, practices, and beliefs of service providers and be evident in the interactions with the children/youth and caregivers that touch the system. The specific values that serve as the foundation of the new service delivery system include the following:

- **Child Centered, Family Focused:** Child/youth centered means that children and youth should be engaged as equal partners in care and should have their voices heard throughout their involvement in the CMH system. Family focused means that caregivers also have a primary decision-making role in the care of their children/youth. Remaining child centered and family focused by involving caregivers and children/youth helps ensure sensitivity to cultural, service, and support needs.
- **Engagement:** Engaging caregivers and youth in the planning and provision of services is one of the most important aspects of care. Engagement emphasizes a respect for child/youth's and caregiver's capabilities and their role(s) as part of the solution to the identified problems.
- **Evidence-Based Practices:** Evidence-Based Practices (EBPs) are programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence, and the values of the individuals receiving the services. EBPs must be appropriate to the target population(s) and service settings in order to achieve the desired outcomes.
- **Fidelity:** Fidelity is the act of implementing an EBP in a manner that is consistent with the treatment model. Fidelity to evidence-based practices will result in the outcomes intended by the intervention.
- The Guidelines outlined in this manual provide a more detailed description of the changes to the system and how these changes will be implemented locally. However, the changes to the CMH system can be broadly summarized as the following:
- *New Assessment Instrument:* Two versions of the Child and Adolescent Needs and Strengths (CANS) assessment will be used to assess the 3-5 and 6-17 year-old populations, respectively;
- *New Levels of Care:* The new service delivery design is based on an intensity model of service delivery where the service array expands based on the child/youth's needs, strengths, and the complexity of need(s);

- *New Interventions:* New evidence-based practices were selected to better equip clinicians in meeting the needs of children, youth, and families receiving services in the CMH system.

It is the hope of TPC that the care provided fosters resilience, hope, and recovery in all those participating in care; and that each individual can develop a healthy sense of identity and well-being, and can succeed in school, the family, and in the community. Towards that aim; the dedication and efforts of providers, clinicians, and all staff within the children’s mental health system are appreciated as invaluable assets.

## 1. Key Components

Because TRR represents a major transformation of the Mental Health system, almost all aspects of the system have been changed to support the goals of TRR.

- Levels of Care: Service packages for both children and adults were developed to ensure the provision of evidence-based services to those individuals who would most benefit from those services. The Levels of Care are described in the Clinical Guidelines. The Clinical Guidelines identify the services available and the intensity of service provision for each package, as well as guide decisions on eligibility and appropriate discharge from a service package. To view the TRR Clinical Guidelines in entirety go to: <http://www.dshs.state.tx.us/mhsa/trr/documents/>
- Utilization Management (UM). Utilization management processes are an important component of TRR, allowing Local Mental Health Authorities (LMHAs) to manage limited resources and ensure reasonable access to effective services.
- Contracts with the LMHAs. Performance contracts between DSHS and the LMHAs include important general provisions denoting the terms of the contract. Attachments to the contracts stipulate the services targets, performance measures, outcomes, and remedies, sanctions, and penalties that may result from failing to fulfill contract expectations.
- Quality Management. One aspect of quality management activities created to support TRR is the development of a fidelity assessment process. This includes a Fidelity Toolkit and processes for assessing fidelity at the provider, authority, and state levels.
- Data Management. Numerous changes were made to provide data support for the TRR initiative, including the enhancement of the Consumer Analysis Data Warehouse, which allows for extensive monitoring of data for decision-making. Analysis of cost information is provided through the Cost Accounting Methodology (CAM).
- For more information, see the TRR Program Manual (PDF, 659 KB) at [http://www.dshs.state.tx.us/mhprograms/TRR/documents/TRR\\_Program\\_Manual.pdf](http://www.dshs.state.tx.us/mhprograms/TRR/documents/TRR_Program_Manual.pdf)

2. **Admission** For each level of care, whether for a child or an adult, there are criteria for admission and discharge that differ from the criteria of any other level of care. These criteria are designed to meet the particular needs of the individual depending on the diagnoses, symptoms, and level of functioning.

3. **Discharge** Although the criteria for discharge vary for each level of care, the criteria can typically be narrowed down to: achieving maximum benefit and individual choice. In some situations, the individual may reach a point at which he/she has attained the maximum

benefit from services. In other cases, the individual, or the individual's parent(s) if the individual is a minor, may choose to withdraw from services.

4. **Stepping Down** As the individual begins to recover, it may be possible for the person to be "stepped-down" to a lower LOC, if his/her ANSA/CANS scores show significant improvement.

5. **Successful Treatment.** As previously noted, the purpose of the levels of care is to promote resiliency and recovery in adults and children. When it is agreed upon by clinicians, family members, and the individual that there is a remission of the major symptoms and improved functioning, it may be appropriate to prepare the individual to transition out of treatment.

Also, if the individual is able to obtain appropriate medications and services through means other than the public mental health system, it may be a good indication that the individual is ready to transition to natural support networks or other available community supports or service providers.

6. **Refusal.** An individual's refusal of services and other forms of resistance to treatment are issues that need to be addressed from a clinical perspective. Failure to address such resistance can result in the individual's deterioration and hospitalization. Thus, it is inappropriate to terminate services or refer an individual out to other providers simply because the individual exhibits resistance to treatment. Providers are expected to exert reasonable and documented efforts toward engaging the individual in clinically appropriate services prior to transitioning the individual to a less appropriate level of care, referral, or discharge from services.

7. **Engaging Individuals.** There are numerous techniques that can be used to engage an individual in services that are clinically appropriate to his/her needs. Examples include:

- a. Basic rapport building – smiles, eye contact, body language, willingness to slow down and listen, respect for the individual, etc.
- b. Staff attitude – confidence in the individual's ability to recover, confidence in their ability and their co-workers' ability to assist the individual in obtaining recovery, belief that what they are doing with the individual has value, etc.
- c. Staff availability – making the provider's interest in and concern for the individual known through repeated contact via home visits, phone calls, and letters. Home visits convey more interest and concern than phone calls. Phone calls convey more interest and concern than letters. More frequent contact conveys more interest and concern than less frequent contact.
- d. Willingness to accommodate the individual – altering clinic hours to accommodate work and school hours, allowing the individual to prioritize his/her

treatment needs, using the individual's own language when identifying treatment goals, etc.

- e. Educating the individual – providing explanations for why the clinically appropriate service package will be more effective, and for why recovery does not happen in a vacuum, and explanations of terms like “Evidence-Based Practices,” etc.
- f. Motivational Interviewing – as a tool for all staff to use starting at intake and throughout the course of service provision. (Numerous resources are available on the Web – key words “Motivational Interviewing” and “William R. Miller.”)
- g. Ensuring that every staff member who interacts with the individual knows his/her role in the engagement process - engagement begins with the very first contact, even if it is just a call to the main switchboard. Regardless of which techniques the provider chooses to employ, those techniques need to be applied consistently from the very beginning. Employing engagement techniques only upon the individual's resistance to treatment is significantly less effective than incorporating engagement techniques as standard practice from the beginning and encouraging the individual to engage in other services when he/she is ready to do so.
- h. Provide services that the individual is willing to accept - an individual may refuse one or more services within a service package and be eligible to receive other services within that service package.

However, if the provider has aggressively addressed treatment resistance and the individual continues to refuse the services within the authorized LOC, then the provider should explore classifying the individual to a lower level service package (if applicable) based on individual preference.

If the individual continues to refuse all services within an authorized service package, then the physician, in collaboration with the treatment team, should weigh the clinical risks and benefits to the individual of referring the individual to another provider. If the physician and treatment team, based on clinical analysis, determine that the individual would benefit from such a referral, then the referral should be made.

In these instances, the provider needs to carefully document how treatment resistance was addressed, the objective evidence of the individual's repeated refusals, and the clinical rationale for referring the individual to another provider. The LMHA needs to assure continuity of services for the individual by ensuring that another provider has accepted the individual for service prior to discontinuing services.

An individual's refusal of one or more services within a package (i.e., partial refusal) should never result in a denial of other services. The proper approach should be to

educate the individual or LAR/parent about the benefits of participating in all services within the package versus some of the benefits.

**8. Requirements for All Services.** The following are required for all services, both Medicaid and General Revenue.

- a. Medical Necessity. The determination of medical necessity must be completed by an LPHA (see glossary for more information) and must be properly documented. A service is medically necessary if it is:
  - reasonable and necessary for the diagnosis or treatment of a mental health disorder or a mental health and substance use disorder in order to improve or maintain an individual’s level of functioning;
  - in accordance with professionally recognized guidelines and standards of clinical practice in behavioral health care;
  - provided in the most appropriate and least restrictive setting in which the service can safely be delivered;
  - provided at a level that is safe and appropriate for the individual’s needs and facilitates the individual’s recovery; and
  - could not be omitted without adversely affecting the individual’s mental or physical health or the quality of care rendered.
- b. All core services must be provided for each LOC as indicated in the UM Guidelines unless there is clinical documentation indicating the reason for not providing a core service.

#### **IV. 1115 Transformation Waiver**

##### **1. Background.**

In December 2011, the Centers for Medicare and Medicaid Services (CMS) approved the Texas Health and Human Services (HHSC) Healthcare Transformation and Quality Improvement Program 1115 demonstration waiver. This waiver aims to transform the health care delivery system for low income Texans and includes an increased focus on access to quality behavioral health services as a recognized means to improve both individual and system level outcomes.

As required by provisions of the 1115 Transformation Waiver, Regional Health Partnerships have been established throughout the state and designated anchors for each region are serving as the coordinating point for development and submission of regional health plans that reflect local solutions designed to reduce costs and improve outcomes.

The regional plan serves as the vehicle for receiving new federal funding as incentive payments for Delivery System Reform Incentive Payment (DSRIP) projects.

## **2. The Role of Community Centers.**

**IGT Entity-** Like public hospitals and other governmental entities, Centers have the ability to transfer locally managed state and local dollars to draw down federal funding for DSRIP projects. This process is called an Intergovernmental Transfer, or IGT.

**Performing Provider-** As a public Medicaid provider, Centers receive direct payment from HHSC when DSRIP outcomes are achieved.

**Regional Health Plan Partner-** As an IGT Entity and Performing Provider, Centers are involved in the RHP process. Centers have contributed to the assessment of community need and worked collaboratively with local partners, including consumers, advocates and private providers, to plan and implement innovative and effective solutions for addressing behavioral health care needs in the region.

## **3. 1115 Waiver Extension.**

In December 2017, HHSC received approval from the Centers for Medicare and Medicaid Services (CMS) for an extension of the 1115(a) demonstration (1115 Medicaid Waiver) which will be effective through September 30, 2022. The new Program Funding and Mechanics Protocol and Measure Bundle Protocol are approved. These documents which cover requirements for participation in the Delivery System Reform Incentive Payment (DSRIP) for Demonstration Years (DY) 7-8, can be accessed at <https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-renewal>. As a Performing Provider within DSRIP, Texas Panhandle Centers has selected national health outcome measures and standardized tools that help quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care. The intent is to incentivize delivery system reform with the ultimate goal being tangible improvements in the healthcare delivery system including better health outcomes and lower costs associated with healthcare. The 1115 Waiver has evolved from a projects-driven demonstration to a focus upon provider-level outcomes.

## **V. Referrals for Internal and External Providers**

Texas Panhandle Centers, as the local mental health Authority, strives to provide our consumers choice in quality mental health services. Where applicable, consumers will have the choice of 2 or more providers to select from as a service provider. Consumers will only be auto-assigned by Texas Panhandle Centers to a Provider if the consumer does not select a Provider within 2 business days of receiving the list of available Providers.



1. After the Consumer's initial choice of Provider and subsequent referral to that chosen Provider during intake (see II.1), there are several other situations wherein a consumer may seek to be referred to a different provider. The Case Manager shall supply a Provider listing to consumers giving the option of changing or choosing a different Provider:
  - a. upon request,
  - b. at each mental health assessment, and
  - c. Each treatment plan update.
2. If the Consumer opts to stay with current provider, there are no referrals made.
3. If the Consumer opts to change Providers, the Case Manager will complete all the necessary documentation to transition the individual to the new provider and send any necessary referral documentation to said Provider as well as schedule the first appointment with the new Provider.
4. Texas Panhandle Centers shall authorize the level of care:
  - a. Approves/denies requests for adjuncted services in the comments section of the authorization portion of the Uniform Assessment.
  - b. The authorization is entered per HHSC UM Guidelines
5. The new Provider will be given a copy of the authorized uniform assessment including the signature on statement of medical necessity of services.
6. The treatment plan is developed by the new Provider per HHSC UM Guidelines including approved adjuncted services if applicable.

Questions regarding authorized services shall be directed to the Provider's designated Texas Panhandle Centers Case Manager or to Network Development Services.

## **VI. Authorization/Re-Authorization Standards**

This details regarding the description of the service, expected outcomes, admission criteria, continued stay criteria, exclusionary criteria, discharge criteria, and treatment activities can be found in the TRR Clinical Guidelines located at:

[http://www.dshs.state.tx.us/mhprograms/TRR/documents/Adult\\_UM\\_Guidelines\\_Revise\\_d20080527.pdf](http://www.dshs.state.tx.us/mhprograms/TRR/documents/Adult_UM_Guidelines_Revise_d20080527.pdf)

All Authorizations and Re-Authorizations will be issued by Texas Panhandle Centers staff within the service limits of these standards. These standards will be reviewed and modified by Texas Panhandle Centers UM staff from time to time.

The reauthorization process

1. The provider must be proactive in the reauthorizations process. Re-authorizations must be requested within two (2) sessions or two (2) weeks, whichever comes first, of the expiration of the current authorization.

2. The provider clinician submits documentation requesting re-authorization and demonstrating continued need for services. This may be in the form of a quarterly report, monthly report, or similar format.
3. Within 72 hours of submission to Texas Panhandle, TPC will either approve and authorize services to the provider or disapprove services based on provider input.
4. Within 72 hours of submission of recommendations to Texas Panhandle Centers, TPC will authorize services to the provider or disapprove services based on the provider recommendation.
5. Services are not approved if medical necessity is not established or if services are not deemed therapeutically appropriate.

If services are not medically necessary, the provider will, within 72 hours send a letter to the customer explaining the decision, outlining the appeal process and reminding them of the 24 hour emergency number.

If services are not therapeutically appropriate, the Provider will, within 72 hours send a letter to the customer explaining the decision. This letter will outline the appeal process and remind the customer of the 24-hour emergency number.

## **VII. Utilization Management Procedures**

Utilization management reviews are conducted for all levels of care with all Network Providers. The goal is to formally review the Customer's clinical record to ensure quality behavioral health services are being provided at the most appropriate level of care, in the most clinically appropriate setting, in the least restrictive environment, by the most appropriate provider in the most cost effective manner possible.

An authorization decision (authorization or denial of authorization) will occur:

1. With the initial request for care from the Case Manager or intake worker;
2. When further care is requested based upon a review of medical necessity therapeutic appropriateness and the Treatment Plan Update;
3. Significant change in Diagnosis or Level of Functioning;
4. Upon review of an emergency admission to an acute care facility; or
5. Before admission to Detox/Rehab/Crisis Stabilization facility/partial hospital program or intensive outpatient program.

## **VIII. Complaints and Grievances**

It is the policy of Texas Panhandle Centers that all individuals have the right to a fair and efficient process for resolving disagreements regarding their services and supports managed or delivered by TPC or their provider network.

Individuals shall not be denied services and supports for arbitrary or capricious reasons, but do need to meet the definitions and criteria of medical and clinical necessity as well as priority population.

All individuals are to be informed of the complaint/grievance process orally and in writing at the time of initial service and the subsequent avenues available if they are not satisfied with decisions regarding services and supports received.

**1. Complaints from Individuals**

- a. Provider must inform Individuals that they may file a complaint with Texas Panhandle Centers specific to services delivered regarding the Provider by contacting his or her designated TPC Case Manager.
- b. Individuals may also call Texas Panhandle Centers' Rights Protection Officer with suspicions of rights violations, abuse, neglect or exploitation at (806) 351-3400.
- c. Individuals may also call the Department of Family and Protective Services Hotline at [800-647-7418](tel:800-647-7418) to report allegations of abuse and neglect.

- 2. Complaints from Provider.** Texas Panhandle Centers desires a successful partnership with Providers to best serve Individuals in need of services. To this end, Texas Panhandle Centers encourages Providers to call with concerns, problems and complaints regarding the TPC's operations and interactions with Providers. Complaints should be directed to the Director of Contract Services at (806) 351-3206. Every effort will be made to address the issues involved.

**3. Filing an Appeal of Non-Authorization of Services**

In the event that the Consumers specific service(s) is not authorized by Texas Panhandle Centers, you will receive telephone and written notification. The written notice will provide a detailed explanation of the medical necessity criteria utilized to make the determination of non-authorization. The notification will include the reason for the non-certification and a mechanism for the Provider to appeal.

The appeal may be initiated by phone but the follow up must be in writing and must be received within 30 days from the date of the original determination. There are no specific documents required to initiate an appeal; however, the Consumer may be requested to complete a release of information form if medical records are needed.

Upon return of this form, the Utilization Management Department will request the medical records from the appropriate provider(s). Upon receipt of an appeal, the Utilization Management Department personnel will obtain all information necessary for the appeal and record the process.

The information will then be forwarded to a “reviewer” of the same or similar specialty as the Provider of service. The review will be conducted by an individual who has not previously reviewed the case.

**4. Care not deemed medically necessary.**

Current Access and Authorization regulations do not allow for Consumers referred by Texas Panhandle Centers to be held responsible or billed for any denied services until the day following receipt of this notice. Therefore, the Consumer cannot be held responsible for payment of any denied services until the day following the date on which the Consumer signs a statement from the Provider (facility) outlining the specific non-covered services.

If the consumer does not agree with the stated reason(s) for the non-authorization of services determination, you have the right to appeal this decision based on the aforementioned Appeal and Grievance procedures.

**IX. Collection Of Co-Payments/Deductibles**

A Provider may only collect applicable deductibles, co-insurance and/or co-payments from the Individuals at the time of service. Providers shall use the Ability to Pay guidelines as outlined in the Texas Administrative Code Chapter 412 Subchapter C. (NOTE: Additional payments or co-payments of any kind are not allowed for Medicaid only covered Customers). Texas Panhandle Centers will reimburse the Provider the balance up to the fee schedule maximum or negotiated per diem upon receipt of a claim form and compliance with TPC policies and procedures. Coordination of benefits, co-payments, and deductibles vary by contract. A Provider will give the Customer a published fee schedule at the first session. When a Provider expects a Customer to pay for missed appointments, the Provider is expected to charge an amount congruent with the Provider’s contracted fee schedule.

**X. Quality Improvement**

The Quality Improvement (QI) program monitors and systematically evaluates the case management process as well as the care delivered by Providers. The approach is clinically directed as it focuses on the appropriateness and quality of care.

The goal is to ensure that cost-effective quality care is provided to all those accessing services. The Quality Improvement program coordinates the review and evaluation of all aspects in delivering of care, Components include:

- Problem-focused studies
- Continuous monitoring of key indicators
- Medical records review
- Assessment of access and availability
- Customer satisfaction surveys

- Provider satisfaction surveys
- Accreditation Reviews

QI assessment and summary reports are made to the Corporate Compliance Committee, senior management, and Providers (when appropriate) in order to identify problems, develop resolutions, and provide adequate follow-up.

Providers are required to support Texas Panhandle Centers' Quality Improvement/Management Program, be familiar with the guidelines and standards, and apply them in clinical work. Specifically, Providers are expected to demonstrate:

- Adherence to all Texas Panhandle Centers' policies and procedures, including those outlined in this manual.
- Communication with the consumer's primary care physician or specialists as warranted (after obtaining a signed release).
- Adherence to treatment record standards.
- Timely response to inquiries by Texas Panhandle Centers staff.
- Cooperation with Texas Panhandle Centers complaint process.
- Adherence to continuity-of-care and transition-of-care standards when the consumer's benefits are exhausted or if Provider leaves the network.
- Cooperation with on-site audits or requests for treatment records.
- Timely return of completed annual provider satisfaction surveys when requested.
- Participation in treatment plan reviews or sending in necessary requests for treatment in a timely fashion.
- Submission of claims with all requested information completed.
- Adherence to consumer safety principles.
- Compliance with state and federal laws, including confidentiality standards.

## **XI. Stakeholder Review**

Data is to be collected and published for the stakeholders. Due to the public nature of our business, Data is available to others under the Freedom of Information Act. Data is collected on agreed upon performance indicators. Some potential indicators may include, Customer Satisfaction, Utilization, and Coordination Performance Outcomes. Data is to be examined at face value. Provider profiles will be considered as part of the contract selection for Network Provider Panel. The underlying goals of stakeholder reviews are to increase competition among stakeholders, enhance overall provider performance, and resolve provider issues.

## **XII. Provider Reviews**

Provider reviews are used to compare results across a peer group or to set a standard or expectation. It can be used as part of the selection and retention guidelines of provider network. Reviews are used in decisions about referrals and as an indicator for intensity of

utilization or quality review. Data will be used as a consideration in rate negotiation and as a tool to focus quality improvement efforts and related training/development.

Some of the Profile Elements may include:

Cost of care

- per case
- Per admission

Care Access Elements

- Timeliness
- Hours of availability
- Related communication/notifications

Denials

- Types of denials
- Denial disposition

Customer diagnosis and acuity

- Severity of illness indicators
- Demonstrated competencies for authorization of care

Customer satisfaction elements

- Complaints
- Survey ratings

Documentation quality control elements

- Timeliness of required components
- Required data elements
- Clinical pertinence of content

Other quality elements

- Performance on key quality indicators
- Compliance to Standards of Care
- Outcome performance measurements

Volume of activity

Source and disposition of referrals and discharges

Utilization management interface

- Adherence to policies and procedures
- Complaints

Billing practices

- Timeliness/frequency
- Accuracy
- Completeness

### **XIII. Statement Of Confidentiality**

It is the expectation of Texas Panhandle Centers that Providers within the Network comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy Rule (45 CFR Parts 160 and 164). Texas Panhandle Centers is committed to keeping all personal health information; documents disclosures and data confidential. Access to any Consumer records will be exclusively limited to TPC staff and those who are under contract to perform appeal and/or reviews.

Texas Panhandle Centers is committed to keeping all Provider information, documents disclosures, and data confidential. Due to the public nature of our business, data collected and published for the stakeholders' meetings is available to others under the Freedom of Information Act. This information will be presented in summary form only with no identification of individual customers.

### **XIV. Network Monitoring**

Texas Panhandle Centers' Network Development staff is responsible for routine monitoring to ensure the Provider complies with the terms of this Provider Manual and the Network Agreement and to ensure that outcomes are appropriately managed. Upon no less than ten (10) days prior written notice by Texas Panhandle Centers, Provider shall participate in an audit which may include on-site inspection of current records conducted to verify that Provider is complying with TPC standards. Provider shall furnish such current administrative policies and procedures, data and/or documentation as the auditing entity may reasonably request. In the event deficits are found, Texas Panhandle Centers reserves the right to re-audit Provider's site to ensure remedial efforts for improvement have been implemented. Following on-site audits, TPC will deliver to the provider a list of comments with regard to the manner in which services are being provided. Failure to provide a plan of improvement, and correction (or justification for lack of action) within a reasonable time as specified by the Texas Panhandle Centers may result in sanctions.

Network Development Services is responsible for monitoring other aspects of the Provider Network. This includes, but is not limited to, Provider changes and updates, re-credentialing, staff competencies (documentation of training as well as the determination of current competencies), environment of care, consumer rights, geographic and specialty access, and Provider relations activities. Network Development Services is responsible for monitoring the providers' compliance to care standards and outcome performance measurements.

To keep Provider Network files current, the Provider is responsible to provide re-credentialing and competency, accreditation, licensing, liability insurance, inspection

reports, and plan of correction information within the defined timelines. When Texas Panhandle Centers receives the new information, they will update the data system and add the documentation to the Provider's file. Failure to submit current copies of expired items may result in termination of payments until the current Credentialing documentation is received.

Providers can help keep files current by notifying Network Development of new practice affiliations, changes in address or licensure, and facility or program involvement. Information can be submitted by faxing or by writing.

Out-of-Network providers are required to meet with the above standards if payment for services to be authorized.

## **XV. Sanctions, Appeals and Contract Termination**

1. Texas Panhandle Centers shall take punitive recourse for actions that pose a hazard to Individuals or potentially violate Services guidelines.
2. **Penalties/Sanctions.** The failure of the Provider to perform any responsibility set forth in this manual, the signed Provider Agreement, its exhibits or attachments, or any law, regulation, rule or requirement incorporated by reference may result in any one or more of the following to be imposed or taken by the Texas Panhandle Centers, subject to notice as provided herein:
  - a. Submission of a Plan of Correction to Texas Panhandle Centers;
  - b. Return Funds to Texas Panhandle Centers
    - i. For serving unauthorized persons with funds subject to the Provider Agreement and
    - ii. For using funds for unauthorized purposes
  - c. Withholding by Texas Panhandle Centers, in whole or in part, any payments due and owing to the Provider until the Provider has cured the breach to the satisfaction of TPC;
  - d. Legal action to protect or remove Individuals when the life, health, welfare, or safety of one or more Individuals is endangered, or could be endangered or if the Texas Panhandle Centers has a reasonable belief that the Provider has engaged in the misuse of state or federal funds, fraud, or illegal acts;
  - e. If Texas Panhandle Centers is able to demonstrate a direct link between a sanction or penalty imposed upon TPC by any State Agency due to Provider's performance, Provider will refund/reimburse/remit to TPC those portions of the sanction/penalty assessed to Texas Panhandle Centers. Examples of such instances would be documentation chart audits, CARE accuracy, failure to report accurate and timely information/data, and etc.



- f. Suspension or withholding of new referrals until performance deficiency or breach is cured to the satisfaction of Texas Panhandle Centers; and/or
  - g. Termination of Provider Agreement.
3. **Imposition of Penalties.** The Texas Panhandle Centers' Contracts' Manager or his/her designee shall commence the imposition of penalties as set out in this section when the Contracts' Manager is of the opinion a failure to perform by the Provider has occurred. This procedure shall utilize the following steps:
- a. Prior to imposing any penalty, Texas Panhandle Centers Contracts Manager shall send the Provider a Proposal of Penalties by certified mail stating any alleged breach(es) and the applicable penalty;
  - b. The Provider shall file any response with Texas Panhandle Centers' Director of Contracts within ten (10) business days from the date the notice is received;
  - c. The Director of Contracts shall review the response, and if the Director concludes that a breach has occurred, shall send out a "Notice of Penalties" by certified mail fifteen (15) days from the date of receipt of the Provider's Response;
  - d. The "Notice of Penalties" shall be sent to the Provider, the Texas Panhandle Centers' Executive Director, and the TPC's Chief Financial Officer. If a Notice of Appeal is not filed by the Provider within fifteen (15) days from the date of the "Notice of Penalties", the appropriate action will be imposed by the Texas Panhandle Centers' Director of Contracts
4. **Appeals.** Any Provider receiving a "Notice of Penalties" may appeal the imposition by filing a "Notice of Appeal" with the Texas Panhandle Centers' Executive Director within fifteen (15) days of the date of receipt of the "Notice of Penalties". The procedure should be as follows:
- a. Texas Panhandle Centers' Executive Director will select three (3) persons to form a resolution panel to hear the appeal within the time period specified. At least one member of the panel must be an employee of another Provider;
  - b. The panel shall hold a conference within the time period specified by the Texas Panhandle Centers' Executive Director. Based upon information presented by the Provider and TPC, the panel shall make recommendations concerning the resolution of the alleged breach(es). Texas Panhandle Centers' Executive Director serves as final authority in the resolution process and may accept or reject all or part of the panel's recommendations. Provider shall be notified of the Texas Panhandle Centers' Executive Director's final determination in writing; and

- c. The appeal of any penalty shall stay in the imposition of such action. If the penalty is affirmed, the Provider shall remit any monetary amounts assessed in the affirmed action to the Texas Panhandle Centers' Chief Financial Officer. TPC may seek recovery of the amount in any court of competent jurisdiction.
  - d. Appeals will be subsequently reviewed by the Planning and Network Advisory Committee (PNAC) for Administrative consistency and recommendations. The PNAC's recommendation(s) have no bearing on this Section but are for internal use only.
5. **Provider Termination.** If a Provider chooses to terminate membership in the Provider Network, a written request should be submitted to Managed Services 90 days prior to termination.

Texas Panhandle Centers  
ATTN: Contracts Management Department  
P.O. Box 3250  
Amarillo, Texas 79116

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

If performance standards are questioned the Provider will be contacted by phone whenever possible or by certified mail to alert the Provider to the issue(s) and review the appropriate documentation in compliance with due process/fundamental fairness procedures.

If the contract/agreement is terminated, Provider is expected to cooperate with the Authority in the transfer of Individuals to other providers.

- Immediate Termination. Texas Panhandle Centers may terminate the Provider Agreement immediately if:
    - Texas Panhandle Centers does not receive the funding allocation to pay for designated services under the Provider Agreement from the Texas Legislature or the designated State Agency responsible for allocating funds to Texas Panhandle Centers for behavioral health services;
    - Texas Panhandle Centers has cause to believe that termination of the Agreement is in the best interests of the health and safety of the persons with mental illness served;
    - Provider has become ineligible to receive Texas Panhandle Centers funds;
    - Provider or its employees has its Texas license or certification suspended or revoked;
    - in the case of Providers providing direct services to clients, failure to disclose a criminal conviction;
    - if the Provider submits falsified documents or fraudulent billings, or if the Provider makes false statements; or
- b. Termination upon Default. Upon written Notice of Default of any of the obligations to be performed under the terms of this Agreement, the defaulting party will have fifteen (15) days in which to correct or cure the default to the reasonable satisfaction of the non-defaulting party. If, at the end of such fifteen (15) days cure period, such default remains uncorrected, then and in such event, the non-defaulting party shall have the right to terminate the Agreement upon an additional fifteen (15) day written Notice of Termination to the defaulting party.
- c. Termination by Mutual Consent. This Agreement may be terminated with ninety (90) days written notice by the parties' mutual consent or by the parties' inability to agree to subsequent amendments to this Provider Manual or the Provider Agreement.
- d. Termination Without Cause. This Agreement may be terminated by either party, without cause, after thirty (30) days written notice to the other party.
- e. Termination for Failure to Disclose Criminal Conviction. Texas Panhandle MHMR may immediately terminate this Agreement at its sole discretion if it determines that the Provider did not fully and accurately disclose the following information concerning persons convicted of crimes:

- The identity of any employee, officer, or other person directly or indirectly involved in this Agreement who has been convicted of any criminal offense related to any state or federally funded program; or
  - The identity of any employee, officer, or other person directly or indirectly involved who is in direct contact with persons served and who has been convicted of a crime including any sexual offense, drug-related offense, homicide, theft, assault, battery, or any other crime involving personal injury or threat to another person.
  - Should any person have a conviction described above, Provider will immediately remove the individual from direct contact with persons served.
  - If the Provider has a conviction described above, the Provider Network Agreement may be terminated immediately.
- f. Effect Upon Notice of Termination. Upon notice of termination, Provider will cooperate fully with Texas Panhandle Centers in the transfer of Individuals to other services. Provider recognizes that during any notice period preceding the effective date of termination, Texas Panhandle Centers, may at its sole discretion, deny authorization to Individuals to receive Services.
- g. Effect upon Termination. Upon termination, the rights of Texas Panhandle Centers and Provider under this Agreement will terminate, except that termination will not release the parties of their respective obligations with respect to:
- i. Payments accrued for **authorized** Services by Provider prior to termination;
  - ii. Provider's agreement not to seek compensation from Individuals for Services prior to termination of the Provider Network Agreement;
  - iii. The continuation of Provider's care for Individuals receiving Services from Provider until continuation of the Individuals' care can be arranged by Texas Panhandle Centers or another provider within the Network. TPC will reimburse Provider for such care pursuant to the terms of the Agreement; and
  - iv. Requirements regarding confidentiality and record retention will survive the Network Agreement.
- h. **Dispute Resolution.** In the event a dispute arises between the parties involving the provision or interpretation of any term or condition of this manual or the provider network agreement, and both parties desire to attempt to resolve the dispute prior to termination or expiration of the Agreement, or withholding payments, then the parties may refer the issue to a dispute resolution panel composed of at least three persons selected by the Texas Panhandle Centers' Executive Director or his designee and adhere to the following steps:
- i. At least one member of the panel must be an employee or designee of the Provider and at least one member must be an employee of Texas Panhandle Centers.

- ii. The panel shall hold a conference within the time period specified by the Texas Panhandle Centers' Executive Director or his designee.
- iii. The panel shall make written recommendations concerning the resolution of the dispute based upon information presented by Texas Panhandle Centers and Provider.
- iv. The recommendation shall be submitted to the Provider within the specified time frame.
- v. Texas Panhandle Centers' Executive Director or his designee serves as the final authority in the resolution process and may accept or reject all or part of the panel's recommendations.
- vi. Provider shall be notified of Texas Panhandle Centers' Executive Director or his designee's final determination in writing.

## **XVI. Billing For Services**

### **1. Getting Your Claim Paid**

- a. Check the validity of the authorization. If further care or authorization is needed you can call your assigned Case Manager.
- b. Verify that you are the approved Provider. The Provider named on the claim form should match the Provider specified on the authorization.
- c. Verify eligibility. If an Individual becomes ineligible for care before the number of sessions or units of care have been exhausted or the time period has expired, then the authorization becomes invalid.
- d. Use the correct claim format. Providers are required to file their claims in an invoice format:
  - i. Name the type of service
  - ii. Specific skill(s) trained on and method used to provide training
  - iii. Date, start and end time, location
  - iv. Treatment plan goal(s) that includes focus of service
- e. Submit claims to all insurance companies with which the Consumer carries coverage. The notification of the decision from that insurance company should be attached to the claim form that is submitted.
- f. When approved by Texas Panhandle Centers, Provider shall bill the consumer per his/her Ability to Pay the amount after all insurance and all other funding sources

have paid. The notification of the decision from that insurance company and the amount billed to the Customer for his/her ability to pay should be attached to the claim form that is submitted.

## 2. Billing the Customer

- a. Providers may only bill (When approved specifically by contract/agreement)
  - For applicable deductibles, co-insurance, and/or co-payments from the Customer at the time of service.
  
  - According to the Ability to Pay guidelines as outlined in the Texas Administrative Code Chapter 412 Subchapter C
- b. Providers may not bill:
  - Non-authorized services
  - Amounts above fee schedule/per diem
  - Additional payments or co-payments

## 3. Coordination of Benefits

Coordination of benefits will be conducted with a Consumer's primary health insurance carrier. Please send a copy of the primary carriers Explanation Of Benefits (EOB) with each claim submitted as well as the amount paid on the Customers Ability to Pay. If the necessary information is not attached the claim will be returned, thus delaying the claim payment. The Provider has up to 60 days from the date of receipt of the primary insurance carrier's EOB to submit the claim.

## 4. Additional Paperwork with Claims

Providers do need to submit copies of their clinical documentation either electronically or in paper format each time a claim is submitted until written notice of release of this obligation is received. Although authorization is a prerequisite to reimbursement, the authorization (both initially and throughout treatment) is entered into the central database system. Your claim may be processed quicker if the authorization number is on the bill claim form.

## 5. Time Limit

Provided all necessary information is received to process the claim, it is the goal of Texas Panhandle Centers for all claims to be paid within 30 days of receipt.

6. Claims Submission:

- (1) Claims and supporting event data must be submitted by the 10<sup>th</sup> day of the month following the services per HHSC encounter data requirements.
- (2) All claims submitted must include a copy of the authorization.
- (3) Provider must have the ability to:
  - (a) Bill according to HHSC requirements
  - (b) Accept and reconcile claims
  - (c) Monitor authorizations
- (4) LMHA authorization of services
  - (a) Assessment completed
  - (b) Treatment plan completed
  - (c) Diagnosis current within the last year
  - (d) Determination of medical necessity
  - (e) NOTE: Services delivered prior to authorization are not allowed and cannot be paid.
- (5) Third Party Authorization (Medicaid HMOs)
  - (a) This is in addition to LMHA Authorization

Please send claims to:

Texas Panhandle Centers  
ATTN: Contracts Department  
P.O. Box 3250  
Amarillo, Texas 79116

\*NOTE: Claims will not be accepted sixty (60) days past the date of services unless it has to be billed to primary insurance first. In this case the claims will not be accepted sixty (60) days from date of EOB notice. It is the Provider's responsibility to provide timely submission of all claims.

## **XVII. The Rights of Individuals Served**

An Individual receiving services has the right to:

### **A. Basic Rights for All Persons Receiving MH Services**

1. You have all the rights of a citizen of the State of Texas and the United States of America, including the right of *habeas corpus* (this means you have the right to ask the court if it is legal, based on the procedures of your court commitment, for you to be kept in the hospital), property rights, guardianship rights, family rights, religious freedom, the right to

register and vote, the right to sue and be sued, the right to sign contracts, and all the rights relating to licenses, permits, privileges, and benefits under the law.

2. You have the right to be presumed mentally competent unless a court has ruled otherwise.
3. You have the right to be treated without discrimination due to your race, religion, sex, ethnicity, nationality, age, sexual orientation, or disability. If you believe you have been discriminated against for any of the reasons listed above, you may contact the HHSC Civil Rights Office at 1-800-458-9858.
4. You have the right to be treated in a clean and humane environment in which you are protected from harm, have privacy with regard to personal needs, and are treated with respect and dignity.
5. You have the right to appropriate treatment in the least restrictive, appropriate setting available that provides protection for you and the community.
6. You have the right to be free from mistreatment, abuse, neglect, and exploitation. If you believe you have been abused, neglected or exploited, you should contact DFPS at 1-800-647-7418.
7. You have the right to protection of your personal property from theft or loss.
8. You have the right to be told in advance of all estimated charges being made, the cost of services provided, sources of the program's reimbursement, and any limitations on length of services. You should be given a detailed bill of services upon request, the name of an individual to contact for any billing questions, and information about billing arrangements and available options if insurance benefits are exhausted or denied. You may not be denied services due to an inability to pay for them.
9. You have the right to fair compensation for any work performed in accordance with the Fair Labor Standards Act.
10. When you are admitted to an inpatient or outpatient program, you have the right to be informed of all rules and regulations related to those programs.

## B. Confidentiality

1. You have the right to review the information contained in your medical record. If your doctor says you shouldn't see parts of your record, you have the right to have the decision reviewed. The right to review your records extends to your parent or conservator if you are a minor (unless you have admitted yourself to services) and to your legal guardian.
2. You have the right to have your records kept private. You also have the right to be told about the conditions under which information about you can be shared without your



permission. You should be aware that your records may be shared with employees of the HHSC system (state facilities and community MHMR centers) who need to see them in order to provide services to you. You should also be aware that your status as a person receiving mental health services may be shared with jail personnel if you are incarcerated.

3. You have the right to be informed of the use of any media devices, such as one-way vision mirrors, tape recorders, television, movies, or photographs.
4. Except in an emergency, medical and/or surgical procedures require your permission or the permission of your guardian or legal representative. You have the right to know the advantages and disadvantages of medical and surgical procedures
5. You have the right to consent or withhold consent to take medication unless a court has ordered you to take them, your guardian has consented to their administration, or there is an emergency situation in which you or someone else might be harmed due to your behavior.
6. You have the right to consent or withhold consent to participate in research.
7. You have the right to withdraw your permission at any time in all matters for which you have previously consented. If you do not grant consent or if you withdraw your consent for any particular treatment, it will have no effect upon your eligibility for any other care and treatment.

### C. Care and Treatment

1. You have the right to an individualized treatment plan. You have the right to take part in developing that plan, as well as the treatment plan for your care after you leave the hospital or community program. Your parent/conservator (if you are a minor), or your legal guardian, has the right to participate in the development of the treatment plan. You have the right to request that any other person that you choose take part in the development of the treatment plan. Your request should be reasonably considered and you will be informed of the reasons for any denial. Staff must document in your medical record that the parent, guardian, conservator, or other person of your choice was contacted and invited to participate.
2. You have the right to be free from unnecessary or excessive medication.
3. You have the right to be told about the care, procedures, and treatment you will be given. You also have the right to be told about the risks, side effects, and benefits of all medications and treatment you will receive, including those that are unusual or experimental, the other treatments that are available, and what may happen if you refuse the treatment.
4. You have the right to meet with the staff responsible for your care and to be told of their disciplines, job titles, and responsibilities. In addition, you have the right to know about any proposed change in the appointment of professional staff responsible for your care.

5. You have the right to request and receive a second opinion from another professional treatment provider at your own expense. You have the right to be granted a review of your treatment plan or a specific procedure by in-house staff.
6. You have the right to be told why you are being transferred to any program within or outside of the agency.
7. You should be notified of your right to appeal a decision by a community MHMR center to deny, terminate, or reduce services or support. If you are a Medicaid recipient, you also have the right to request a Medicaid Fair Hearing.
8. You have the right to receive services that address both psychiatric and substance use disorders.
9. You have the right to appeal a decision made by the MHMR center to deny, terminate or reduce services or support, based on non-payment.

To obtain a copy of the Department of State Health Services Consumer Rights Handbook or to review the rights related to residential/inpatient services, go to:

[www.dshs.state.tx.us/mhservices/MHConsumerRights.shtm](http://www.dshs.state.tx.us/mhservices/MHConsumerRights.shtm)

## **XVIII. Reporting Requirements**

- a. **Abuse, Neglect, Exploitation.** Providers must report to the Department of Family and Protective Services (at 800-252-5400) all allegations (which effects all individuals being served by the Provider whether under this Network or not) of abuse, neglect, and exploitation in compliance with federal and state law, rules, and regulations, and Authority policies and procedures. Furthermore, if the client receives behavioral health services with Texas Panhandle Centers, and the accused is an employee, agent, or contractor of TPC, the allegation must also be reported to The Department of State Health Services. A written report must be emailed to [performance.contracts@dshs.state.tx.us](mailto:performance.contracts@dshs.state.tx.us) within 48 hours after the incident. The email must contain the DFPS report number
- b. **Critical Incidents.** Providers are required to fax an incident report with information regarding the occurrence of any of the following critical incidents within 24 hours to the Authority's Rights Protection Officer at (806) 351-3346.
  1. Deaths
  2. Suicide attempts/threats with plan
  3. Serious injury
  4. Allegations of abuse, neglect, or exploitation
  5. Allegations of homicide/attempted homicide/threat with a plan
  6. Serious medication errors -- the incorrect or wrongful administration of a medication (such as a mistake in dosage, route of administration or intended

consumer), a failure to prescribe or administer the correct drug, medication omission, failure to observe the correct time for administration, or lack of awareness of adverse effects of drug combinations which place the Individual's health at risk so that immediate medical intervention or enhanced surveillance on behalf of the Individual is required.

7. Incidents of restraint or seclusion

## **XIX. Staff Training Requirements**

1. **Training.** The Provider and Provider staff are required to meet training or certification requirements to work with Authority clients, which may include the following:

### **A. HHSC Required Training – all Licensed Professional of the Healing Arts (LPHA) staff**

- Patient and Family Education Program (PFEP)
- Texas Resilience and Recovery Guidelines (TRR)
- Medicaid rules
- Uniform Assessment, Treatment Planning & Documentation
- Prevention and Management of Aggressive Behavior (PMAB)
- Ask About Suicide to save a life (ASK?)
- Cognitive Behavioral Health Therapy Training and Competency (CBT)
- Co-occurring Psychiatric and Substance Use Disorders (COPSD)
- The Adult Needs and Strengths Assessment (ANSA) or The Child and Adolescent Needs and Strengths Assessment (CANS)

### **B. HHSC Required Training – all Qualified Mental Health Professional (QMHP) staff**

- Texas Resilience and Recovery Guidelines
- Medicaid rules
- Uniform Assessment, Treatment Planning & Documentation
- Prevention and Management of Aggressive Behavior (PMAB)
- Ask about Suicide to save a life (ASK?)

- Co-occurring Psychiatric and Substance Use Disorders training (COPSD)
- The Adult Needs and Strengths Assessment (ANSA) or The Child and Adolescent Needs and Strengths Assessment (CANS)
- Social Skills and Aggression Replacement Techniques (START)
- Assertive Community Treatment (ACT)
- Supported Employment (SE)
- Permanent Supportive Housing (PSH)
- Clinical supervision by an LPHA, including chart reviews

Provider may submit training policies, procedures and materials to verify that training requirements are met. Authority Staff Development Director will review submitted training materials upon request. Training may be provided by the Provider or obtained from another entity as long as the training meets the required job competencies, as determined by Authority. Questions regarding training should be directed to the Authority’s Human Resource Development Department at (806) 351-3244 or (806) 351-3282.

**2. Scheduling Training with Authority.** The Authority will provide a calendar of annual training opportunities for each fiscal year to the Provider. Provider may register staff for classes by sending a fax listing the names of those who will attend to Human Resources Department at (806) 358-1681 at least two weeks prior to the scheduled class. Provider will be billed for any persons registered who do not give 24 hour cancellation notice by fax.

**3. Training Costs.** Provider may use Authority’s Training Center to meet the required training for staff and will be billed per person per class as follows:

Required Trainings	
CPR & First Aid	\$85.00
Personal Outcomes	no charge
PMAB Physical	\$45.00
PMAB (communication only)	\$10.00
PMAB Refresher	\$20.00
Documentation (Texas Panhandle Centers Liaison staff)	no charge
Continuing Education Courses (3.0)	\$30.00

- (Required) Study Manual/Self Paced Test
  - AIDS/HIV Disease/Infection Control
  
  - Intro to Intellectual and Developmental Disabilities
  - Normalization
  - Screening & Crisis
  - Client Rights/Confidentiality/Reporting Abuse and Neglect
  - Corporate Compliance
  
- (Required) Videos
  - Seizure Management
  - Client Rights/Confidentiality/Reporting Abuse and Neglect
  - Corporate Compliance
  
- Payment must be made in advance for each training with a charge.

## **Glossary of Terms**

### **Physical Abuse:**

- (1) an act or failure to act performed knowingly, recklessly, or intentionally, including incitement to act, which caused or may have caused physical injury or death to a person served;
- (2) an act of inappropriate or excessive force or corporal punishment, regardless of whether the act results in a physical injury to a person served; or
- (3) the use of chemical or bodily restraints on a person served not in compliance with federal and state laws and regulations

### **Sexual Abuse:**

Any sexual activity, including but not limited to:

- (1) kissing a person served with sexual intent;
- (2) hugging a person served with sexual intent;
- (3) stroking a person served with sexual intent;

- (4) fondling a person served with sexual intent;
- (5) engaging in:
  - (A) sexual conduct as defined in the Texas Penal Code, §43.01; or
  - (B) any activity that is obscene as defined in the Texas Penal Code, §43.21;
- (6) requesting, soliciting, or compelling a person served to engage in:
  - (A) sexual conduct as defined in the Texas Penal Code, §43.01; or
  - (B) any activity that is obscene as defined in the Texas Penal Code, §43.21;
- (7) in the presence of a person served:
  - (A) engaging in or displaying any activity that is obscene, as defined in the Texas Penal Code §43.21; or
  - (B) requesting, soliciting, or compelling another person to engage in any activity that is obscene, as defined in the Texas Penal Code §43.21;
- (8) committing sexual exploitation as defined against a person served;
- (9) committing sexual assault as defined in the Texas Penal Code §22.011, against a person served;
- (10) committing aggravated sexual assault as defined in the Texas Penal Code, §22.021, against a person served; and
- (11) causing, permitting, encouraging, engaging in, or allowing the photographing, filming, videotaping, or depicting of a person served if the employee, agent, or contractor knew or should have known that the resulting photograph, film, videotape, or depiction of the person served is obscene as defined in the Texas Penal Code, §43.21, or is pornographic.

**Sexual Exploitation:**

- (1) A pattern, practice, or scheme of conduct against a person served, which may include sexual contact, that can reasonably be construed as being for the purposes of sexual arousal or gratification or sexual abuse of any person.
- (2) The term does not include obtaining information about a patient's sexual history within standard accepted clinical practice.

**Verbal/Emotional abuse:**

Any act or use of verbal or other communication, including gestures, to:

- (1) curse, vilify, or degrade a person served; or
- (2) threaten a person served with physical or emotional harm

**Neglect:**

A negligent act or omission by any individual responsible for providing services to a person served, which caused or may have caused physical or emotional injury or death to a person served or which placed a person served at risk of physical or emotional injury or death. Neglect includes, but is not limited to, the failure to:

- (1) establish or carry out an appropriate individual program plan or treatment plan for a person served;
- (2) provide adequate nutrition, clothing, or health care to a specific person served in a residential or inpatient program; or
- (3) provide a safe environment for a specific person served, including the failure to maintain adequate numbers of appropriately trained staff.

**Exploitation:**

The illegal or improper act or process of using a person served or the resources of a person served for monetary or personal benefit, profit, or gain.