



AMHD
ADULT MENTAL HEALTH DIVISION

PROVIDER MANUAL

This manual was developed as part of an ongoing effort to provide you with guidelines to make your interactions with the Adult Mental Health Division (AMHD) as efficient and helpful as possible. The manual is an evolving reference work and is intended to be as accurate as possible and will be updated as policies and procedures change. If you have any questions about the Manual, please contact AMHD.

Last Updated 4/2019

Table of Contents

CHAPTER 1

General Information

Adult Mental Health Division	4
Recovery.....	5
Practice Guidelines.....	9
AMHD Programs and Services	10

CHAPTER 2

Consumers

Consumer Eligibility and Enrollment.....	12
Notification of Change in Consumer Status	13
Consumer Rights and Responsibilities	13
Consumer Grievance and Appeal Process.....	18
Transitioning Youth to Adult	18
Discharge.....	18

CHAPTER 3

Provider Requirements

General Provider Requirements	20
Types of Providers.....	20
Requirements for Participation as a Provider	21
Medicaid Rehabilitation Option	22
Notification of Change in Provider Information	23
Accreditation	24
Credentialing	24
Confidential Communications and Disclosure Requirements	25
Standards of Conduct	25
Fiscal Integrity.....	26
Utilization Management Program	26
Quality Management Program	28
Treatment Records Management.....	30
Fraud and Abuse.....	33
Provider Compliance Program	34
Consumer Protection	35
Consumer Abuse and Neglect	36
Provider Monitoring, Audits and Site Visits	37
Provider Grievances and Appeal Process.....	39

CHAPTER 4

Claims

General Guidelines	40
Claim Forms	40
Procedure and Diagnosis Codes	41
Third Party Liability	42
Claims Submission	43
Provider Appeals of Claims Payment.....	44

Corrected Claims	44
Additional Payment Requests	45
Expediting Claims Processing/Preventing Common Errors.....	45
Pricing and Payment Processing	45
Editing Process	45
Adjustments, Voids, and Resubmissions of Claims	46
Overpayments and Recoveries	46
Resubmissions	46
The Remittance Advice	47
AMHD Payments	47
Claim and Payment Inquiries	48
Fiscal Records Management.....	48
Fiscal Audits and Reconciliation.....	49
Provider Billing to Consumer.....	49

APPENDICES

Appendix A

Definitions	51
-------------------	----

Appendix B

AMHD/Phone Contact Numbers & AMHD Areas of Responsibilities	57
-------------------------------------------------------------------	----

Appendix C

Treatment Record Documentation Standards.....	58
-----------------------------------------------	----

Appendix D

Commonly Used Acronyms.	61
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Chapter

1

General Information

Adult Mental Health Division

- **Mission**

As part of the Hawaii State Department of Health (DOH), the Adult Mental Health Division's (AMHD) mission is to provide integrated, mental health services for consumers with serious mental illness (SMI) who are uninsured or underinsured, those who are court ordered for evaluation, care and custody to the DOH and individuals in crisis.

AMHD provides services to eligible adults with SMI through State-owned and operated facilities (Community Mental Health Center's located statewide and the Hawaii State Hospital on Oahu) and through State-developed contracts with private providers.

- **AMHD Organizational Vision**

The AMHD strives to be a national leader in providing an accessible, culturally responsive, integrated, and best practice based system of mental health services to support consumers in their recovery.

In order to implement its vision, AMHD uses the following principles to guide its work:

- Mental health treatment works.
- People recover every day in Hawaii.
- AMHD supports recovery in all aspects of our work.
- Appropriate housing and employment are keys to recovery.
- We strive to treat our consumers in independent living settings.
- Behavioral Health is essential to health; we partner with other health care professionals to provide integrated treatments.
- We strive to use technology to work smarter.
- We strive to educate ourselves and provide training to others.

- AMHD supports the use of innovative strategies to reduce involvement of individuals with mental illness in the criminal justice system.

AMHD is organized to separate its oversight functions from its provider operations.

1. Oversight functions are designed to ensure that both State-operated providers and contracted Purchase of Service Providers (POS) offer the same high quality of services. Additional oversight functions include development of information-based statewide plans and distribution of resources for services that effectively and efficiently meet the needs of the target population.
2. Provider operations are the day-to-day management of Hawaii State Hospital (HSH) and State-operated Community Mental Health Centers (CMHC).

- **AMHD Basic Functions and Responsibilities**

The basic functions or responsibilities of AMHD include, but are not limited to:

1. Defining the services to be provided to consumers by providers;
2. Developing the rules, policies, regulations, and procedures to be followed under the programs administered by the AMHD;
3. Procuring, negotiating, and contracting with selected providers;
4. Determining initial and continuing eligibility of consumers;
5. Enrolling and dis-enrolling consumers;
6. Reviewing and ensuring the competency and adequacy of the provider and their employees;
7. Monitoring the quality of services provided by the providers and subcontractors;
8. Reviewing and analyzing utilization of services and reports submitted by providers;
9. Handling unresolved consumer grievances and appeals with the providers;
10. Certifying Medicaid Rehabilitation Option providers;
11. Authorizing services and pre-adjudicating claims;
12. Monitoring the financial status and billing practices of providers;
13. Identifying and investigating fraud and abuse;
14. Analyzing the effectiveness of the program in meeting its objectives;
15. Conducting research activities;
16. Providing technical assistance to the providers and consultation;
17. Providing consumer eligibility information to the providers; and
18. Providing payments to contracted providers.

Recovery

Hawaii's adult mental health service delivery system is based on the concept of recovery. The guiding principle of Hawaii's adult mental health service delivery system is that persons with a mental illness can recover. Consumers are capable of leading fulfilling lives regardless of a diagnosis of SMI. Treatment is focused on the needs of the individual, not merely on symptom relief and stabilization, but also on individual empowerment with skills needed to lead satisfying, hopeful, and contributing lives.

- **Guiding Principles of Recovery**

AMHD follows the Substance Abuse and Mental Health Services Administration's (SAMHSA) guiding principles of recovery to support the recovery of persons with SMI, plans, implements, and provides treatment, Psychosocial Rehabilitation (PSR) services, and other community services, and oversees and administers the AMHD system. The four dimensions of recovery include:

- *Health* Overcoming or managing one's disease(s) or symptoms – for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem – and for everyone in recovery making informed and healthy choices that support physical and emotional wellbeing.
- *Home* A stable place to live.
- *Purpose* Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- *Community* Relationships and social networks that provide support, friendship, love, and hope.

- **Recovery Plan**

Each consumer shall be provided a single, individualized, coordinated, master recovery plan (MRP) referred to as an Individual Service Plan (ISP) that complies with AMHD standards for recovery planning. There must be documented evidence of each consumer's input into all aspects of their recovery planning, inclusive of service-related decisions.

Through the ISP/MRP, the consumer, case manager and psychiatrist or Advanced Practice Registered Nurse with prescriptive authority (APRN-Rx) are part of a team that work together to set goals toward recovery. The plan helps each member of the team know what other persons/providers are doing to help the consumer. The plan describes psychotherapy, medication, clinical services, general health services, dental services, and living-support services.

Each consumer's ISP/MRP shall guide service delivery even if the consumer changes providers. The ISP shall:

1. Include an initial recovery plan completed within 72-hours of admission to case management that describes the services to be immediately provided and identifies any further assessments that are required;
2. Address all of the consumer's needs identified through the assessment process;
3. Be completed within thirty (30) days of admission to case management;
4. Involve the consumer and others chosen by the consumer in the development of the ISP;
5. Be recovery-focused, culturally-informed, and strengths-based;
6. Contain at least the following elements:
 - a. Written explanations of why an identified need was not addressed in the ISP/MSRP;

- b. A written quote by the consumer describing what he/she considers to be the measure of success;
 - c. A case formulation that results from the multidisciplinary assessments used in developing the ISP/MRP;
 - d. Written treatment goals that are prioritized based on the consumer's preferences, strengths, and needs;
 - e. Goals that are worded in behavioral terms with a completion timeframe for each goal;
 - f. At least one corresponding objective for each goal that is a step to be taken to achieve the goal and shall be behaviorally worded, measurable, and have timeframes for completion;
 - g. Identification of specific treatment and Psychosocial Rehabilitation (PSR) services and other community supports to be provided to the consumer, including the amount, duration, and scope;
 - h. Designation of the person responsible for each intervention of the ISP/MRP;
 - i. Crisis planning that shall include the preferences of the consumer and detail the steps to be taken if a crisis occurs;
 - j. Written criteria for discharge or transition from one level of care to another as appropriate;
7. Be reviewed and updated at least once every six months or whenever there is a significant change in services, whichever comes first; and
 8. Comply with requirements of the service provider's accrediting body, and/or Center for Medicare and Medicaid Services (CMS).

Requested services should be reflected in the ISP/MRP except for urgent, unforeseen crisis services. New services should be added to the ISP/MRP as needed. The consumer, case manager, and psychiatrist or APRN-Rx must sign the ISP. If consumer is unable to sign or refused to sign, it must be documented in the record that the consumer refuse or unable to sign the ISP/MRP. The consumer shall sign the amended plan upon the next face-to-face contact.

Progress notes shall be documented in the clinical record, describing the consumer's progress toward achievement of his/her goals and objectives, interventions provided, and their results.

- **Recovery Team**

The recovery team shall include, at a minimum, the consumer, the psychiatrist or APRN-Rx, and the case manager.

The psychiatrist or APRN-Rx shall be in charge of the recovery team and has ultimate authority for all clinical decisions. The psychiatrist or APRN-Rx shall:

1. Ensure that the recovery plan is the result of the recovery planning process, and that the plan fully directs and integrates all treatment and PSR services and other community supports;
2. Ensure that all necessary disciplines are involved in the recovery planning process as directed by each consumer's needs and preferences, including the preference for consumer requested advocates of consumer-defined family members;

3. Be responsible and accountable for ensuring that the ISP/MRP is implemented; and
4. Shall ensure that performance improvement findings are used to improve recovery planning.

- **Role of Case Manager**

AMHD uses a Community-Based Case Management (CBCM) Model of consumer case management.

All consumers are assigned a case manager. The case manager assists the consumer in getting the mental health, medical, dental and living-support services needed. The case manager coordinates a recovery program for the consumer. If the consumer is in the hospital because of mental illness, the case manager works with the hospital staff on a discharge plan and coordinates community services designated in the plan.

The case manager collaborates with other CBCM team members who include a psychiatrist or APRN-Rx, Hawaii Certified Peer Specialist (HCPS), and a Registered Nurse (RN). The case manager further initiates linkages with community programs and informal supports to further assist the consumer.

The case manager must assist the consumer in obtaining needed services, including those not funded by AMHD. In those cases, the case manager is expected to work with the other possible resources to find help for the consumer. Consumers must be informed in advance and in writing of any out-of-pocket cost for services not funded by AMHD.

When providing case management services to consumers with forensic encumbrance (i.e., on conditional release, released on conditions, Mental Health Court or Jail Diversion), the following is required:

1. Case managers must obtain and keep all court orders in the consumer's file;
2. Documentation must be present to show that court orders have been reviewed regularly with the consumer so that the consumer's responsibilities to the court are understood by the provider and consumer alike;
3. Call the consumer's probation officer and/or public defender when a consumer begins to violate terms of conditional release, probation and/or parole, to have a dialog about amending the recovery plan and/or conditions of release to address the consumer's current situation. When the consumer is on conditional release status, the assigned AMHD Forensic Coordinator shall also be consulted;
4. Case managers should communicate with the consumer's public defender when legal issues arise; and
5. A consumer on conditional release, released on conditions, in Mental Health Court, or Jail Diversion program cannot be discharged from case management services if the terms of the court order mandate mental health services are to be provided by AMHD. Questions on individual cases should be directed to the AMHD Forensic Coordinator.

- **Role of the Medical Primary Care Provider**

If the treatment team has obtained consent from the consumer to share or release information, the medical Primary Care Provider (PCP) should be included in treatment planning when medical conditions are a concern. Consumers being discharged from a hospital should have a PCP appointment within seven (7) calendar days of discharge. The PCP should be informed of all psychotropic medications being prescribed as these medications may be adversely impacted by medications prescribed by the PCP. Every consumer should have a PCP and the case manager has the responsibility to assist the consumer in establishing a relationship with a PCP. The PCP, case manager, and the rest of the treatment team should work together to support the consumer's overall health goals including preventative health. Each consumer's treatment record should contain the name and phone number of the consumer's PCP.

- **Coordination with PCP, Medical Specialists and Dentists**

The case manager is responsible for coordinating care with the consumer's PCP any medical specialists, and dentists. It is also the case manager's responsibility to ensure that any medical or dental concerns are included in the ISP/MRP.

- **Co-Occurring Substance Use Disorders**

Understanding that a large percentage of individuals with SMI also have a co-occurring substance use disorder, providers are expected to have the capability to work effectively in addressing both mental illness and substance use issues. AMHD has technical assistance and consultation support for planning, implementing, and coordinating services for consumers with a co-occurring mental illness and substance use disorders. Technical assistance to the CMHCs is provided by the Center's Mental Illness/Substance Abuse (MISA) Coordinator.

Practice Guidelines

To ensure that service delivery within the AMHD service system is in line with AMHD's Guiding Principles, the "AMHD Practice Guidelines," were developed by the AMHD Clinical Operations Team with broad input from stakeholders. This document serves as a bridge between principles and practice. It is not meant to be an exhaustive list, rather to assist in operationalizing some of the Guiding Principle's concepts.

Similarly, the "Psychopharmacology Practice Guidelines for Individuals with Substance Use and Serious Mental Illness," were created to provide some system guidelines for consistent prescribing practices within the AMHD service system. In addition to providing guidelines and practice standards, it also provides resources and information of special interest for prescribing personnel. The "Psychopharmacology Practice Guidelines for Individuals with Substance Use and Serious Mental Illness" can also be used as an orientation document for new physicians entering the AMHD system of care.

AMHD Programs and Services

- **Covered Services**

Case Management

Community-Based Case Management- Recovery Supports (CBCM-RS)

Support Services

Homeless Outreach

Peer Coach

Representative

Payee

Treatment Services

Inpatient Specialty/State Hospitals

Specialized Residential Service Program

(SRSP) Intensive Outpatient Hospital
(IOHP)

Day Treatment for Dual

Diagnosis Outpatient Clinic

Services Assessment Services

Therapeutic Living Program (TLP)

Long-Term Care

Expanded Adult Residential Care Home (E-ARCH)

Crisis Services

Crisis Line of Hawaii

Crisis Mobile Outreach (CMO)

Licensed Crisis Residential Service (LCRS)

Crisis Support Management (CSM)

Walk-In Urgent Care at Community Mental Health Centers

Community Housing

24-Hour Supervised Group Home

8-16 Hour Group Home

Semi-Independent Living

Supported Housing/Bridge Subsidy Program

Psychosocial Rehabilitation Services

Clubhouse

Supported Employment

- **General Limitations of Services**

The following services are not funded by AMHD:

1. Care outside Hawaii;
2. Experimental drug trials;

3. Services funded by another payer;
4. Experimental therapies; and
5. Services not medically necessary.

- **How to Contact AMHD**

General contact information can be obtained through the following:

Department of Health
Adult Mental Health Division
P.O. Box 3378
Honolulu, HI 96801-3378
Phone: (808) 586-4686
Fax: (808) 586-4745

Crisis Line of Hawaii:

Telephone contact is available 24 hours a day, 7 days a week:
From Oahu, (808) 832-3100
From Neighbor Islands, 1-800-753-6879 (toll-free)

- **AMHD On-Line**

The AMHD's website is: <http://www.health.hawaii.gov/amhd/>

Chapter

2

Consumers

Consumer Eligibility and Enrollment

The following individuals are eligible to receive AMHD services:

1. Adults who have a SMI and demonstrate severe functional impairment;
2. Adults who are in a state of crisis and need help for a short time;
3. Adults who are victims of natural disasters and terrorism;
4. Adults who are ordered by the courts for medically necessary treatment to be provided by the DOH;
5. Must be at least eighteen (18) years or older;
6. Live in Hawaii;
7. Be a U.S. citizen or have U.S. permanent residency status;
8. Are not covered by third party commercial health insurance;
9. Are not covered by a QUEST Integration health plan; or
10. Have insufficient financial assets which could be used to pursue health care or health care insurance.

- **Eligibility Determination**

Individuals may request an appointment for an eligibility determination assessment by contacting the AMHD Eligibility Line, toll-free statewide (643-2643) Monday through Friday during business hours or by visiting a CMHC Monday through Friday during clinic hours. If a consumer is already linked with QUEST Integration health plan, their health plan may make a referral to the Med-QUEST Division to determine eligibility for the carve-out program, Community Care Services (CCS), which is the managed care organization that provides intensive behavioral health services.

- **Eligibility Line Screening and Assessment Process**

1. The Eligibility Line staff shall complete an initial screening form, verify third party insurance coverage, and schedule an appointment for a mental health assessment;
2. The Eligibility Line staff must assess the consumer's language proficiency and obtain an interpreter to assist the assessor, if needed;

3. An assessor shall conduct an eligibility determination assessment and notify the consumer of his/her eligibility status;
4. If the consumer is found eligible, AMHD's Utilization Management (UM) section will provide the consumer with a referral to an appropriate AMHD funded continuing services provider within 48 hours of receipt of the completed eligibility determination assessment; and
5. If the consumer is found ineligible for AMHD services, the assessor shall notify the consumer of his/her appeal rights in writing at the close of the assessment appointment. The assessor should provide at least two (2) other community mental health services agency referrals in writing to the consumer. The assessor shall inform the consumer of the availability of the Crisis Line of Hawaii for crisis services as necessary.

Notification of Change in Consumer Status

Upon admission, and periodically thereafter, providers shall verify with consumers the following information:

1. Change in address;
2. Change in name;
3. Change in phone number;
4. Institutionalization (imprisonment or long term care); and
5. Current health insurance coverage.

It is expected that not all consumers may remember to or be able to provide AMHD with information on changes to their status. Therefore, it is important for the provider, who has more contact with the consumers, to forward such information to AMHD on a timely basis and to inform the consumer of his/her responsibility to report changes directly to the case manager.

The provider shall notify the consumer's case manager and AMHD of changes in consumer status by calling or faxing the information to AMHD UM within five (5) calendar days of discovery.

Consumer Rights and Responsibilities

AMHD providers must ensure that consumers' rights are upheld and respected in accordance with Chapter 11-175, of the Hawaii Administrative Rules.

Each provider must have a statement designed to protect the consumer's rights. The statement shall be:

1. Consistent with Federal and State laws and regulations; and
2. Posted in strategic and conspicuous areas to maximize consumer, family, and staff awareness.

Each consumer must be given a consumer's rights statement that complies with AMHD consumer rights requirements. The statement shall be:

1. Signed and dated by the consumer upon admission, and
2. Maintained in the consumers' treatment records.

The statement given to consumers must include, at a minimum, language that states:

1. Consumers have rights in all situations. AMHD and all providers are expected to uphold these rights. Consumers have rights regardless of:
 - a. Age;
 - b. Race;
 - c. Sex;
 - d. Religion;
 - e. Culture;
 - f. Amount of education;
 - g. Lifestyle;
 - h. Sexual orientation;
 - i. National origin;
 - j. Ability to communicate;
 - k. Language spoken;
 - l. Source of payment for services; and
 - m. Physical or mental disability.
2. Consumers have the right to be treated with respect and dignity, and to have their rights to privacy respected;
3. Consumers have the right to know about the services they can receive, and who shall provide the services, their training and experience;
4. Consumers have the right to receive a Notice of Privacy Practices at the time of their first visit;
5. Consumers have the right to have as much information about the treatment and service choices they need so they can give informed consent or refuse treatment. This information must be told to them in a way they can understand. Except in cases of emergency services, this information shall include a description of the treatment, medical risks involved, any alternate course of treatment or no treatment and the risks involved in each;
6. Consumers have a right to information about their medications; what they are, how to take them, and possible side effects;
7. Consumers have a right to be informed of continuing care following discharge from the hospital or outpatient services;
8. Consumers have a right to look at and get a reasonable explanation of any bills for non-covered services, regardless of who pays;
9. Consumers have a right to receive emergency services when prudent layperson acting reasonably would believe that an emergency medical condition existed;
10. Consumers have a right to visit their usual provider when receiving services;
11. Consumers have a right to honest discussions with their providers of the options for their treatment, regardless of cost and benefit coverage;
12. Consumers have a right to be advised if a provider wants to include the consumer in experimental care or treatment;
13. Consumers have the right to refuse to be included in such research projects;
14. Consumers have a right to complete an advance directive, living will, psychiatric advance directive, medical durable powers of attorney, or other directive to their providers;
15. Consumers have a right to have any person who has the legal responsibility, make decisions for them regarding their mental health care. Any person with

- legal responsibility to make health care decisions for a consumer shall have the same rights as the consumer;
16. Consumers have the right to know all their rights and responsibilities;
 17. Consumers have the right to get help from AMHD in understanding their services;
 18. Consumers are free to use their rights. The consumer's services shall not be changed and/or the consumer shall not be treated differently if the consumer exercises his/her rights;
 19. Consumers have the right to receive information and services in a timely manner;
 20. Consumers have the right to be a part of all choices about their treatment. The consumer has the right to have a copy of his/her written ISP/MRP;
 21. Consumers have the right to disagree with their treatment or to ask for changes in their ISP/MRP;
 22. Consumers have the right to ask for a different provider or case manager. If the consumer wants a different provider or a different case manager, AMHD and the provider shall work with the consumer to find another one in the AMHD network;
 23. Consumers have the right to refuse treatment to the extent allowed by the law. A consumer is responsible for his/her actions if the consumer refuses treatment or does not follow the provider's advice;
 24. Consumers have the right to receive services in a way that respects their cultural values, communication style, and religious beliefs;
 25. Consumers have the right to an interpreter to help the consumer speak to AMHD staff or his/her providers. Consumers have the right to have an interpreter in the room when seen by the provider;
 26. Consumers have the right to ask AMHD to send the consumer mail and to call the consumer at the address or telephone number of the consumer's choice in order to protect the consumer's privacy. If AMHD cannot honor the consumer's request, AMHD shall let the consumer know the reason;
 27. Consumers have a right to a second opinion when deciding on treatment;
 28. Consumers have the right to expect that their information shall be kept private according to the Privacy law;
 29. Consumers have the right to complain about their services and to expect no retribution from the provider or AMHD. If the consumer complains, the consumer's services shall not stop unless the consumer elects or wants to stop;
 30. Consumers have the right to be free from being restrained or secluded unless a doctor or psychologist approves, and then only to protect the consumer or others from harm. Seclusion and restraints should never be used to punish the consumer, keep him/her quiet, make the consumer do something the consumer doesn't want to do, or get back at the consumer for something the consumer has done.

Consumers with questions or concerns about these rights may be referred to the Rights Advisor at any CMHC if receiving services from a CMHC or the AMHD Office of Consumer Affairs if receiving services from an AMHD contracted provider. Consumers have the right to make a privacy complaint to the agency's Privacy Officer or Coordinator.

Orientation to the program or service must be provided at a level educationally appropriate for the consumer and communicated in a language the consumer can understand. Documentation of the orientation must be kept in the consumer's treatment record and signed and dated by the consumer.

If a consumer who received the orientation refuses to sign the form acknowledging that he/she received information regarding his/her rights, the staff shall document on the form that the consumer refuses to sign and the date that the information was provided to the consumer. At a minimum, the orientation must include:

1. An explanation of the:
 - a. Rights and responsibilities of the consumer;
 - b. Grievance and appeal procedures;
 - c. Ways in which consumer input is given regarding:
 - i. the quality of care;
 - ii. achievement of outcomes; and
 - iii. satisfaction of the consumer.
2. An explanation of the organization's:
 - a. Services and activities;
 - b. Expectations;
 - c. Hours of operation;
 - d. Access to after-hour services;
 - e. Code of ethics;
 - f. Confidentiality policy, including the Notice of Privacy Practices;
 - g. Requirements for follow-up for the mandated consumer served, regardless of his/her discharge outcome; and
 - h. An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization.
3. Familiarization with the premises; including emergency exits and/or shelters, fire suppression equipment, and first aid kits.
4. The program's policies regarding:
 - a. The use of seclusion or restraint;
 - b. Smoking;
 - c. Illicit or licit drugs brought into the program; and
 - d. Weapons brought into the program.
5. Identification of the person responsible for case management.
6. A copy of the program rules to the consumer, that identifies the following:
 - a. Any restrictions the program may place on the consumer;
 - b. Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the consumer, and
 - c. Means by which the consumer may regain rights or privileges that have been restricted.
7. Education regarding advance directives, when legally applicable.
8. Identification of the purpose and process of the assessment.
9. A description of how the ISP/MRP or other plan shall be developed and the consumer's participation.
10. Information regarding transition criteria and procedures.
11. When applicable, an explanation of the program's services and activities including:

- a. Expectations for consistent court appearances.
- b. Identification of therapeutic interventions, including:
 - i. Sanctions;
 - ii. Interventions;
 - iii. Incentives; and
 - iv. Administrative discharge criteria.

- **Consumer Responsibilities**

AMHD promotes consumer inclusion at every level in a culturally informed manner, delivered in the least restrictive setting, based on national standards and evidence-based practices which may be adapted for area differences and are supportive of families.

Consumers are expected to be responsible in the following ways:

1. Keep to scheduled appointments. If the consumer cannot make an appointment, call the provider at least 24 hours before the appointment or as soon as possible and schedule a new appointment;
2. Answer all questions in an honest way;
3. Take an active part in the ISP/MRP Team;
4. Know about and participate in one's own treatment;
5. Take one's medication as prescribed by the doctor. Know about dosage, side effects, and adverse reactions. Let the doctor or case manager know right away if there are any problems with the medication or the medication is about to run out;
6. Ask questions when the consumer does not understand something about one's treatment or medications;
7. Treat all individuals who provide services and other consumers with respect; and
8. Inform AMHD, the case manager, providers and health care insurer (i.e. commercial health plan, Medicare, Medicaid, Veterans Administration) of any changes, e.g., new address, phone number, primary care provider, other health insurance, income or assets, permanent residency status.

Consumers are reminded to make sure they are the only ones to use their health care insurance card; and

1. Bring their health care insurance card with them to show their providers;
2. Let their health care insurer know if their insurance identification card is lost or stolen;
3. Let AMHD, their case manager and their providers know if they have another health care insurance company, or if there is another payer that would pay for their care;
4. Remember that any other insurance or payer must pay for care before Medicaid or AMHD;
5. Let their case manager know right away if there are any changes in their family situation; and
6. Remember that the use of AMHD services is voluntary, unless ordered by the court.

Consumer Grievance and Appeal Process

An individual receiving services through the AMHD may file a grievance against AMHD, its CMHCs, HSH, or any of the contracted providers that offer services funded by the AMHD. Ideally, grievances should be resolved at the provider level if the grievance concerns a provider, but consumers may ask AMHD to assist by contacting:

Department of Health
Adult Mental Health Division
Office of Consumer Affairs
P.O. Box 3378
Honolulu, HI 96801-3378
Phone: (808) 586-4688
Fax: (808) 586-4745

If the consumer who filed a grievance is not satisfied with the results, he/she may file an appeal through AMHD's Office of Consumer Affairs. For more information on how to file an appeal, please contact the AMHD Office of Consumer Affairs.

All AMHD contracted providers must develop and implement a mechanism for receiving, documenting, and responding to consumer grievances and appeals.

Transitioning Youth to Adult

Consumers receiving services from the Department of Health's Child and Adolescent Mental Health Division (CAMHD) who would no longer be eligible for services (age 18-21) may be referred to AMHD to determine if they are eligible for AMHD services and are uninsured or legally encumbered. AMHD has consultation and technical assistance available to assist providers with the transition from children to adult services.

- **Developmentally Disabled and Mentally Ill**

Consumers receiving services from the Developmental Disability Division (DDD) may also be eligible for AMHD services if they meet AMHD eligibility. Consultation and technical assistance is available to providers serving dual eligible DDD/AMHD consumers.

Discharge

AMHD funded services may stop if the consumer:

1. No longer meets criteria for AMHD funded services;
 - a. Shows a significant improvement in functioning and clinically no longer needs the services provided;
 - b. Diagnosis' changes and the new diagnosis does not meet AMHD definition of a SMI;
 - c. Obtains third party commercial health care insurance coverage;
 - d. No longer lives in Hawaii;
 - e. Loses U.S. permanent residency status; or
 - f. Dies.

2. Refuses services that are not court ordered; or
3. Cannot be located after multiple attempts to contact over a proscribed period of time, unless the consumer is court ordered to receive AMHD services.

Unless the consumer is court ordered to receive services from AMHD, he/she has the right to stop services at any time. The consumer may cancel services by informing the provider directly.

It is the responsibility of the service provider to advise the consumer about the impact of their decision on other services they may be receiving through AMHD. The service provider must immediately notify AMHD UM about the discharge and assist the consumer in obtaining transitional services unless the consumer expressly refuses transitional assistance. A refusal and termination of services must be documented in the consumer's treatment record.

Chapter

3

Provider Requirements

General Provider Requirements

Payment for covered goods, care and services can only be made by AMHD to AMHD contracted providers for consumers and services.

Types of Providers

Contracted providers are individuals or private agencies within the State who provide a wide range of mental health and support services. AMHD has a contract with them to provide those services through fee-for-service or cost-based reimbursement.

- **Contracted Providers**

A *fee-for-service* arrangement is when an established dollar amount is paid for a particular service, such as through CPT or revenue codes.

Cost based reimbursement is an allocation of dollars based on program cost as stipulated in the provider contract.

- **Community Mental Health Centers**

The Community Mental Health Centers (CMHC) is funded by AMHD and have case managers, social workers, nurses, psychiatrists, and psychologists available statewide. CMHCs are located on all four of the major islands with clinics throughout the State. CMHCs help individuals with SMI that cannot pay for or find the mental health services they need anywhere else.

- **Hawaii State Hospital and other Contracted Inpatient Facilities**

Hawaii State Hospital (HSH) is a specialized psychiatric hospital run by the AMHD. It is a hospital for seriously mentally ill adults, and is primarily for persons who are court ordered to the care and custody of the Director of Health.

Community hospitals are hospitals within the community that provide general medical hospital services. Some community hospitals have staff to treat patients with mental illness. Specialty hospitals are psychiatric hospitals which provide evaluation and diagnosis, supportive counseling and psychotherapy, medication, medication adjustment, and help with discharge plans.

- **Provider Directories:**

For a copy of AMHD Purchase-of-Service (POS) contracted providers, and Community Mental Health Center Centers (CMHC's) go to the AMHD website at: www.health.hawaii.gov/amhd/

Requirements for Participation as a Provider

- **Licensed or Certified**

Qualified Mental Health Professionals (QMHP) are Psychiatrists, Clinical Psychologists, Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Mental Health Counselors and Advanced Practice Registered Nurses (APRN) in behavioral health licensed in the State of Hawaii. Permits, temporary licenses or any form of license or permit that requires supervision of the licensee do not allow the individual to be considered a QMHP.

The DOH must license or certify a medical or health-related institution or facility under the applicable public health regulations of the State and standards established by the State or Federal government.

Providers of any health care services must practice within the scope of his/her profession in accordance with State law. All providers must comply with all standards and all requirements.

- **General Conditions**

All AMHD providers shall comply with the State's General Conditions for health and human services, which may be accessed from the State Procurement Office's website, <http://hawaii.gov/spo/spoh/>

- **Warm and Welcoming Environment**

Service delivery and program planning must be done in accordance with the AMHD Policy on Warm and Welcoming.

All consumers seeking treatment, or already in treatment, with AMHD providers shall have services which are provided in a warm and welcoming environment manner. Clinical competencies in all programs and settings are written in human resource policies that require welcoming attitudes, accepting values, and skills in conveying empathy and hope to individuals served. Providers must include consumer involvement and feedback in all levels of service delivery.

- **Cultural Awareness Training**

Providers of direct service and those who provide supervision must participate in cultural awareness training on an annual basis. Providers must offer this training to their staff by using their own trainer or allowing their staff to participate in training opportunities in the community. Training topics must include aspects of diversity, which include, but are not limited to ethnicity, culture, language, religion, sexual orientation, and the unique needs of rural areas.

- **Acceptance of Payment in Full**

Providers must accept as payment in full, the amount paid by AMHD for AMHD contracted services. Providers may not seek any additional payment, in case or kind, from Medicaid recipients, Medicaid, or AMHD consumers, for the difference between the AMHD payment and a provider's charge except for third party payments and/or identified cost shares. If reimbursement by a third party exceeds the AMHD rate, the provider is entitled to the amount paid by the third party but must accept it as payment in full and not bill AMHD. If reimbursement by a third party is less than the payment would be from AMHD, the provider shall bill AMHD up to the AMHD reimbursement rate. If payment is received from a third party for services for which payment from AMHD has already been received, the provider must reimburse AMHD within thirty days of receipt of the double payment.

Medicaid Rehabilitation Option

The Medicaid Rehabilitation Option (MRO) is a program that allows certain specialized behavioral health services to Medicaid recipients to be paid using Federal Medicaid funds. The Medicaid agency in the State of Hawaii is the Med-QUEST Division, Department of Human Services. All AMHD contracted providers for these services must become MRO providers.

The services included as MRO Services are:

1. Community Based Case Management-Recovery Services (CBCB-RS);
2. Crisis Mobile Outreach (CMO);
3. Crisis Support Management (CSM);
4. Licensed Crisis Residential Services (LCRS);
5. Intensive Outpatient Hospital Services (IOHP);
6. Specialized Residential Service Program (SRSP);
7. Financial Management Services (Representative Payee);
8. Club House;
9. Peer Support Services;

10. Supportive Employment; and
11. Supportive Housing.

- **MRO Provider Certification & Accreditation**

To ensure a standardized process for the provision of MRO Services to Medicaid fee-for-service recipients in the State of Hawaii, the Med-QUEST Division requires certification of all agencies providing MRO Services. AMHD is responsible for administering the MRO Provider Certification process on behalf of the Department of Human Services, Med-QUEST Division.

All agencies providing MRO Services must receive organizational and service-specific certification. Organizational certification assures that the agency has the appropriate infrastructure to provide one or more MRO Services. Accreditation or certification by a national accrediting/certifying organization that is appropriate for the specific service being provided is required. Examples of accepted accrediting bodies are:

Joint Commission (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF), the Commission on Accreditation (COA), Utilization Review Accreditation Commission (URAC); Clubhouse International Accreditation (CIA), or National Committee for Quality Assurance (NCQA). If the agency is not accredited at the time of the MRO certification application, accreditation must be obtained within the time period specified in their AMHD contract. Agencies must be certified to provide all of the MRO Services for which a provider is contracted.

AMHD may perform an onsite survey of any applicant. An onsite survey may occur when:

1. The applicant is a new AMHD contracted agency (e.g. has not contracted with AMHD in the past 12 calendar months); or
2. The application is for a new service for an agency.

After a desk review and/or an onsite survey, AMHD shall notify the applicant of:

1. Certification awarded;
2. More information needed which shall start the process again; or
3. Denial of certification.

Notification of Change in Provider Information

Providers are required to notify AMHD sixty (60) days in advance in writing of a change of any contact information, such as addresses of service sites, closure of a site, addresses for correspondence and claims payment, and new phone and fax numbers. Providers are required to notify AMHD of these changes via the *AMHD Provider Contract Change Form* available in the "Provider Forms" section of the AMHD website (<http://www.amhd.org/>).

Any change in ownership or sub-contracting of any portion of contracted services to another organization must be reported to AMHD immediately in writing. Consumer treatment, fiscal, and administrative records must continue to be maintained.

Accreditation

Providers who are required by contract to obtain national accreditation or certification must inform AMHD of any changes or renewal of their accreditation status when they are notified by the accrediting body.

Credentialing

Providers are expected to have a credentialing process that ensures that only appropriately qualified individuals are involved in the care and treatment of AMHD consumers. The Provider's credentialing process must include primary source verification for staff that provide direct clinical care or provide clinical supervision.

Primary source verification functions must include:

1. Verification of Hawaii State licensure and/or certification (if applicable);
2. Verification of Education/Board Specialty Certification;
3. Verification of work history (at least 5 years);
4. Verification of Drug Enforcement Agency (DEA) and Controlled Substance Registration Certificate (CSC), (if applicable);
5. Verification of any restrictions or revocations from Federal agencies such as the Office of the Inspector General (OIG), Center for Medicare/Medicaid Services (CMS), the Department of Health and Human Services or State agencies;
6. Verification of admitting privileges (if applicable); and
7. Malpractice insurance (if not covered by employer and a licensed health care professional) of \$1 million per incident and \$3 million aggregate.

The credentialing process is expected to be completed and the individual be in good standing prior to the individual providing any clinical services to AMHD consumers.

The re-credentialing process must occur every three (3) years to re-verify licensure, restrictions or revocations, and malpractice insurance.

Any providers delegating a function of the provider's contracted services must receive prior written approval from AMHD before subcontracting and ensure that the subcontractor's contract has performance provisions indicating:

1. Credentialing process is as rigorous as outlined above;
2. Language in the contract that indemnifies the State of Hawaii;
3. Allows access to files (clinical and administrative) by AMHD and its agents and representatives and, for MRO Services, to CMS, the Medicaid Investigations Division (MID) of the Department of the Attorney General, the Med-QUEST Division, the OIG and their agents and representatives;
4. Audits the subcontracted delegated entity annually and monitors delegated functions; and
5. Meets all the performance specifications required by AMHD for those functions delegated.

Confidential Communications and Disclosure Requirements

- **Confidential Records**

AMHD providers must maintain confidential records on each consumer receiving services pursuant to Section 334-5, Hawaii Revised Statutes, 43 U.S.C. sections 290dd-3 and 290ee-3 and the implementing Federal regulations, 42 C.F.R. Part 2, and any other applicable confidentiality statute or rule. The records shall be made available to AMHD, its agents and representatives, and, in the case of Medicaid reimbursable services, to CMS, the Med-QUEST Division, the MID of the Department of the Attorney General, and the OIG and their agents and representatives, upon request without prior consent of the consumer. Failure to provide access to records by the provider shall be considered a material breach of the contract and may result in contract termination or affect future procurement of AMHD services.

- **Consumer Consent**

Providers must obtain consumer consent for persons served and services funded by AMHD. Consumer consents shall include, but not be limited to, consent for evaluation and treatment, consent to release information to other service providers as needed for continuity of care, and other consent documentation as needed.

Providers are expected to comply with all security and privacy standards which include a system and process to protect consumer Protected Health Information (PHI), and to conform with electronic coding where it relates to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) code set and transactions rule.

- **Privacy Notice**

Providers shall create, distribute, and update their privacy notice as required by the HIPAA.

Standards of Conduct

Provider agencies should adhere to their published mission, vision, and code of ethics. Provider agencies, their employees, and subcontractors must not have any conflict of interest, direct or indirect, which would interfere with their performance. Providers who offer AMHD contracted or complimentary representative payee services should be especially careful to adhere to standards of conduct and avoid any conflict of interest. Providers cannot charge, solicit, accept, or receive, any amount in the form of a gift, money, donation or other consideration otherwise required to be paid as a condition of a consumer's admission or continued services except in cases where the consumer has to pay a cost share. Professional clinical staff is expected to follow the professional code of conduct for their given discipline.

Provider agencies shall not knowingly hire any persons who are currently or have been employed by AMHD within the past twelve months to assist or represent them in matters in which he/she participated as an AMHD employee.

During the procurement activities, provider agencies shall not knowingly hire or otherwise enlist the services of any former AMHD employees within twenty-four months of separation date from AMHD if he/she participated in procurement activities for AMHD. Provider agencies or their employees cannot offer or give any gift, money, or anything of value or any promise of doing so to any AMHD employee.

It is AMHD's expectation that the AMHD contracted providers shall make every best effort to collaborate and partner with other contracted providers to resolve inter-agency conflicts, i.e., difference of opinion or management style between agency staff, miscommunications, etc. AMHD Provider Relations should be contacted as a last effort to assist in conflict resolution when a consumer's quality of care is negatively impacted.

Fiscal Integrity

Provider agencies must be financially solvent in order to assure AMHD they have the ability to perform their contracted obligations. It is the responsibility of contracted providers to manage their resources effectively. Providers shall be monitored by AMHD on a regular basis. Provider agencies are required to have an annual financial and compliance audit of their financial statements relating to their Agreement. Providers expending federal funds may be required to have an A-133 audit. Upon request, providers shall be required to submit a copy of their annual audit to the AMHD Fiscal Office.

Utilization Management Program

A Utilization Management (UM) program assures that appropriate services are provided at an appropriate level of care for the appropriate length of time in a timely and cost-effective manner. The UM program is broken into two distinct functions Utilization Management and Eligibility Assessments.

- **Eligibility Assessment**

AMHD ensures that members of the population who meet the age, insurance coverage, income, and residency status requirements are provided a timely standardized assessment to assist in determining eligibility.

AMHD uses a clinical eligibility assessment protocol that:

1. Includes assessment instruments that are approved by AMHD and include assessment of risk, functional level, substance use and diagnosis;
2. Are administered by assessors who are at least master's level, independently licensed behavioral health clinicians who have completed AMHD competency-based assessment training;
3. Are available in each county for in office assessments, during normal working hours;
4. Are monitored by AMHD Assessments for timeliness and quality of assessments based on AMHD standards;
5. The AMHD Eligibility Line is responsible for screening and scheduling eligibility determinations with a Community Mental Health Center (CMHC); and

6. If a consumer is found eligible for AMHD services the Eligibility Line will authorize case management services.

- **Utilization Management Review**

AMHD UM reviews medical necessity using established criteria, and evidenced based assessment tools. These reviews may take the form of:

1. Prospective reviews, otherwise known as Prior Authorization requires that a provider obtain approval from AMHD UM before a service may start;
2. Concurrent reviews or continued stay authorization requires that the provider submit a service authorization to AMHD UM in order to request to extend a previously authorized service past its current expiration date. The provider may request continued stay authorization sixty (60) days prior to the expiration date of the current authorization; and
3. Retrospective reviews are when AMHD UM evaluates if a previously authorized service met clinical necessity.

If a Prospective, Concurrent, or Retrospective review by AMHD UM determines that a service was not medically necessary, AMHD UM may issue a denial, partial authorization or reduced the intensity, or duration of a service.

The Provider, its employees or contractors shall not attempt to collect the reduced or denied payments from the consumer.

All services must be requested within thirty (30) days of initiating the service and AMHD may take up to thirty (30) day after receipt of a completed service authorization request to authorize the service.

- **AMHD Utilization Management Documentation Requirements**

1. Request for services must be submitted in writing using the *AMHD Service Authorization Request* form available in the “Provider Forms” section of the AMHD website (<http://www.amhd.org/>) or by using AMHD’s web-based authorization system.
2. Requests for services must be prior-authorized, and must be submitted in writing to AMHD UM prior to the expected date of admission to the specific program. Documentation must be submitted by the program providing the service.
3. Service authorization requests must be filled out legibly and completely. The provider may not add additional fields, categories or otherwise amend required fields on a service authorization request.

- **Utilization Management Retrospective Record Review**

AMHD UM Specialists are responsible for the system’s day-to-day management of service utilization by individual consumer/provider and by the system as a whole. AMHD UM Specialists can provide both clinical and resource consultation to individual case managers and providers; however, the specialists shall not be responsible for placement of consumers in services or locations or for direct clinical supervision of any provider staff.

The purpose of record review at the AMHD UM level is to ensure that services are rendered at the appropriate levels of care. The primary focus of record review is the individual consumer or groups of consumers.

There are three (3) separate circumstances under which record reviews may occur:

1. On a yearly basis, a random sampling of records of persons served;
2. When there are questions about the clinical appropriateness of the service(s) requested during an initial or continuing stay request for authorization; and
3. When there is a need to review trends and outliers in utilization patterns (both under- and over-utilization). These reviews could be either service or provider specific and would be time limited. Either total populations or random samples may be used for the review.

- **Provider's Utilization Management Plan**

Each provider is required to have a Provider UM Plan. The plan shall detail how an agency monitors and tracks authorizations, as well as ensures that appropriate services are being provided to the appropriate consumers.

The provider has the responsibility to format and develop a Provider UM Plan that best suits the needs of the consumer and the organization. The plan must detail the formal system of ongoing UM and methods used.

A utilization management plan assures that appropriate services are provided at an appropriate level of care for the appropriate length of time in a timely and cost-effective manner. As part of their internal Provider UM Plan, every provider must have a system to ensure that all AMHD services have an AMHD authorization number and those requiring prior authorization before starting services have been prior authorized. They must also monitor internal data to identify and analyze potential under- and over-utilization of services and make determinations of appropriateness of services provided.

AMHD will deny payment for unauthorized or unregistered services or services that should have been prior- or retro- authorized or registered with AMHD.

The AMHD Performance Improvement program staff shall review this plan during the annual monitoring visit.

- **Transition between Providers**

Consumers have the right to request a change in providers, including changing individual practitioners within an agency. AMHD and its contracted providers shall attempt to accommodate such requests, whenever possible.

Quality Management Program

AMHD's Quality Management (QM) Program is founded on the Continuous Quality Improvement (CQI) model. AMHD requires all providers to have their own QM program and processes, which includes a Quality Improvement (QI) reporting committee. The QM program must be evaluated and updated annually.

Providers are required to participate in AMHD QM activities, including but not limited to sentinel event investigation, quality of care investigation, regular quarterly reporting, case reviews, specific data gathering and reporting, peer review, concurrent review, site visitation, special studies, monitoring, credentialing, and training. As part of their QM activities, providers are required to:

1. Establish a QM Program Work Plan annually and select goals and activities that are based on the annual program evaluation and are relevant to the AMHD consumer and problem area under review, with designated timelines for the project and indicate department/persons responsible for carrying out the project(s) on the QM Program Work Plan;
2. Provide for the periodic measurement, reporting, and analysis of well-defined process and outcome measures and performance indicators of the delivery system.
3. Establish a system for tracking and resolving consumer complaints, grievances, and appeals;
4. Establish a process of regular and systematic treatment record review, using established review criteria;
5. Establish a method to assure that services are available and accessible to consumers, including reasonable waiting times;
6. Establish a method to assure that services are delivered in a manner that is sensitive to a consumer's cultural needs;
7. Establish and maintain policies and procedures required by AMHD;
8. Provide a mechanism for training staff on topics required by AMHD and maintaining documentation of such training;
9. Create a consumer handbook/orientation brochure(s) that outline services available to the consumer, hours of operations, contact information (phone numbers, and instructions on emergency services), is written at a sixth grade reading level, provides an overview of the provider's approach to care, and clearly outlines any major program rules that could lead to discharge from services offered by the organization;
10. Provide a method for assuring that consumers are informed of their rights, including the right to file a complaint, grievance, or appeal a service delivery decision;
11. Provide a method for assuring that consumers are involved in their service planning; and
12. Indicate how it will use the information from the above activities to improve its services.

- **Required Reporting**

The QM reporting requirements provide:

1. Information on the activities and actions of the provider's QM and related programs; and
2. Performance measures.

In addition to the above mentioned activities, providers are required to report to AMHD the following:

1. Direct care personnel changes within thirty (30) calendar days;
2. Written notification of suspected fraud within thirty (30) calendar days of discovery;

3. Direct care staff to consumer ratios; and
4. Direct care staff turnover rates.

The AMHD reserves the right to request additional data, information and reports from the provider, as needed, to comply with external requirements and for its own management purposes.

- **Provider Participation**

AMHD holds regular meetings with AMHD providers. These meetings are informational and used to discuss policies, procedures and current initiatives so providers are aware of the services available through the AMHD system and how providers and consumers access these services. Providers include physicians and non-physicians.

- **Delegation**

Any delegation of QM activities by an AMHD provider does not relieve the provider of the responsibility to ensure that the delegated function is performed according to AMHD standards, policies, procedures and other AMHD contractual guidelines. Any delegation and subcontracting must have prior written approval from AMHD before contract finalization and implementation. Appropriate structures and mechanisms must be in place to ensure accountability and responsibility by the organization delegating the responsibility. AMHD maintains an oversight role and is ultimately responsible for all activities and services to AMHD funded consumers.

- **Quality Management Evaluation Instrument**

The *Quality of Life Interview (QOLI)* instrument samples important areas in a consumer's life and measures the consumer's perspective of their experience. It is an outcomes measure which helps the provider and AMHD to consistently monitor and improve services as needed. The *QOLI* must be administered at intake, every six (6) months thereafter, and at discharge. The time of administration must be circled on the instrument. The data must be captured using software provided by AMHD.

Treatment Records Management

A treatment record shall be developed for every consumer receiving clinical services from AMHD providers. Every provider organization shall develop policies and procedures for treatment record organization, time frame for each type of record entry, responsibility for the control of records including ease of retrieving medical records, confidentiality, handling of missing records, criteria for active, inactive, and closed cases, electronic record standards if appropriate, and compliance monitoring.

All clinical documents generated by AMHD providers about an individual consumer shall be part of the consumer's treatment records.

All treatment records shall be maintained in a protected and confidential manner consistent with Federal, State, and AMHD regulations.

- **Record-Keeping System and Standards for the Availability of Treatment Records**

1. Treatment records shall be accessible to authorized persons only. Authorized persons include members of the staff who are providing direct and indirect services to the consumer; and those who may be administratively authorized, including AMHD, regulatory personnel and other State or Federal reviewers.
2. Consumers may have access to their treatment records, pursuant to Federal and State regulations.
3. Although duplicate treatment records may be available at multiple sites, there must be a centrally located treatment record which is current and complete. The centrally located treatment record is a legal document and contains the original documents.
4. Treatment records shall be maintained for a minimum of seven (7) years after the last entry data, except in the case of minors whose records shall be maintained for a period of seven (7) years after the minor reaches the age of majority. Basic information from the medical record is required to be retained for twenty-five (25) years after the last entry, except in the case of minors, whose records shall be retained during the period of minority plus twenty-five (25) years after the minor reaches the age of majority.
5. All pages of the treatment record shall be secured in order to avoid the loss of records or inadvertent disclosure.

Basic information from the records of an outpatient provider shall include the consumer's name and birth date, current address, a list of diagnoses and intrusive treatments, a history of all drugs prescribed or given. Basic information from a health-care facility shall include the consumer's name and birth date, dates of admission and discharge, names of attending physicians, medications ordered and/or administered, admission, current and discharge diagnoses, major procedures performed, operative reports, pathology reports, discharge summaries and current home address.

If records are destroyed after the required maintenance time period, destruction shall be accomplished in a manner which shall preserve the confidentiality of the information contained in the record, and the name of the person authorizing destruction shall be kept along with the basic information which must be retained.

- **Confidentiality of Treatment Records**

1. All privacy and security requirements of HIPAA, DOH policies and other Federal and State privacy laws shall be followed.
2. When not in use, records shall be filed in lockable cabinets, away from public access.
3. Authorized staff shall not leave unlocked file cabinets with records unattended during the normal work day. All records shall be returned at the end of the normal work day for filing. Access to electronic records shall be restricted and controls put in place to prevent accidental disclosure.
4. Computer screens with electronic records shall not face public areas or be accessible to unauthorized individuals. Records shall not be removed from any program or administrative facility during non-office/program hours.
5. Transported records must be under the direct control of assignee staff member(s) at all times and protected from inadvertent disclosure.

6. All closed records shall be filed in a designated, centralized “Closed Records” section in lockable file cabinets.
7. Records shall be kept in an area reasonably protected from water damage, fire, and/or other natural disasters, or hazards.
8. A system for monitoring the location of all records temporarily removed from the designated file locations shall be developed and implemented.
9. Procedures shall be developed for creation of backup files for electronically stored material(s).
10. A designated staff member shall be responsible for the overall management and control of records.

- **Improving the Quality of Treatment Record Keeping**

The QM program of each AMHD provider organization shall include a process for the internal review of records for compliance with treatment record standards, quality of service delivery, appropriateness of services, and compliance with billing requirements. The Provider’s QM committee shall also establish performance goals and track the provider organization’s progress in meeting the goals.

The process shall include a system for reviewing records to identify incomplete and/or inadequate records to assure their compliance with requirements.

- **Other Types of Records**

Providers who provide any sort of financial management of consumer funds shall maintain records and receipts and disbursements of the consumer’s funds by the provider such as ledger accounts, credits, debits, balances, and consumer signatures authorizing and acknowledging payments.

Cost report files of a provider shall contain reimbursable cost finding schedules and other financial and statistical data to support reimbursable cost, receipts and other primary source documentation to support data, and payroll records of all personnel, owners, and corporate officers.

- **Examination and Access to Records**

Access to records by AMHD, its agents and representatives, and for MRO Services, CMS, the Med-QUEST Division, the Department of the Attorney General including but not limited to the MID, the OIG and their agents and representatives shall be permitted by providers, their employees, sub-contractors and contractors without consumer consent. In the event that a provider is suspended or terminated, the same conditions apply.

The types of records which may be examined include, but are not limited to:

1. Records which disclose the type and extent of health care services or supplies provided to consumers including but not limited to progress notes, treatment plans, prescriptions, diagnostic testing, assessments, consultation reports, employee appointment books, or other schedules, and any other document used for the treatment and care of the consumer no matter who the payer is;
2. Records and invoices of services or supplies received or distributed;

3. Records of employee time sheets, payroll checks, and records; and
4. All contracts with employees, subcontractors, contractors, or consultants used to provide any service or part thereof claimed by the provider.

Providers shall make copies of any documents requested at no cost to the State or its agents or representatives. No provider, including terminated or suspended providers, shall refuse or fail to make available at the provider's place of business or appropriate location during normal business hours immediate access to all records.

Any records obtained by the State or its agents or representatives shall be kept in safekeeping and released to other State or Federal agencies according to applicable laws, rules, and regulations. When a provider fails to keep adequate supporting records as required by AMHD, the provider may be terminated from participation as an AMHD provider, future procurement if AMHD services may be affected, and the provider shall be referred for appropriate penalties.

Fraud and Abuse

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit. It includes any act that constitutes fraud under applicable Federal or State law.

Abuse means provider practices that are inconsistent with sound fiscal business and medical practices and result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

- **Types of Fraud and Abuse**

There are numerous types of fraud and abuse by providers and consumers. Common types include, but are but not limited to, the following examples:

1. Billing for services that were not provided include but are not limited to:
 - a. No Shows. Provider bills for services when consumer misses their appointment;
 - b. Up Coding. Provider provides services at one level and bills AMHD for a higher level of service;
 - c. Provider bills for services that were not provided according to AMHD contractual terms; and
 - d. Provider bills for services that are not billable or are part of an AMHD global fee (unbundling).
2. Billing for services not medically necessary including but not limited to:
 - a. Numerous return office/home/community visits not medically necessary (usually same problem without attempts to resolve consumers' problem using outside intervention);
 - b. Unnecessary referral of consumers (to receive a monetary kickback or promise of excessive referrals);
 - c. Intentionally submitting false or incorrect information to AMHD UM to obtain authorization; and
 - d. Intentionally keeping consumers in restrictive placements to benefit from the financial return.

3. Billing for services provided by another include but are not limited to:
 - a. Billing for services provided by unsupervised staff who are not qualified by AMHD standards with regards to education and experience;
 - b. Double billing for services provided by separate providers (one provider delivers services and bills AMHD for a global fee and a different provider bills for a partial payment of the same service already included in the initial global fee); and
 - c. Provider sends patients' blood to lab and the lab bills AMHD for a chemistry panel screening. Provider then bills AMHD for the same lab services included in the panel.
4. False statements including but not limited to:
 - a. When requesting AMHD authorization and payment, knowingly and willfully making, causing to be made, inducing or seeking to induce the making of, any false statement or representation of a material fact regarding:
 - i. Services provided to a consumer; or
 - ii. The actual status and need of a consumer.

- **Payment Suspension**

A payment suspension occurs when payment on claims that have already been processed is held in abeyance while there is an investigation to determine whether there has been involvement in a fraudulent activity, or in response to a refusal to participate in any monitoring, auditing, investigative process or improperly paid service.

Provider Compliance Program

Provider agencies are required to have a written plan for compliance which addresses fraud and abuse. The plan should identify the person or role in the agency that is responsible for overseeing the plan to include, a baseline audit at regular intervals, a tracking system, a compliance committee and at least an annual review. It is strongly recommended that provider agencies conduct their own fraud and abuse risk assessment in order to identify practices that may encourage inappropriate claims, such as employee billing incentive programs.

Through its compliance program, the provider agency should identify employees, subcontractors or providers who may be committing fraud and/or abuse. These activities may include, but are not limited to: monitoring the billings of its employees, subcontractors or providers to ensure consumers receive services for which the provider agency and AMHD are billed; monitoring the time cards of employees that provide services to consumers under cost payment arrangements; investigating all reports of suspected fraud and over-billings, monitoring for over; or under-utilization; verifying with consumers the delivery of services, and reviewing and trending consumer grievances regarding employees, subcontractors and providers.

The provider agency must report in writing to the AMHD Business Compliance Officer, instances in which suspected fraud has occurred within thirty (30) days of discovery. The provider agency shall provide any evidence it has on the billing practices

(unusual billing patterns, services not rendered as billed and same services billed differently and/or separately). If the billing has not been done appropriately, the provider agency shall notify the AMHD Business Compliance Officer in writing of its findings, adjustments made to billings, and education and training provided to prevent future occurrences.

- **Investigation of a Violation**

AMHD shall conduct a preliminary investigation of all complaints of contract violations including fraud and abuse received from all sources. If the findings support full investigation, a referral shall be made to agencies external to AMHD depending on the nature of the suspected violation. An investigation shall be considered ongoing until legal or civil action is taken, the case is closed due to insufficient evidence, or the matter is resolved between AMHD and the provider.

Consumer Protection

Consumer Protection (CP) is a systematic, organized effort to reduce the likelihood of harm to consumers, providers, the organization, and the public. The providers must develop and implement a comprehensive consumer protection program that addresses the goals and objectives listed below. The program should seek to ensure that the possibility of adverse events/harm is reduced through early identification of actual or potential problems, the use of appropriate interventions, and outcome monitoring.

The goals of the provider's CP program are to:

1. Develop and implement appropriate CP policies and procedures that address all areas of risk;
2. Ensure conformance to statutory and regulatory requirements;
3. Evaluate the effectiveness of CP activities;
4. Ensure staff are educated to risk standards and providers have the internal capacity to identify and analyze consumer sentinel events, and implement risk-reduction strategies as appropriate;
5. Provide feedback to AMHD that supports efforts to improve quality; and
6. Provide regular review of the CP process.

Objectives are to:

1. Create a standardized process and clinical expectation that risk assessment is an integral part of daily clinical interventions;
2. Ensure that identified risk issues are included in the ISP;
3. Ensure that risk occurrences after intake are documented, the incident assessed and the ISP modified as needed;
4. Ensure that case managers and other non-QMHP staff know when to ask for clinical intervention;
5. Ensure that providers have an effective procedure for the management of "high risk" individuals, and that risk information is accessible by all caregivers and AMHD staff when they need it;
6. Ensure prompt investigations and responses to incidents of abuse, neglect, death, or serious injury of any consumers within AMHD services;

7. Support an adequate number of trained individuals within each program to provide consumer protection oversight and program activities; and
8. Include any other activities necessary or likely to support consumer safety.

If a provider fails to implement a CP program or is identified as having significant and continual risk management issues, AMHD can request a review of the effectiveness of the provider's clinical/peer review and/or quality improvement process, or submit a report to the provider's State licensing agency that some review/investigation may be warranted.

- **Dedicated Resources**

The CP program should have appropriate clinical and administrative oversight and as such the following dedicated resources should be involved:

1. Provider/Program's Medical Director for clinical concerns;
2. Provider/Program's Administrator;
3. Provider/Program's QI Manager; and
4. Regular staff training on consumer protection.

Consumer Abuse and Neglect

AMHD is committed to zero tolerance for any abuse or neglect of consumers receiving services. Any suspected case of physical, emotional or financial abuse or neglect of an AMHD consumer must be reported immediately upon discovery to Adult Protective Services, to Child Protective Services if the case involves suspected abuse of a child, and to AMHD Performance Improvement.

- **Sentinel Events**

Providers are required to report sentinel events, as defined in AMHD Sentinel Event policy. AMHD providers are required to report all consumer sentinel events to the AMHD Performance Improvement (PI) unit by the next business day by faxing the completed Sentinel Event form to (808) 453-6939.

In the event of unexpected death of a consumer the provider shall verbally report the event immediately to the AMHD Crisis Line of Hawaii and follow up with a completed Sentinel Event form faxed to the AMHD PI unit by the next business day.

AMHD providers shall ensure that staff is knowledgeable of sentinel event reporting requirements. AMHD providers shall develop the internal capacity to identify and analyze consumer sentinel events and incidents including the capacity to investigate and analyze root cause and to implement risk-reduction strategies as appropriate.

AMHD provider documentation concerning sentinel events and incidents shall be maintained in administrative files separate and apart from clinical records that shall be available to AMHD immediately upon request. AMHD providers shall maintain a record of all consumer sentinel events, noting consumer's name, date of occurrence and sentinel event-type.

Provider Monitoring, Audits, and Site Visits

The monitoring and auditing of providers and their subcontractors by the AMHD utilizes a standardized process to evaluate providers of services and programs funded by the AMHD and the Department of Human Services MRO.

The AMHD PI and Business Compliance develop and direct all processes related to the monitoring and evaluation of services and programs furnished by AMHD contracted and public providers:

1. All providers of AMHD funded and MRO funded programs and services shall be monitored on a regular basis and at any other time as deemed necessary. The AMHD monitoring team shall have access to all records and documents necessary to verify compliance with AMHD standards, and may conduct interviews with staff, consumers and other AMHD service providers;
2. The AMHD monitoring team(s) may include PI staff, Business Compliance staff, and Service Coordinators, as appropriate;
3. Monitoring activities shall include, but are not limited to, an evaluation of:
 - a. Program policies, procedures and other service documents;
 - b. Program Staffing and Human Resource documents;
 - c. Review of Consumer records;
 - d. Interviews with provider staff;
 - e. Interviews with consumers;
 - f. Review of compliance with data requirements;
 - g. Quality Management Program and processes;
 - h. Utilization Management Program and processes;
 - i. Consumer Protection Plan;
 - j. Compliance Program and processes; and
 - k. Billing/claims review, including a claims audit.
4. The tools to be used in the PI monitoring shall be developed from the AMHD contract in force for the time period to be monitored. The contract is composed of the Request for Proposal (RFP), the RFP appendices, written questions and answers to the RFP, RFP amendments, the provider proposal, the executed AMHD contract and contract amendments. All memoranda, directives, provider manual, and other relevant documents are considered part of the contract and shall be additional sources for tool development. Non-contracted MRO providers shall be held to AMHD programmatic, operational, and fiscal requirements;
5. The monitoring tools shall be developed with a designation of items which are key indicators of contract requirements and quality service delivery, and items which supplement those key indicators with additional detailed information. Monitoring may also include pilot questions for data gathering which are not scored;
6. All MRO providers and other AMHD contracted providers shall be monitored by the AMHD Business Compliance team annually regardless of previously achieved audit findings. Additional business compliance monitoring, audits or investigations may be required by AMHD based on monitoring findings/results or other reported business compliance issues;

7. A copy of all the monitoring tool(s), list of documents needed for review, and interview questions that will be used for provider staff or consumers, and the exact dates of service that the monitoring period will review shall be mailed or sent by facsimile to the provider. All materials requested must be available at the time of the monitoring;
8. AMHD may review records on site but reserves the right to request copies made of any documentation subject to review;
9. AMHD reserves the right to schedule a site visit at any time during agency work hours for monitoring and to present a list of the consumer records and tools to be used at the start of the on-site visit;
10. The provider shall designate an individual who will orient the review team(s) to the program(s) being reviewed and consumer records. It is the responsibility of the provider to ensure that a representative who is knowledgeable about the organization's documentation and records shall be available to the monitoring team(s) to answer any questions;
11. Supporting documentation to verify compliance with requirements may include, but is not limited to:
 - a. Agency policies and procedures for the specific service reviewed;
 - b. QM, UM, Compliance Programs and their associated annual reviews, work plans, and committee meeting minutes;
 - c. Current staff roster for each service site and staffing schedule for each service site including on-call coverage if appropriate;
 - d. Human resource records to verify staff credentials (licensure, education and experience);
 - e. Schedule of rehabilitation programming and structured activities for each service site, and resource material utilized to design activities if appropriate to the service being monitored;
 - f. Attendance log for rehabilitation programming and structured activities for each service site if appropriate to the service being monitored;
 - g. Clinician appointment books or other schedules for individually billed services;
 - h. Consumer grievances and appeals, including policies and procedures, tracking logs and response letters;
 - i. Consumer incident reports and sentinel event reports and associated documentation of investigation and follow up actions;
 - j. Consumer Satisfaction Surveys for the service including; hard copy of individual surveys, aggregate data, and resulting quality improvement opportunities identified and actions undertaken;
 - k. Staff training records for the service, attendance log for in-service training, records of training attended off-site;
 - l. Documentation of clinical supervision of direct care staff by the service QMHP, as appropriate;
 - m. Consumer Clinical Records for AMHD funded consumers only;
 - n. Medication Administration Record (MAR) for the service site as appropriate;
 - o. Demographics
 - p. Annual Assessments/Evaluation/Updates
 - q. Individual Treatment plan/Master Recovery Plan/Crisis Plan
 - r. Progress notes

- s. Physician Medication Order sheets; and
 - t. Electronic or hard copies of the detailed Remittance Advice (RA) from consumer's primary insurance for each business compliance date.
12. The provider shall receive a written report summarizing the findings of the AMHD monitoring team;
 13. Providers who wish to dispute the monitoring findings must do so in writing, identifying the specific finding(s) that are in dispute, the rationale for the disagreement with the finding(s), and attaching any additional supporting documentation. Providers may submit additional written documentation that existed and was in force during the period under review but was not made available to the monitoring team during the review. However, AMHD will not consider any documentation that was created or implemented after the start of the monitoring review;
 14. AMHD may determine that additional information is necessary in order to verify the implementation of corrective actions or to determine the extent of a critical deficiency. AMHD may require the provider to submit additional documents to AMHD for review. AMHD may also schedule an additional monitoring or audit visit. The timing of these actions shall be dependent on the immediacy of the corrective actions required; and
 15. AMHD monitoring and auditing shall be conducted on given dates unless it conflicts with a licensing/certification/accreditation survey site visit or other governing/regulatory agency audit.

Provider Grievance and Appeal Process

Every contracted provider has the right to appeal an adverse action. If the provider who filed a complaint is not satisfied with the results, they may file an appeal through AMHD Provider Relations.

All appeals by providers shall be in writing and sent with supporting documentation to the AMHD Provider Relations unit at the following address:

Department of Health
Adult Mental Health Division
Grievance and Appeals Coordinator
1250 Punchbowl Street, Room 256
Honolulu, HI 96813
Phone: (808) 586-4109; Fax: (808) 586-4745

Chapter

4

Claims

General Guidelines

When claims are submitted for payment the provider is certifying that:

1. Service(s) are performed in accordance with Federal and State laws, rules, policies, and AMHD standards and requirements;
2. Service(s) claimed were medically or clinically indicated and necessary for the health of the consumer. The provider is responsible for determining the necessity of the service(s) subject to AMHD UM review;
3. Service(s) claim is accurate and the provider has written documentation to support the claim; and
4. Provider staff is qualified to provide the service(s) in accordance with AMHD contractual requirements.

Claim Forms

Depending on the service provided, either a paper CMS 1500, a paper UB-04, State office procurement form, or an electronic format may be used to bill for authorized services. All health services fee-for-service claims shall be submitted using a HIPAA compliant format. There are no exceptions to this Federal requirement. This assures uniformity in billing and reduces the chances of errors. Electronic billing is recommended in order to expedite payment, decrease errors in processing, and improve provider tracking of claims status. The subsection in this chapter that discusses electronic billing contains more information. The following claims forms are approved for filing claims for services or goods to AMHD consumers:

Unit Rate Invoices:

1. CMS 1500;
2. 837 Professional for Outpatient and Residential Services;
3. UB-04 for Inpatient Services; or
4. Web interface.

Cost Reimbursement Invoices:

1. AMHD Form 210, Report of Actual Expenditures/Invoice; and
2. AMHD Form 210A, Report of Actual Expenditures, Personnel Cost-Salaries and Wages.

- **Form Availability**

CMS 1500 and UB-04 claim forms can be ordered from the U.S. Government Printing Office. In addition, forms can be ordered from vendors in Hawaii.

SERVICE	TYPE OF BILLING FORM		
		CMS 1500	UB-04
24-Hour Supervised Group Home		X	
8-16 Hour Group Home		X	
Acute Inpatient Psychiatric		X	X
AMHD Eligibility Determination			
Assessment Services			
Community Based Case Management		X	
Crisis Mobile Outreach		X	
Crisis Support Management		X	
Day Treatment for Persons with a Dual Diagnosis		X	
E-ARCH		X	
E-ARCH RN Case Management		X	
Inpatient One to One		X	X
Inpatient Psychiatric		X	X
Intermediate Care Facility		X	X
Licensed Crisis Residential		X	
Mental Health Service Plan Development – Non-physician		X	
Peer Coaching		X	
Psychosocial Rehabilitation		X	
Representative Payee Services			
Skilled Nursing Facility		X	X
Specialized Residential Services		X	
Supportive Employment		X	
Therapeutic Living Program		X	

Procedure and Diagnosis Codes

Diagnosis Codes are based on the International Classification of Diseases, Tenth Revision, and Clinical Modification (ICD-10) and are the only diagnosis codes recognized by AMHD. The only accepted procedure codes for health care services are the CMS Healthcare Common Procedural Coding System (HCPCS).

HCPCS includes current year Current Procedural Terminology (CPT) codes, CMS codes, and State-assigned codes. Local modifiers that are designated by AMHD as required codes for billing must be used where specified. AMHD may add local codes for services which are non-health care services or for which no description exists within the HCPCS Taxonomy for internal use only. It is the responsibility of each provider to use accurate coding, including diagnosis codes. It is expected that if there is a change in diagnosis, the correct code shall be used for each claimed date of service.

Third Party Liability

- **Determining Third Party Resources**

Providers must request and record health insurance coverage information from all consumers and submit this information to AMHD UM when requesting authorization of services and submitting claims. QUEST Integration and Medicaid fee-for-service coverage can be verified through the use of one of the eligibility verification processes offered by the Department of Human Services, such as the Automated Voice Response System (AVRS).

All providers are required to follow the utilization requirements and bill other payers first for AMHD services that is covered by the payer and wait for payment or rejection notification before billing AMHD. Other payers may include commercial managed care health plans such as Hawaii Medical Services Association (HMSA) and Kaiser Permanente, Med-QUEST Division's Community Care Services (CCS), one of the Med-QUEST Division's QUEST Integration managed care health plans, the Veterans Administration (VA), or TRICARE. AMHD shall not pay for services that are rejected because the provider did not follow the administrative rules of the other payer. Claims that have been rejected by another payer must have the rejection attached to the claim showing the reason for the denial such as patient ineligible, not a covered benefit, etc. AMHD shall not pay for services that would have been covered by the payer if the consumer utilized their network of providers.

Third Party Liability (TPL) payment information must be submitted on claims sent to AMHD in the field allocated:

1. If there is insurance primary to AMHD, enter the insured's policy or group number and proceed to fields 11 a-d (If field 11d is marked – complete 9 and 9 a-d, otherwise leave blank).
2. Fields 4, 6 and 7 must also be completed if there is insurance primary to AMHD.

Claims for consumers with third party coverage that do not indicate a third party payment or denial shall be rejected to bill the third party.

- **Medicaid Rehabilitation Option Program**

Medicaid reimbursement under the MRO shall be administered by AMHD. AMHD shall receive federal Medicaid money from the Med-QUEST Division based on the paid claims data submitted to Med-QUEST by AMHD.

- **Medicaid Enrollment Program**

Case management providers shall complete a Medicaid application for uninsured consumers at the time of the first appointment.

Claims Submission

Provider billing must include the consumer's name exactly as it appears on the AMHD authorization letter, home address (current for the date of service), authorization number, consumer number, procedure code and modifiers, service description, service amounts/units, diagnosis code, provider agency identification number, rendering provider name with National Provider Identifier (NPI) or other identification number, and date of service. Only one date of service per line may be used for billing. A range of dates may be used only for a contiguous date range of per diem services. By using this standardized method of billing, claims can be adjudicated more efficiently and required data is assured of being included on the invoice.

- **Hard Copy Claims**

All claims or encounter data for health care services shall be submitted in a HIPAA compliant format.

Cost reimbursed services should be billed using AMHD Form 210, Report of Actual Expenditures/ Invoice, and AMHD Form 210A, Report of Actual Expenditures, Personnel Cost-Salaries and Wages.

Hard copy claims may be **mailed to:**

Department of Health
Adult Mental Health Division
P.O. Box 3378
Honolulu, HI 96801-3378; **or**

Hand delivered to:

Department of Health
Adult Mental Health Division
1250 Punchbowl Street, Room 256
Honolulu, HI 96813
Attention: Fiscal

- **Electronic Claims**

Electronic claims must be submitted via SharePoint. All providers shall participate in AMHD's testing and certification process and sign a user agreement prior to gaining access to SharePoint. Providers shall inform AMHD of changes in personnel to ensure that only current employees have a logon to their SharePoint site.

- **Consumer Identification Number**

Each consumer has a reference number which is a unique identifier number for the consumer that is to be used when billing for services. This number is printed on the authorization letter or may be requested from the AMHD UM staff. Medicaid and other insurers have their own unique identification number for their members and that number must be used for billings to those payers. Any identifying number(s) that are not on the claim will result in the claim being denied and returned to the provider.

- **Provider Numbers**

Each provider, whether an agency or an individual has an AMHD provider identification number (PIN) and this number shall be used on all AMHD claims.

- **Filing Deadline**

The claim filing deadline is defined in the AMHD Purchase of Service Agreement. Please reference your Agreement for the guidelines.

- **Prior Authorizations**

It is the responsibility of the provider to assure that services have been authorized or registered. Authorization numbers are faxed to providers or may be provided through AMHD's web-based interface. If AMHD UM does not issue an authorization number, it is the responsibility of the provider to follow-up with AMHD UM. Retro-authorizations shall be considered within thirty (30) days of the first date of service. AMHD UM shall not retro-authorize services beyond thirty (30) calendar days after the first date of service. Claims that do not have the required authorization number shall be denied payment.

Provider Appeals of Claims Payment

Please contact AMHD Provider Relations for a copy of the current AMHD policy. A provider may file a claim appeal only for the following reasons:

1. Claims not paid for authorized services;
2. Claims not paid at the contracted amount (underpayment or overpayment for services); or
3. Claims not paid in a timely manner.

Corrected Claims

Invalid, incomplete or inaccurate claims shall be rejected and shall be returned to the provider. AMHD staff shall not correct claims for providers. Requests for payment are considered legal documents and the responsibility for accurate claims lies solely with the provider submitting the claims. Providers must factor sufficient time when submitting claims in case correction and re-submission is needed for payment.

The provider has thirty (30) days to re-submit corrected claims for reprocessing.

Additional Payment Requests

When submitting a claim for a particular day, it is the responsibility of the provider to ensure that all claims for services on that day are submitted on the same CMS 1500 claim form. **Multiple encounters on the same day shall be rolled up and reported on one claim line.**

Expediting Claims Processing and Preventing Common Errors

The following are some reminders that will assist in preventing common errors that will result in a denial of claims:

1. Use the correct consumer identification number;
2. Use the consumer name exactly as printed on the AMHD authorization letter;
3. Include the address where the consumer resided on the date of service;
4. Validate consumer's date of birth;
5. Use correct and current diagnosis codes, HCPCS codes and revenue codes;
6. Use correct provider identification number;
7. Use correct rendering provider identification number;
8. Submit claims only for eligible consumers;
9. Submit original claims within the filing deadline (365 days from the first date of service);
10. Use the correct authorization number for the billed dates of service;
11. Bill all encounters with the same billing code for a day as one line item; and
12. Service line charges must add up to match total charge.

Pricing and Payment Processing

Services with contracted fee-for-service charges shall be paid according to the AMHD fee schedule. General excise tax is not paid. The fee schedule reimbursement rates shall be all inclusive. Cost-based reimbursement payments shall be made in monthly installments upon the monthly submission of AMHD Form 210, Report of Actual Expenditures/Invoices and AMHD Form 210A, Report of Actual Expenditures, Personnel Costs – Salaries & Wages. Payments are for services provided for the billing month in accordance with the scope of services and with the costs identified in the approved budget per contract.

Editing Process

Optimally, the claims system is to apply all edits during a single processing cycle. If certain information is missing, incorrect, or invalid, completion of the entire processing cycle may not occur. When a claim fails an edit, an error message is displayed in the claims section of the Explanation of Benefits or Remittance Advice (RA).

The claim may stop processing if the claim requires medical review. If that is the case, the claim will be pended to AMHD UM for review. The reviewers may request documentation from the provider to support the claim such as progress notes, treatment plans, or other materials.

The claim will be denied if the data required for processing is complete but the provider is not registered as a provider or the consumer is not eligible for services on the date of service claimed.

Adjustments, Voids, and Resubmissions of Claims

A Claim Reference Number (CRN) is assigned to all claims when first submitted to AMHD. The CRN does not change no matter how many times the claim is resubmitted or adjusted. When submitting documentation, the CRN of that claim should be written on the documentation to help AMHD link the documentation to the claim. The documentation could be requested for medical review, denial by a third party payer, or other materials.

Providers shall also provide the CRN when resubmitting, adjusting, or voiding a claim. If the claim is resubmitted without a CRN, the claim may be treated as a first time claim and may not pass the filing deadline and/or the claim could also be denied as a duplicate claim.

A great deal of effort is made by AMHD to ensure accurate claims payment, however, adjustments may be necessary based on incorrect eligibility data, post payment fiscal reviews, or a retroactive denial of a service or payment by the medical reviewers.

Overpayments and Recoveries

If overpayments are identified by AMHD, notification is sent to the provider explaining the reason for the overpayment and the amount involved. Overpayments shall be deducted from the provider's future AMHD payments until the overpayment is paid back.

Providers shall notify AMHD if they discover any overpayments. If the overpayment is confirmed, AMHD shall initiate a take back of the overpayment amount by deducting this amount from the provider's future AMHD payment(s) until the overpayment is paid back in full.

Duplicate payments from other insurers or payers shall be reported to AMHD within thirty (30) days of receipt of the payment by submitting a void or adjustment claims. If the overpayment is confirmed, AMHD shall initiate a take back of the duplicate overpayment amount by deducting this amount from the provider's future AMHD payment(s) until the overpayment is paid back in full.

Resubmissions

A provider may submit a request for payment or additional payment if records indicate a routine claim may have been rejected, or underpaid due to incorrect claim information such as service date, procedure code, or identification number. This would be considered a resubmission. Resubmissions shall be submitted within thirty (30) days of the receipt of the rejection or underpayment and should be marked **resubmission**.

The Remittance Advice

The Remittance Advice (RA) is sent to providers following claims processing with the mailing of the check. The RA lists the claim number, consumer name, consumer reference number, birth date, sex, authorization number, service category, dates of service, amount paid for all services, denials, and reasons for denials.

- **Electronic Remittance Advice**

An electronic RA in the 835 format shall be provided for all fee-for-service claims submitted electronically.

- **Electronic Claims Exception Report**

If the provider submits an electronic claim with an authorization number which does not match the consumer name or is otherwise not recognized by AMHD, an Exception Report listing the Batch Number, Consumer Name, Provider Name, Provider Tax Identification Number, Service Date, Procedure Code, Modifier, Date Error Occurred, and Reason shall be provided on hard copy to the Provider. Providers can resubmit an electronic claim identified on this report using the correct authorization number. The resubmitted electronic claim shall be submitted within thirty (30) days of the receipt of the Electronic Claims Exception Report.

Providers who need assistance with resolving items on their exception report can fax their questions, with a copy of the report, to Attn: AMHD Information Office at (808)236-8365.

- **Return-to-Provider (RTP) Form**

Claims that are not payable shall be returned by the AMHD Fiscal Office with a Return-to-Provider (RTP). The RTP informs the provider with the reason claims were not processed.

AMHD Payments

- **AMHD Payment Schedule**

The AMHD goal for payment of clean claims is thirty (30) days from the date of receipt. Although most clean claims are paid within thirty (30) days, additional processing time may be needed if claims have to be manually reviewed for medical necessity or to verify inconsistent claims information. If questions regarding possible fraudulent activities arise, payment may be suspended for up to one hundred eighty (180) days. AMHD checks are prepared by the State Department of Accounting and General Services (DAGS).

- **Expired Checks**

AMHD provider check payments expire within one (1) year of the date issued. Expired checks must be returned to the AMHD Fiscal Office with the completed appropriate form.

- **Lost Checks**

Lost AMHD checks must be reported to the AMHD Fiscal Office so that a stop payment request can be made and a replacement check issued. The AMHD Fiscal Office shall send the appropriate forms and instructions to the provider. This process can take several weeks before a new check is issued.

Claim and Payment Inquiries

Claim and payment inquiries may be made to AMHD via the *AMHD Provider Claim and Payment Inquiry* form available in the “Provider Forms” section of the AMHD website (<http://www.amhd.org/>).

- **Common Inquiries and Required Information**

Sufficient information is needed to appropriately assist providers in researching claims. The following information is needed: Provider name and number, consumer’s name, consumer’s identification number, authorization number, service date, charge on claim, claim number, payment date, or if not paid yet remittance date, and procedure code.

- **Waiting Period for Claim Status Inquiries**

Providers who have not received payment should wait thirty (30) days before asking about status since the volume of inquiries slows processing time. Claims are generally processed by thirty (30) days of receipt of the last submission, therefore inquiries before thirty (30) days shall be returned to the provider.

Fiscal Records Management

Providers shall, in accordance with generally accepted accounting principles, maintain fiscal records and supporting documents and related files, papers, and reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the provision of services to AMHD consumers. Costs to provide services and billing information shall be readily ascertainable from these records.

Providers shall make available at their local office, during normal working hours, any of the records of the contracted work for inspection or audit by any authorized agent or representative of AMHD or in the case of MRO services, the Med-QUEST Division and its agents or representatives.

Providers shall preserve and make available their fiscal records for a period of three (3) years from the date of final payment. If a provider is suspended or terminated, the records relating to the services shall be preserved and made available for a period of three (3) years from the date of any resulting final settlement.

Records related to appeals, investigations, litigation, or the settlement of claims, or exceptions taken by the Department of the Attorney General or the State Auditor or any of his/her authorized representatives, shall be retained by the provider for three (3) years after the appeals, litigation, claims, or exceptions have been resolved.

If the provider's business is sold or ends, the provider shall ensure the safe storage and accountability of these records for the time periods outlined above.

Fiscal Audits and Reconciliation

Provider agencies may be required to have an independent annual financial and compliance audit of their financial statements relating to their agreement. Providers expending Federal funds may be required to have an A-133 audit.

In addition, AMHD conducts fiscal monitoring of providers on a routine and as needed basis to ensure that contractual requirements are met and fiscal integrity is maintained.

Provider Billing to Consumer

- **Billing Limitation**

Providers shall accept AMHD payment(s) as payment in full. Providers shall not bill consumers for the difference between what they have been paid by AMHD and their charge or costs. Providers shall not bill consumers for services that are payable but were not paid due to provider non-compliance with authorization or claims procedures.

Providers shall not bill consumers for finance charges or no-show fees.

Consumers shall be informed by the provider that their services cannot be terminated by the provider for non-payment of co-payments, finance charges, no-show fees, and non-covered services or for receipt of services from unauthorized provider agency employees or providers.

- **Acceptable Billing Situations**

Consumers may only be billed for services that are non-covered services if the consumer has signed a written acknowledgement of financial responsibility prior to the time services are rendered. It is expected that providers will assist consumers in finding other funding sources to prevent unnecessary payment for services that would be reimbursable otherwise.

Providers must submit a rate schedule to AMHD which outlines charges made to consumers for service(s) rendered.



AMHD
ADULT MENTAL HEALTH DIVISION

PROVIDER MANUAL

APPENDICES

Appendix A

DEFINITIONS

Abuse: Incidents or practices of providers that is inconsistent with accepted sound medical practices or physical, emotional for financial mistreatment by individuals of others.

Access: Access refers to the degree to which services are quickly and readily available.

Advance Practice Registered Nurse: A registered nurse with advanced education and clinical experience who is qualified within his/her scope of practice under state law to provide a wide range of primary and preventive health care services. An APRN with prescriptive authority (APRN-Rx) is licensed to prescribe certain medications, and diagnose and treat illnesses and injuries.

Adverse Event: An occurrence that is inconsistent with or contrary to the expected outcomes.

Aged: A person who is 65 years of age or older.

Ambulatory Care: Preventive, diagnostic, and treatment services provided on an outpatient basis by psychiatrists, psychologist, nurses, social workers, and other behavioral health care specialists.

AMHD: Adult Mental Health Division

Appeal: An appeal is a request from a consumer, provider, or consumer representative for the reversal of an action taken that is considered adverse.

Assessment Services: Services performed to define, assess, evaluate, or diagnose the consumer's current status and problems. Services include but are not limited to, psychiatric assessment, psychological assessment, educational and vocational assessment, housing assessment, risk assessment, or a psycho-social assessment provided by the respective disciplines and providers as a basis upon which to develop the ISP/MRP.

Behavioral Health Services: Services provided to persons who have a mental illness and/or who, abuse or are addicted to alcohol or other drugs.

Benefits: Those behavioral health services to which an AMHD consumer is entitled and which AMHD provides.

Board-Certified: A certification approved by the American Board of Medical Specialties, the American Osteopathic Association, or another organization as accepted by AMHD.

Case Management: A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health

needs using communication and available resources to promote quality cost-effective outcomes.

Certified Substance Abuse Counselor: A person who is certified as a substance use counselor by the Department of Health.

Community Services: Services that are provided in a community setting. Community services refer to all services not provided in an inpatient setting.

Consumer: An individual person who is the direct or indirect recipient of the services of AMHD.

Continued Stay Authorization: Utilization management conducted during a consumer's hospital stay or course of treatment (including outpatient procedures and services). Sometimes called "continued stay review."

Contract: Written agreement between AMHD and the contractor.

Contractor: A successful applicant who has executed a contract with AMHD.

Cost-based Reimbursement: A successful applicant who has a goods and services contract with AMHD.

Crisis Line: The Crisis Line of Hawaii is the organizational unit within AMHD which provides a 24 hour/7 days a week, crisis hotline and links to crisis services, eligibility assessments and other services.

Days: Calendar days.

Delegation: The process by which an organization permits another entity to perform functions and assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight of the delegate.

Detoxification: Short term medical treatment for substance use withdrawal which may include, individual medical assessment, evaluation, intervention, substance use counseling, and post-detoxification referrals, These services may be provided in licensed freestanding or hospital-based programs.

Director: Director of Department of Health, State of Hawaii.

Discharge Planning: The process that assesses a patient's needs in order to help arrange for the necessary services and resources to affect an appropriate and timely discharge or transfer from current services or level of care.

DOH: Department of Health

Dually Diagnosed: A person who has both an alcohol or drug problem and an emotional/psychiatric problem is said to have a dual diagnosis.

Effective Date of Enrollment: The date from which an individual is covered by AMHD.

Eligibility Determination: A process of determining whether an individual is eligible to receive services from AMHD after an evaluation.

Emergency: Defined as a consumer involved in an active crisis where the safety of the consumer or others is at risk within the next 24-hours. Safety may be at risk due to suicide, homicide, and/or severe decompensation of functioning.

Employment/Vocational Rehabilitation Services: A broad range of services designed to address skills necessary for participation in job-related activities.

Enrollment: The process by which an applicant who has been determined eligible becomes an AMHD consumer.

Expedited Appeal: An appeal of a denial in a case involving urgent care.

Experimental Therapies: Investigational services, procedures, drugs and treatments; Drugs not approved by the FDA.

Family/Collateral Support and Education: Services provided to a family either in a group with other families or with a family (with or without the consumer), to gain assistance/support of the family in the treatment of the consumer, to coordinate or evaluate the implementation of ISP/MRP objectives, and to provide education to increase understanding and ability to cope with their seriously mentally ill family member.

Family Therapy: Planned therapeutic sessions involving the family with or without the consumer.

Fee-for-Service: An established dollar amount is paid for a particular service, such as through CPT or revenue codes.

Grievance: Any expression of consumer dissatisfaction. This term is used instead of complaint.

Group Therapy: Planned therapeutic sessions involving group dynamics or interaction among a number of consumers.

Individual Therapy: Therapy tailored for a consumer that is administered one- on-one.

Legal Advocacy: Legal services provided to ensure the protection and maintenance of a client's/consumer's rights.

License: A license or permit (or equivalent) to practice medicine or a health profession that is 1) issued by the State of Hawaii; and 2) required for the performance of job functions.

Licensed Clinical Social Worker: A master's prepared social worker, licensed in Hawaii with advance clinical experience and skills for behavioral health consumers.

Medical Director: A doctor of medicine or doctor of osteopathic medicine, who is duly licensed to practice medicine, has a specialty in behavioral health, is a party to or has a contract with the organization and has responsibility for oversight of the organization's quality management program and clinical functions.

Medication Therapy: Prescription, administration, assessment of drug effectiveness, and monitoring of potential side effects of psycho-tropic medications.

Mental Health Professionals (MHP): Mental Health Professionals (MHP) must meet the following minimum requirements:

1. Licensed Social Worker (LSW);
2. Master of Science in Nursing (MSN);
3. APRN in a non-behavioral health field;
4. Master's degree from accredited school in behavioral health field:
 - a. Counseling;
 - b. Human Development;
 - c. Marriage;
 - d. Psychology;
 - e. Psychosocial Rehabilitation; and
 - f. Criminal Justice.
5. Master's degree in health related field with two (2) years' experience in behavioral health; or
6. Licensed Registered Nurse with a Bachelors in Nursing and five (5) years' experience in behavioral health.

The MHP may supervise para-professional staff if the MHP is clinically supervised by a QMHP. The MHP may function as the AMHD Utilization Management Liaison. Supervision requirements are as follows:

1. Clinical supervision of all staff is ongoing and sufficient to ensure quality services and improve staff clinical skills and is according to community standards, scope of license as applicable, and agency policies and procedures. Treatment team meetings are consumer focused whereas clinical supervision is staff focused. Therefore treatment team meetings do not meet clinical supervision requirements;
2. One-on-one clinical supervision of MHP team leaders and direct care providers, if there is no MHP team leader, must be performed by the QMHP at a minimum of once per month. If a MHP is the team leader, the MHP must provide one-on-one monthly clinical supervision of non-MHP and non-QMHP staff;
3. The supervision must be documented in writing, legible, signed and dated by the QMHP or MHP as directed by the provider agency's policies and procedures;
4. The AMHD funded provider agencies must have policies and procedures to select and monitor the MHP team leaders if non-QMHP team leaders are used; and

5. The QMHP and non-QMHP staff does not have to work in the same physical setting but must have routine meetings as defined in the provider agency's policies and procedures.

Outcomes: Outcomes are reflected by the extent to which services provided to individuals with behavioral disorders have a positive or negative effect on their well-being, life circumstances, and capacity for self-management and recovery.

Primary Care Provider or (PCP): 1) Is a physician, either a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), licensed to practice in the state of Hawaii and must generally be a family practitioner, general practitioner, general internist, pediatrician, or obstetrician/ gynecologist (for women, especially for pregnant women), or 2) Is a nurse practitioner, licensed in the state of Hawaii and must generally be a family nurse practitioner, pediatric nurse practitioner, or nurse midwife. Has the responsibility for supervising, coordinating and providing initial and primary care to the consumer and for initiating referrals and maintaining the continuity of consumer care.

Prior Authorization: Utilization management conducted prior to a patient's admission, stay, or other course of treatment (including outpatient procedures and services).

Proposal: The offer submitted in the procurement process to provide the contracted services. Is a part of the contract with AMHD.

Provider: An individual, clinic or institution, including but not limited to psychiatrists, clinical psychologists, nurses, social workers, and hospitals, responsible for the provision of behavioral health services to AMHD consumers.

Psychiatrist: A physician, who is board-certified and licensed in the State of Hawaii.

Psychologist: Holds a doctoral degree, either Ph.D. or Psy.D. and is licensed to practice psychology in the State of Hawaii.

Qualified Mental Health Professional (QMHP): Defined as a licensed Psychiatrist licensed clinical Psychologist (Ph.D. or Psy.D.), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (MFT) or licensed Advance Practice Registered Nurse (APRN) in behavioral health. All Qualified Mental Health Professionals (QMHP) must be currently licensed in the State of Hawaii

Quality Improvement Project: An organization-wide initiative to measure and improve the service and/or care provided by the organization.

Quality Management Program: A systematic data-driven effort to measure and improve consumer services.

Registration: Entering a consumer and service into the authorization system which allows the claim to be paid.

Representative: A person who can make AMHD related decisions for a consumer who is not able to make such decisions themselves.

Resident of Hawaii: A person who is physically present in the State.

Retrospective Review: Review conducted after services (including outpatient procedures and services) have been provided to the consumer.

Risk: The likelihood of an adverse event or outcome.

Risk Assessment: An estimation of the likelihood of particular adverse events occurring under particular circumstances within a specified period of time.

Risk Management: Aims to minimize the likelihood of adverse events within the context of the overall management of an individual, to achieve the best possible outcome, and deliver safe, appropriate, effective care.

Sentinel Event: Any unexpected occurrence involving death or serious physical or psychological injury or the risk thereof.

Service Area: The geographical area defined by counties or other geographic subdivisions served by a provider as defined in its contract with AMHD.

Staff: The organization's employees, including full-time employees, part-time employees, and consultants.

State: The State of Hawaii.

State Hospital: A publicly funded inpatient facility for persons with mental illness.

Subcontract: Any written agreement between the contractor and another party to fulfill the requirements of the contract.

Unexpected Death: Death by suicide, homicide of or by a consumer, death as a result of an accident, death as a result of a suspected drug overdose, and untimely death for medical reasons.

Urgent: Consumers are experiencing distress that will develop into a crisis state without intervention, but there is not yet imminent threat of harm to the consumer or others. Distress may be defined as at risk due to suicide, homicide, a recent major loss and/or severe decompensation of functioning.

Utilization Management: Evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of AMHD.

Written Notification: Correspondence transmitted by mail, facsimile, or electronic medium.

Appendix B

AMHD/Phone Contact Numbers & AMHD Areas of Responsibility

AMHD Areas of Responsibility	Contact Numbers (Oahu) - NI's Use "1-808" When Calling
Adult Mental Health Administrator	Phone: 586-4770 or Fax: 586-4745
Provider Relations	Phone: 586-4689 or Fax: 586-4745
Office of Consumer Affairs	Phone: 586-4688 or Fax: 586-4745
Contracts	Phone: 586-8282 or Fax: 586-4745
Fiscal	Phone: 586-8293 or Fax: 586-4745
Utilization Management	Phone: 453-6904 or Fax: 453-6995
Performance Improvement	Phone: 453-6954 or Fax: 453-6939
AMHD Service Coordinators: <ul style="list-style-type: none"> • Case Management and Support Services • Housing Services • Long-Term Care 	Fax: 453-6995 Phone: 453-6430 Phone: 453-6944 Phone: 453-6987

Provider Directories

For a list of AMHD Purchase of Service contracted providers, and Community Mental Health Center Providers (CMHC's) go to the AMHD website: www.amhd.org

Appendix C

Treatment Record Documentation Standards

Providers shall adhere to Treatment Record Documentation standards set out by the AMHD as follows:

1. Treatment records must be organized, clear, complete, current, and legible.
2. Treatment records for consumers who have been seen shall include at least the following:
 - a. Consumer identification data (i.e., name, date of birth, consumer identification number, clinical record (CRN) number);
 - b. Consumer address(es) for residential and correspondence, telephone number;
 - c. Date of admission;
 - d. Emergency contact names, addresses and phone numbers;
 - e. Name, address, and phone number of the personal representative, conservator, guardian, and/or representative payee, if one has been appointed for the consumer;
 - f. Name, address, and phone number of the person currently coordinating services;
 - g. Health insurance information, if applicable;
 - h. Pertinent information including:
 - i. health history;
 - ii. diagnosis(es)
 - iii. medication list of prescribed and over-the-counter including herbal preparations, and name and phone number of prescribing physician or Advance Practice Registered Nurse (APRN), dosage, frequency, and route of administration; and
 - iv. any relevant medication information (e.g. allergies, compliance);
 - i. Special status situations, such as forensic status, imminent risk of harm, suicidal or homicidal ideation, or elopement potential, are prominently noted, documented, and revised;
 - j. Preadmission screening, if conducted;
 - k. Documentation of orientation and provision of consumer handbook and other consumer information;
 - l. Evaluations/assessments for needs, strengths, level of care, substance use, etc.;
 - m. Individualized Service Plan (ISP) or other treatment plan(s) including reviews;
 - n. List of providers involved in consumer's care such as primary care medical physician including name, address, and phone number;
 - o. Documentation of services provided including category or description of the service and consumer response;
 - p. Phone contacts with consumer, other organizations, and relevant parties;
 - q. Medical and legal documents such as consents and authorizations for release of information;

- r. Advance directives;
 - s. Lab results, if applicable;
 - t. Correspondence and reports pertaining to the consumer;
 - u. Documentation of referrals;
 - v. Reports of team conferences;
 - w. Reports of conferences with family or other individuals identified as supports for the consumer;
 - x. Discharge summary that includes:
 - i. date of admission;
 - ii. presenting condition;
 - iii. extent treatment goals and objectives were achieved;
 - iv. services provided;
 - v. reasons for discharge;
 - vi. status of consumer at discharge;
 - vii. recommendations for further services and support;
 - vi. date of discharge;
 - y. Other pertinent information such as language proficiency or unique cultural nuances; and
 - z. Completed mandatory forms
3. Records for consumers seen less than four times must document at a minimum:
 - a. Records of documented consumer encounters documenting the complaint or medical necessity of the encounter;
 - b. Consumer history forms, assessments, psychiatric and medical history records received;
 - c. Prior diagnosis and medications, interventions, consumer's progress and ISP;
 - d. Records of requests for laboratory and radiological tests and results of tests or examinations or consultations ordered; and
 - e. Records of prescriptions ordered or furnished.
 4. Data shall be recorded and maintained in typewritten, black ink, or in a secure, retrievable electronic format.
 5. Each page of the treatment record shall have at the minimum the consumer's name.
 6. All contacts with or attempts to contact a consumer or others involved in the consumer's care, including phone calls and community or institutional visits, must be recorded in chronological order; and the entry must be dated, signed with full name (not initials), degree, if any, and title of the provider of services. All entries shall be kept current.
 7. An electronic signature may include "Authenticode Verisign" or equivalent signatures. An electronic system that has a verifiable automatic process to document the identity of the writer and date of record entries is a requirement for the use of electronic records.
 8. Late entries are permissible as long as they are noted as such. Late entries should note the date of service, date of entry, and display "Late Entry" at the beginning of the notation.
 9. If an error in documentation is made, a single line shall be drawn through the incorrect information and shall be initialed by the person making the correction. The correct information is then entered. Erasures, white-out, scribbling or blocking-out is not permissible.
 10. The clinical record is a legal document, and as such, only original entries are

acceptable. Mechanical reproductions (e.g., photocopies) shall not replace original entries.

11. If it is necessary to leave blank sections at the bottom of progress notes before starting a new sheet, the blank sections must be lined out.
12. All entries made by volunteers or students must be co-signed by a professional clinical staff member or the student's instructor/clinical supervisor.
13. The progress notes or other documentation of case management or other services reimbursed by units based on time shall have a begin time and end time for each entry.
14. The progress notes must include location of where the service is provided.
15. The treatment record shall include the documentation necessary to justify the service provided on the claim (s) billed to AMHD for payment.

Appendix D

AMHD Commonly Used Acronyms

ADAD	Alcohol and Drug Abuse Division, DOH
AG	Attorney General
AMHD	Adult Mental Health Division, DOH
APRN	Advance Practice Registered Nurse
APRN-Rx	Advance Practice Registered Nurse with Prescriptive Authority
BC	Business Compliance, AMHD
BH	Behavioral Health
CAMHD	Child and Adolescent Mental Health Division
CARF	Commission on Accreditation of Rehabilitation Facilities
CBCM	Community Based Case Management
CMHC	Community Mental Health Center
CMO	Crisis Mobile Outreach
CMS	Centers for Medicare and Medicaid
CMSS	Case Management and Support Services
COA	Commission on Accreditation
CP	Consumer Protection
CPT	Current Procedural Terminology (American Medical Assoc.)
CR	Conditional Release
CRF	Consumer Resource Fund
CSAC	Certified Substance Abuse Counselor
CSM	Crisis Support Management
DD/MR	Developmentally Disabled/Mentally Retarded
DOH	Department of Health
DOJ	Department of Justice
DSM-V	Diagnostic and Statistical Manual, Fifth Edition
DVR	Department of Vocational Rehabilitation
Dx	Diagnosis
E-ARCH	Expanded Adult Residential Care Home
ED	Eligibility Determination
FC	Forensic Coordinator
FY	Fiscal Year
GAF	Global Assessment of Functioning
HAR	Hawaii Administrative Rules
HCPS	Hawaii Certified Peer Specialist
HIPAA	Health Insurance Portability & Accountability Act
HSH	Hawaii State Hospital
ICM	Intensive Case Management
IDDT	Integrated Dual Diagnosis Treatment
IMSR	Illness Management and Self Directed Recovery
ISP	Individualized Service Plan

JCAHO	Joint Commission
LCRS	Licensed Crisis Residential Services
LCSW	Licensed Clinical Social Worker
MFT	Marriage & Family Therapist
MH	Mental Health
MH-1	Occurs when a police officer has reason to believe that an individual is imminently dangerous to self or others, is gravely disabled, and/or is obviously ill. Authorizes the transport of the individual to a designated licensed psychiatric facility for further evaluation.
MH-2	Person in imminent danger due to mental disease, disorder, or defect; may be held involuntarily for psychiatric observation for 48 hours. Also called a 48-Hour Hold, Involuntary Hold, or <i>Ex-Parte</i> .
MH-6	Imminently dangerous: Initiate a civil commitment to a state inpatient facility (typically HSH) at the end of 48 hours.
MHA	Mental Health America
MHP	Mental Health Professional
MI/SA	Mental Illness/Substance Abuse
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MRO	Medicaid Rehabilitation Option
NAMI	National Alliance for the Mentally Ill
OCA	Office of Consumer Affairs, AMHD
P&P	Policy & Procedure
PCP	Primary Care Provider
PI	Performance Improvement, AMHD
POS	Purchase of Service
PSR	Psychosocial Rehabilitation
RA	Remittance Advice
RFI	Request for Information
RFP	Request for Proposal
SAA	AMHD Service Area Administrator
SAB	Service Area Board on Mental Health and Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SCMH	State Council on Mental Health and Substance Abuse
SD	AMHD Service Director
SE	Sentinel Event
SMI	Serious Mental Illness
SOSRP	State Operated Specialized Residential Program
SRSP	Specialized Residential Service Program
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TLP	Therapeutic Living Program
Tx	Treatment
UM	Utilization Management, AMHD
WRAP	Wellness Recovery Action Plan

704-404	Suspension of legal proceedings for forensic examination with confinement or stay in community.
704-405	Fit to proceed with resumption of legal proceedings.
704-406	Unfit to proceed, confined to hospital setting.
704-406(1)	Unfit to proceed, served on an outpatient basis.
704-411(1) (A)	Dangerousness a concern, acquit and commit to Director of Health for inpatient treatment.
704-411(1) (B)	Dangerousness a concern, acquit and release to Director of Health for outpatient treatment.
704-411(1) (C)	Acquitted of charges and not dangerous