Interface EAP

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PROVIDER SERVICE MANUAL

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**** CONFIDENTIAL ****

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AS A PROVIDER OF IBH, YOU AGREE TO ABIDE BY ALL POLICIES AND PROCEDURES IN THIS MANUAL

Introduction

Welcome to the Interface Behavioral Health (IBH) Employee Assistance Program and Behavioral Health Management Services network. You have joined other practitioners throughout the United States who are offering their experience and training to IBH contracted businesses.

We thank you for serving IBH members and hope you enjoy your partnership with IBH. As a provider of our network, we recognize that you are an integral and necessary part of our team, and we will work diligently to maintain a mutually beneficial and professional relationship. We will do our best to help you provide our clients with the highest quality of service.

Questions and comments about our philosophy, mission and procedures may be directed to our Provider Relations Department:

IBH Provider Relations Department – (800) 324-4327

Purpose

The purpose of this manual is to assist providers by providing the following:

- the IBH service philosophy, and
- information to assist in billing, authorization and reimbursement procedures

Mission Statement

Our mission is to improve the quality of life and wellness of our members through easy access to quality, compassionate and supportive behavioral health care, including:

- EAP/BHM access to a wide range of resources and tools that empower members to take charge of their wellbeing.
- Supervisor consultation to equip management teams with tools to recognize, manage and assist employees who may have personal problems that impact job performance. IBH can also conduct training sessions that help managers and supervisors identify behaviors that indicate possible workplace use of drugs and alcohol.
- Substance Abuse Evaluations and treatment recommendations that support Drug Free Workplace Policies.

EAP/BHM Philosophy and Protocol

IBH encourages a brief, solution-focused, and psycho-educational counseling approach. This model is designed to assist members through the normal, everyday problems. The objective of this approach is to empower members to accept responsibility for dealing with their own personal issues and challenges. The Employee Assistance Program is designed to work within a limited number of sessions, usually three (3) to twelve (12). The intended use of an EAP is to help members assess the nature of the problem and identify solutions within the number of sessions contracted by their employer. It is not the intent of the EAP to provide treatment for problems requiring long-term, specialized or chronic care.

IBH credentialing requirements include providers who are trained to use brief solution focused counseling, as appropriate, or to make timely referrals when on-going care is clinically and ethically appropriate. The EAP is designed to deliver preventive services and short-term problem-resolution services.

IBH is more than an EAP as we provide personalized treatment for behavioral healthcare needs. This commitment relies on the expertise and dedicated partnership of our contracted providers. We expect providers will deliver appropriate clinical services within the available EAP plan design.

GENERAL POLICIES AND PROCEDURES

PRECERTIFICATION/AUTHORIZATION OF TREATMENT

EAP Treatment

It is the policy of IBH to authorize all available EAP sessions upfront for assessment and short-term resolution therapy. IBH providers have the responsibility to educate the participant regarding the brief solution-focused counseling they will receive, according to the allotted number of eligible authorized sessions. The participant must be informed of the eligible number of authorized sessions allowed and be involved in the treatment plan process.

An IBH care managers will talk with the participant about the options available. Participants may utilize authorized EAP sessions and if IEAP manages insurance-based treatment, continue counseling through an insurance referral for treatment required after the use of the eligible EAP sessions. EAP sessions are not designed to provide on-going care or consecutive counseling sessions for multiple, related life problems.

1. Authorization of EAP Counseling Sessions

Participants contacting IBH to use services are assigned an IBH case number. This number becomes the process by which all participants are tracked. Participants and providers must refer to this case number when calling or writing IBH concerning a case.

a) The participant must call IBH to open a case. Providers may not open a case for a participant unless the participant is incapable of speaking with IBH and no family member is available. IBH will:
   (1) Assign participant an IBH case number
   (2) Refer participant to an appropriate provider
   (3) Give participant the provider's name, phone number and address
   (4) Instruct participant to call the provider using IBH case number and schedule an EAP appointment
   (5) Instruct participant to arrive early for the first appointment to allow time to read and sign required office forms
   (6) Inform the participant that they must call before the third session if they feel their provider is not a good fit for counseling needs.

b) Provider will be authorized allotted number of sessions under the participant's EAP plan. A care manager will contact the provider office with the following:
   (1) Given participant's name, case number and confidential phone number
   (2) Mailed a letter documenting this authorization within 2 business days (*this authorization may also be given to the provider or their staff by telephone*)
   (3) Reminded of procedures and billing needs required by IBH

Providers unable to schedule an IBH referral within 3 working days (unless otherwise requested by participant) should direct the participant back to IBH for an alternate referral.

2. Referrals

It may be clear during the authorized sessions that the participant issues are inappropriate for, or beyond, the scope of the allotted EAP sessions. Participants who need long-term counseling or services outside the scope of or beyond the use of the EAP services will require the provider to be familiar with the participants insurance for appropriate referral assistance. It is the participant's responsibility to verify and know their EAP/BHM benefits especially when care may require higher clinical level of care, such inpatient detoxification, partial hospitalization or intensive outpatient treatment than that offered through the EAP. When determined that a referral is clinically and ethically appropriate IBH expects provider would discuss with participant and refer participant back to IBH for review and coordination of necessary treatment beyond the scope of the EAP.

3. New Problems

Participants may access their EAP based on a "per problem/issue, per family, per provider/per EAP benefit year" model for the allotted number of EAP sessions by their employer contract. Participants are not allowed continued treatment with the same provider in the same benefit year for a different issue; nor can multiple family members receive treatment from the same provider, in the same benefit year, unless stipulated differently by the employee's employer group.

Sometimes a participant presents with several problems. However, it is the provider's responsibility to help the participant to prioritize and focus on the primary problem. The provider should partner with the participant in the development of a quality treatment plan that would make counseling goals achievable within the allotted number of EAP sessions. It is important from the very first session that the provider prepares the client to reach problem resolution and treatment termination by the end of the allotted number of sessions.

Authorization for an EAP referrals good for one year from the effective date of authorization.

Failure to obtain authorization may result in provider not being paid by IBH. Provider agrees not to bill participant for any EAP sessions not paid as a result of provider's failure to obtain authorization.

Rights and Responsibilities

Interface Behavioral Health (IBH) protects and preserves the rights and responsibilities of all participants. IBH is committed to allowing all levels of providers involved in the delivery of participant care and/or treatment with respect, dignity, worth, and the privacy of each participant without regard to gender, cultural differences, economic status, religion, education, or sexual orientation. The following is an outline of the rights and responsibilities of the parties involved in the delivery of participant care.

Participants Rights:

Participants have the following rights:

1. To know names, specialties and qualifications of IBH panel providers.
2. To receive information concerning their EAP benefits.
3. To be involved in all decisions related to their treatment to facilitate informed consent.
4. To be treated with dignity and respect.
5. To voice complaints concerning care or services.
6. To received answers related to care and or consent of treatment.
7. To have crisis services available 27/7/365 through telephone consultation and access to on-site or face-to-face.
8. To be provided complete privacy and confidentiality in accordance with Federal (including HIPAA), State and professional guidelines.

Participants Responsibilities:

Participants have the following responsibilities:

1. To provide complete and accurate information
2. To work with providers to comply with agreed upon treatment plans.
3. To attend scheduled sessions, arriving on time.
4. To report complaints, problems, comments and suggestions concerning the delivery of the EAP services.
5. To request information and understand their services provided by Interface Behavioral Health.
6. To work with providers to clarify benefits and eligibility of health care providers when referral to services beyond the EAP is recommended.

Provider Responsibilities:

Providers have the following responsibilities:

1. To treat participants with dignity and respect
2. To maintain participants confidentiality in accordance with State and Federal guidelines, including HIPAA as well as applying appropriate professional codes of conduct and ethics.
3. To inform participants concerning the EAP benefit, number of allotted sessions and type of counseling involved.
4. To assess and evaluate participants and monitor changes as they occur.
5. To include participants in the development of treatment plants. To include family involvement in the treatment of children and adolescents.
6. To inform participants of complaint procedures and their right to voice opinions, complaints, or suggestions concerning services and care.
7. To coordinate with IBH in providing quality services.
8. To comply with IBH published billing procedures.
9. To demonstrate professional competence and adherence to clinical practice guidelines.
10. To accept participants feedback and concerns.
11. To notify IBH care manager of a serious injury, suicidal or homicidal ideations, or an incident of violence that was experienced by an IBH EAP participant.
12. To offer appointment availability that would accommodate an emergency.
13. To offer appointment availability within three to five working days for routine referrals.

IBH Responsibilities:

IBH has the following responsibilities:

1. To keep participant care as a priority.
2. To educate participants and providers regarding the Employee Assistance Program benefits.
3. To reimburse providers with established billing guidelines.
4. To improve participants services and care by collaborating and coordinating with Behavioral Healthcare providers.
5. To respond efficiently to participant and provider feedback.
6. To minimize paperwork and administrative requirements for both participants and providers.
7. To provide employers with reports and information to evaluate the usage of the program without breaching confidentiality of program users.
8. To provide clinical support and consultation to panel providers.
9. To respond promptly and appropriately to participants and providers complaints and concerns.

Managed Behavioral Health Care Treatment

IBH requires a participant or, in the case of a minor or incapacitated adult, a parent or authorized member of the participant's family to contact IBH to begin the pre-certification process for authorizing treatment. In cases of psychiatric emergencies, intake data can be obtained from a provider. Beyond the initial set of authorizations, clinical data may be required for continued managed behavioral health authorizations.

- For clinicians, clinical information will be requested beyond the initial set of yearly authorizations for continued authorizations, or if a clinical procedural/CPT code is for a higher-level request or if the frequency of sessions requested exceeds weekly.
- For psychiatrists/APRNs, clinical information may be requested if using a higher level clinical procedural code/CPT code beyond a medication management session or if authorized sessions are used before the end date of the yearly authorization.
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At IBH, it is not our policy to contact a health care provider more often than is reasonably required to obtain needed clinical data. IBH feels that the health care provider has primary responsibility for providing the clinical data needed to certify requested treatment as medically necessary. Case managers are available to discuss this data **(Monday - Friday, 7:30 am –6 p.m. CT).**

In managing mental health care, IBH relies upon pre-certification of **all** facets of a participant's treatment. To receive maximum insurance reimbursement of benefits, each provider must provide any needed clinical data to IBH promptly.

Pre-certification/Authorization of Managed Care Treatment

IBH authorizations are based on medical necessity. It is the responsibility of the participant (or provider) to verify eligibility, coverage and modality of treatment. Authorizations under the insurance plan are not a guarantee of payment.

a) Participants contacting IBH to request treatment are assigned an IBH case number. This number becomes the process by which all participants are tracked. Participants and providers must refer to this case number when calling or writing IBH concerning a case.

b) The participant must call IBH to open a case. Providers may not open a case for a participant unless the participant is incapable of speaking with IBH and no family member is available. IBH will:
   (1) Assign participant an IBH case number
   (2) Refer participant to an appropriate provider
   (3) Give participant the provider's name, phone number and address
   (4) Instruct participant to call provider using their case number to schedule an assessment
   (5) Instruct participant to contact their TPA to verify eligibility and coverage

c) IBH will contact provider to authorize initial assessment session under the participant's Managed Care. IBH will:
   (1) Give provider participant's name and IBH case number
   (2) Mail provider a letter documenting this authorization, although this may be given to the provider or their staff by the telephone. Letter will be mailed within 2 business days of authorization.
      (a) This authorization will be specific regarding frequency, length and number of sessions
   (3) Remind provider to contact the participant's TPA to verify eligibility and coverage

Additional Authorizations for Regular Outpatient Treatment Beyond the Initial Set of Authorizations

The provider and his/her staff are expected to track authorizations and sessions used by a participant. Beyond the initial set of authorizations, clinical data may be required for continued managed behavioral health authorizations.

d) For clinicians, clinical information will be requested beyond the initial set of yearly authorizations for continued authorizations, or if a clinical procedural/CPT code is for a higher-level request or if the frequency of sessions requested exceeds weekly.
e) For psychiatrists/APRNs, clinical information may be requested if using a higher level clinical procedural code/CPT code beyond a medication management session or if authorized sessions are used before the end date of the yearly authorization.
f) IBH will mail the provider a letter documenting this authorization, although this may be given to the provider or their staff by the telephone. An authorization letter will be mailed within 2 business days of authorization.
   (a) This authorization letter will be specific regarding CPT codes, frequency, and number of sessions
g) IBH will provide the name and phone number for the TPA. Provider will be solely responsible for verifying eligibility and coverage.
h) Provider will be responsible to provide IBH clinical updates on participant's progress before authorization expires.

Failure to obtain authorization may result in insurance claims being processed and recommended payment as non-network.

Structured Program or Inpatient Treatment

IBH is committed to maintaining a high level of participant involvement in treatment planning. Our policies require that IBH have contact with either the participant or a family member of the participant **before** *(or within 48 hours in the case of an emergency)* admission to a facility. If a provider or hospital makes the initial telephone call to IBH, they will be expected to assist in our efforts to contact the participant or family of the participant.

Pre-certification Procedures for Inpatient Care

i) Pre-certification of an admission is not equivalent to authorization. Pre-certification of treatment ONLY acknowledges the facility's notification of IBH that an individual is seeking treatment.

j) Whatever the source of a facility's initial contact with a participant (*participant call, physician call, etc.),* as soon as the facility has been notified of IBH's role of managing the mental health care in a case:

k) The facility **must** contact IBH to certify the admission.
   (1) IBH case managers are available Monday - Friday, 8 am - 5 pm CST. Messages left after business hours will be returned on the next business day.
   (2) Each admission is assessed for medical necessity per IBH's admission criteria. The criteria is available upon request.

l) IBH requires contact with either the participant or the participant's family to pre-certify treatment in a case.
   (1) If a participant contacts a facility directly requesting an assessment, please have the IBH participant or participant's guardian contact IBH for directions in seeking treatment.

Authorization of Treatment At A Facility

a) The following details are the **minimum** clinical data required for initial authorization of an admission:
   (1) Date and time of admission
   (2) Admitting physician
   (3) Attending physician
   (4) Reason for admission
   (5) If an emergency admission, nature of the emergency
   (6) DSM IV Axes I-V
   (7) Vital signs upon admission
   (8) Relevant mental health history
   (9) Current symptoms, including level of impairment of daily functioning
   (10) Level of risk for harming self or others
   (11) Treatment plan, including type and length of treatment
   (12) Discharge criteria

b) IBH typically authorizes inpatient treatment for only a few days at a time. A facility's UR Department is required to maintain a regular schedule of communication with IBH. Clinical updates and requests for additional treatment must be provided promptly (*i.e., **prior** to services being rendered*). IBH will make reasonable efforts to contact a facility's Utilization Review Department to receive clinical data on a case.
   (1) It is the responsibility of a facility to ensure that treatment has been authorized.
   (2) Reduced payment of benefits resulting from failure to obtain authorizations will be the responsibility of the facility.

c) IBH requires that the *IBH Hospital Admissions Form* be faxed to IBH upon admission or within the first 24 hours of admission. While much of the clinical data and authorization of treatment takes place via the telephone, it must also be supported by documentation in the participant record and available on request for IBH review. Written data transmitted via the fax machine must be complete and legible. IBH has several forms to assist a facility in providing this needed data.

d) All authorizations are documented in IBH's computer case file, and a letter detailing the specifics of the authorization *(dates and level of treatment)* is sent to the physician and the facility within 2 business days of authorization.

Authorization of Psychological/Neuropsychological Testing

PSYCHOLOGICAL TESTING **must be requested and authorized prior to the services** being rendered. For certification of any such testing, the **provider** must provide IBH with the completed "Request for Psychological/Neuropsychological Evaluation" form which includes the following:

a) Referral questions -- What are specific purposes of testing?
b) Any diagnoses being considered, even if on a rule-out basis
c) List of specific tests being considered for test battery
d) Cost of **each** test *(do not report testing in terms of cost per hour)*
e) Name, credentials and phone number of clinicians who will be administering the testing
f) IBH sends provider a "Request for Psychological/Neuropsychological Evaluation" form to be completed and returned prior to authorizing testing

IBH reserves the right to substitute an In-Network Provider to render psychological testing services for inpatient cases.

After testing is completed, IBH will expect a brief statement *(via telephone or in writing)* of the results of tests, specifically:

a) Diagnoses indicated by testing
b) The treatment implications of the test results

The **provider** is responsible for verifying with the TPA that testing is covered by the participant's health plan.

Failure to provide this data to IBH may result in a delay in processing claims for psychological testing services or could result in no benefits being paid on this claim.

Authorization of Treatment With Non-Facility Therapists

IBH's contract with facilities includes payment for individual, group and family therapy as part of the negotiated per diem rate. Authorization for treatment by an outside therapist *(one not working for the facility)* is given **only** in cases where the advantages of that therapy can be clearly shown to outweigh the added financial burden on the participant.

1. In the event that the physician requests a non-facility therapist provide services for a participant, the facility, physician or non-facility therapist must contact IBH to obtain prior authorization for the treatment.
2. In cases in which a participant has a history of outpatient treatment with a non-facility therapist, IBH is generally willing to authorize a limited number of sessions for the non-facility therapist to provide needed data to the facility treatment team and to re-establish rapport with participant prior to their discharge from the hospital.
3. As with any treatment, all sessions with a non-facility therapist **must be** pre-authorized by IBH.

Failure to obtain pre-authorization may result in a reduction in the proportion of the claim reimbursable by insurance.

Authorization of Consultations/Referral To Other Providers

1. MEDICAL - IBH is only empowered to authorize mental health/chemical dependency treatment. Any consultation of a medical nature should be pre-authorized with the participant's TPA or medical managed health care company.

2. PSYCHIATRIC - All treatment provided by other mental health professionals to whom you refer a participant **must be pre-authorized by IBH**. As with any treatment to be rendered, IBH will require data on the reason for treatment, the provider and her/his credentials, and the approximate costs of the service. Failure to obtain pre-authorization may result in a reduction in benefits or penalties (*possibly including non-payment of the claim*).

IN-NETWORK VERSUS OUT-OF-NETWORK TREATMENT

For Interface participants to receive in-network benefits, they must receive treatment from an IBH network provider. IBH does not publish a listing of our In-Network providers. You must contact an IBH case manager to obtain network treatment options prior to making any referrals to other MN/SA professionals or treatment programs.

CONFIDENTIALITY

Participant's confidentiality is a top priority with IBH. Confidentiality is the cornerstone of the EAP as we stringently promote all State and Federal regulations including the Health Insurance Portability and Accountability Act – HIPAA concerning confidential information. In all circumstances, except where applicable by law, a release of confidential information must be authorized by the IBH client. Clear and Imminent Danger/Duty to Warn: Under certain circumstances, it may be necessary for an IBH provider to release confidential information without informed consent. Of specific concern are situations that indicate a clear and imminent danger to self or others, and the responsibility to notify potential victims of imminent threat (duty to warn).

The IBH provider may release confidential information without the participant's permission when the IBH provider determines that there is a clear and imminent danger to self or others and an adequate safety plan cannot be agreed upon.

If the imminent danger includes threats to the workplace or individuals at the workplace, the provider may enlist the assistance of the EAP Program to notify the workplace and determine the "need to know" criteria to protect the intended victims and the safety of the workplace.

Any breach of confidentiality must be brought to the attention of the EAP Program within 5 business days of occurrence.

VERIFICATION OF PARTICIPANT'S MANAGED HEALTH CARE BENEFITS

Authorization of insurance-based treatment by IBH **only** reflects this company's agreement with the apparent medical necessity of the mental health/chemical dependency care being provided. Authorization of treatment **should not** be construed as verification of any existing insurance benefits. IBH assumes no financial obligation for payment of claims, regardless of prior authorization. Each provider holds sole (complete) responsibility to contact a participant's TPA and obtain specific data on available insurance benefits, which include but are not limited to coverage in place, coverage of the diagnosis, coverage of provider's license, dollar limitations and prior treatment, co-pay, and deductible. The participant's insurance plan benefits are not furnished to IBH; therefore, IBH cannot provide any benefit information on individuals.

TELEHEALTH SERVICES

IBH defines telehealth as a method of delivering behavioral health services using interactive telecommunications when the member and the behavioral health provider are not in the same physical location. Telecommunications must be the combination of audio and live, interactive video. The IBH member must have a covered mental health benefit that permits telehealth for providers to receive payment for telehealth services.

Consultations, office visits, individual psychotherapy and pharmacological management services may be reimbursed when provided via telecommunication technology. The provider will utilize the IBH authorization billing form for authorized EAP service reimbursement. EAP telehealth services will be reimbursed at the same rate as a face-to-face service.

SUPERVISORY REFERRALS

The purpose of a Formal Supervisor Referral is to assist an employee with job performance issues as presented by the employer. The EAP has two clients: the employee and the employer. In this case, the focus is on the employee's role in improving his/her job performance or conduct, and not on management. While management may be a factor, this should be discussed directly with the IBH case manager, but not made the primary focus of the treatment with the employee. A formal supervisor referral requires the employee to sign a general release of information form, so the supervisor knows he/she is attending the EAP counseling sessions and complying with recommendations. Typically, this is done prior to your seeing the client using a form provided by IBH as part of the supervisor packet. Some formal supervisor referrals are mandatory and are a condition of continued employment. Typically, these cases involve substance abuse or a policy violation and involve a last chance agreement for the employee.

IBH will require that the employee sign a supervisor release of information form to allow IBH to speak with the employee's supervisor regarding his/her contact and compliance.

A. Referral is made to an IBH provider for assessment and counseling requiring use of all allotted EAP sessions.
B. Participant is mandated to follow the recommendations of the assessment or may risk disciplinary actions as determined by participant's supervisor. This may include loss of his/her job.
C. IBH does suggest a default plan for employees who deny any current problem with drug or alcohol use or those who seem to use drugs or alcohol episodically. Any or all of the following components may be considered:
    1. Participation in AA, NA or CA meetings at least 2 times per week for 6 weeks
    2. Attending local Alcohol and Drug Council's educational group
    3. Authorization of the remaining EAP sessions available for stress and lifestyle management counseling as well as monitoring attendance
D. IBH will send an "IBH Compliance Form" to Provider when updates are needed.
E. IBH will provide supervisor with compliance information as directed in the release signed by employee.
F. IBH will act as the liaison between supervisor and employee's treatment provider
G. IBH Providers should not contact the employee's supervisor directly. All correspondence should be coordinated through IBH. Supervisors that contact an employee's provider should be directed back to IBH for questions and information.
H. Upon completion of the supervisor referral the employee will be eligible to see the IBH provider for personal counseling after completing supervisor referral.

Please refer the participant to IBH for any other referrals that may be necessary or any requests from participant regarding his/her needs with the supervisor.

CRITICAL INCIDENT STRESS DEBRIEFINGS

IBH provides Critical Incident Stress Debriefings (CISD) to employees who witness a traumatic event in the workplace. As an IBH affiliate provider, you provide consultation and guidance through on-site support. IBH strives to provide an immediate supportive response, thorough assessment, and effective intervention which addresses the long-term needs of the organization. Ideally this will take place 24 to 72 hours after the incident. When an incident occurs, IBH will conduct an intake and receive communication from our client organization informing us of a traumatic event or crisis. An IBH care manager will place calls to IBH panel providers to determine availability to assist with the response which may include psychological first aid, debriefing groups, bereavement groups, resiliency groups, and 1:1 intervention. IBH care manager will collaborate with you through the CISD process and specifics with you to ensure the response is a good fit with your ability and comfort level to support the client company. Reimbursement will be timely and based on the rate agreed upon with the IBH staff member. The IBH panel provider is follow up and debrief with management following response.

VERIFICATION OF TREAMENT RENDERED

At times, IBH may request additional clinical information to verify that the treatment being billed is consistent with the level of care documented. IBH will not assume any financial responsibility for the cost of copying, collating, or transmitting of said information UNLESS the specific cost of such services has been agreed upon prior to IBH's receipt of the medical records. ADVERSE DETERMINATION

In the case of a recommendation of an adverse determination, all verbal and written communications with the health care provider will include a clear and concise statement of the principal clinical reasons for the denial/adverse determination, a description of the criteria used/data reviewed to make the adverse determination, a description of IBH's appeal procedures, and a statement of the reviewing physician's specialties and clinical qualifications.

Physician to Physician Review

In cases in which time is an important factor in making a determination of medical necessity, a direct telephone consultation between the physician treating the participant and IBH's Medical Director or outside review company can be used to appeal a recommendation of an adverse determination.

1. To schedule a physician-to-physician review, the health care provider appealing the adverse determination must provide IBH with:
   a) The name of the physician who will provide clinical data
   b) The telephone number where the physician can be reached
   c) The dates and times that the physician is available for consultation with an IBH Medical Director or outside review company
2. In most cases, a physician-to-physician review can take place within 1 business day of the initial request; however, scheduling of such a consultation is dependent upon the availability of the physician who will provide the clinical data. If the physician-to-physician review yields another recommendation of an adverse determination, a letter detailing the principal reasons for the determination will be sent to the TPA, physician and facility within 10 business days of the telephone consultation.

Review of Records

To appeal a recommendation of an adverse determination, a facility may submit copies of pertinent medical records for review by an IBH Medical Director. All subsequent requests for review will require submission of additional clinical information not previously submitted.

1. IBH will not assume any financial responsibility for the cost of copying, collating, or transmitting of these records; unless the specific cost of such services has been agreed upon prior to IBH's receipt of the medical records.
2. All records should be mailed to IBH to the attention of the Managed Care Supervisor.
3. Pertinent records include:
   a) All case notes from unit staff, psychiatrists, etc.
   b) Intake forms, psychological reports
   c) Case notes from mental health consultations
   d) Laboratory reports (*particularly in substance abuse cases*)
   e) Other data that directly addresses participant symptoms and the recommended treatment plan
   f) Copies need to be legible
4. Results of a review of records will be available by way of telephone within 1 business day of the outcome of the review. If the review of records yields another recommendation of an adverse determination, a letter detailing the principal reasons for the determination will be sent to the TPA, physician, and facility within 10 business days.

2nd Level Review and Appeal Of An Adverse Determination

IBH serves in an advisory capacity to TPAs in determining the medical necessity of mental health and chemical dependency treatment. Thus, IBH can only make recommendations to the TPA regarding the medical necessity of a particular course of treatment. The procedures governing this are designed to allow health care providers every reasonable opportunity to discuss their plan of treatment for the participant and provide clinical data to support their recommendations.

1. Concurrent or retrospective second opinion reviews, including requests accompanying previously submitted records, will be forwarded to the Medical Director or to an Independent or External Review Organization.
2. Results of 2nd Level Review will be available via telephone within 1 business day of the outcome of the review and will supersede previous adverse determination. If the 2nd level review yields another recommendation of an adverse determination, a letter detailing the principal reasons for the determination will be sent to the TPA within 10 business days of the telephone consultation or review of records.

In the case of a recommendation of an adverse determination, all verbal and written communications with the health care provider will include the principle reasons for the denial, a description of the criteria used to make the determination, and a description of IBH's appeal procedures. For appeals in which the health care provider submits copies of medical records, IBH will not assume any financial responsibility for the cost of copying, collating, or transmitting of said records.

IBH's policies and procedures for utilization review and appeals are in keeping with those of the various health care plans that we manage and with the rules and regulations that govern them.

BILLING

EAP Billing Procedure

IBH providers who have agreed to provide EAP services are prohibited from billing the participant or the TPA for these services. EAP services are free of charge to the participant. Provider shall accept the contracted EAP rate as payment in full. IBH pays for these services and requires providers to follow specific billing procedures. These procedures are different from insurance claims.

IBH processes payments for EAP services on the last business day of each month. IBH will process only the *billing* forms correctly submitted and received at IBH by the 10th of the month. All *billing* forms received after the 10th of the month will be processed for payment on the last business day of the following month.

1. **To ensure that your requests for payment are identified and processed timely PLEASE:**
   a) Submit all EAP sessions on IBH BILLING form. Requests made incorrectly will be returned.
   b) Insert each date of session on the IBH BILLING form and sign form before returning. BILLING forms missing necessary information will be returned.
   c) When billing for a No-Show you will need to insert the schedule session date and write "No-Show" next to the session date.
   d) Submit your request for payment within ninety (90) days of the date of the EAP session. Requests made over 90 days from date of EAP session will be denied.

All requests for payment of EAP sessions should be submitted by mail to:

Interface EAP
ATTN: EAP BILLING DEPARTMENT
PO Box 421879
Houston, TX 77242-1879
Fax: 713.784.3241

(Do not send certified or registered mail requiring signature for delivery as this may result in a delay of receipt by our office). Billing forms will be accepted via fax or department email address. Please contact the provider relations department for this information.

2. **Private Pay Beyond EAP**
   a) Provider agrees to allow participants, who do not have insurance benefits and who need treatment beyond the EAP, to self-pay at a rate not to exceed provider's contracted IBH rate for EAP services.

   b) A participant in need of treatment beyond the EAP and with insurance benefits managed by IBH will be allowed to use both services with the same provider. The provider managed care rate would apply according to the authorized CPT code. The provider will be required to verify insurance benefits; however, cannot charge participant beyond the managed care rate.

3. **No-Shows**
   Participants who do not give the provider a 24-hour advance notice of inability to keep a scheduled appointment are considered no-shows. *IBH's reimbursement rate for no-show is $25*. IBH will pay the allowed reimbursement rate for no-show up to two (2) missed appointments. ***No-shows always count as an authorized session.***

IBH will rescind all remaining EAP authorizations after the 2nd billed no-show. Provider should contact IBH with this information. Provider should refer any participants wishing to schedule beyond that point to IBH. Provider agrees not to bill participants for any EAP sessions, this includes no-shows.

4. Insurance Claims

All IBH contracts with In-Network providers contain a provision prohibiting balance billing (*billing the participant for the difference between the rates contracted with IBH and the provider's standard fees*). By becoming an IBH In-Network provider, you agree to hold participants responsible only for the IBH contracted rate of the services and to bill the participant only for any deductible and/or co-payment as determined by their specific insurance plan.

Any telephone conversation with a provider or their staff authorizing treatment will be confirmed in a written letter from IBH. This letter will contain the specific dates and level of authorized treatment. The provider will be directed to submit claims to IBH. IBH will forward claims to the TPA upon processing. Failure to submit claims to the correct location will result in a significant delay in the processing of the claims.

SUBMITTING A CLAIM FOR MANAGED CARE SERVICES TO IBH

In all cases that IBH has a part in managing care, authorized services should be submitted on the appropriate claim form. ***Without the attached IBH coversheet, a TPA will generally assume that the claim is not within plan compliance and could be subject to a significant reduction in the amount reimbursed by the health plan may occur.***

a) All claims requiring processing by IBH should be submitted to:
Interface EAP
Attention: INSURANCE CLAIMS DEPARTMENT
PO Box 421879
Houston, TX 77242-1879
****refer to the IBH authorization letter for payor ID number for electronic claim submission****
(Do not send certified or registered mail requiring signature for delivery as this may result in a delay of receipt by our office)

b) Upon receipt of claims, IBH will attach a cover sheet and forward the claims to the appropriate TPA for final processing. IBH's role is to:
(1) Review all billings for accuracy
(2) Advise the TPA of which treatment was authorized and re-price the claim based on IBH's negotiated rates with the provider

USE OF IBH FORMS

IBH supplies providers with originals of all required forms. Copies should be made for use with each IBH participant. Providers who fail to give participants the required forms will be denied payment of EAP sessions.

The following pages contain examples of the IBH forms along with the purpose of the forms. You should have received original copies of IBH's required forms with this manual and your contract. IBH asks providers to keep the originals in a file and make copies as needed for IBH participants. Thank you for your cooperation with this. If at any time you find yourself needing new originals, please contact the Provider Relations department at IBH.

EAP FREQUENTLY ASKED QUESTIONS

QUESTION	ANSWER
What telephone number do I call regarding provider relations questions	For provider contracting and credentialing question, please contact the Provider Relations team at 800-324-4327 between 8 a.m. and 5 p.m. CT, Monday through Friday
If an EAP participant needs ongoing treatment beyond their EAP benefit, am I allowed to refer to myself?	If IBH manages the participant's mental health/substance use disorder benefits, you should contact IBH to coordinate a referral to a network provider. If IBH is not the manager of the participant's MH/SUD benefits, you should help link the participant to their employer sponsored benefit program.
How will I know the number of visits that are covered under the participants EAP plan design?	IBH Care Manager will advise you of the number of sessions available for the participant being referred to you. The authorization billing form will also have the number of sessions available.
If I am not available, can I refer a participant to someone else in my practice for EAP counseling?	Authorizations are assigned to a specific provider. If you are not available to accept the referral but another provider is credentialed and approved by IBH, please call the Care Manager to obtain a new authorization. This will prevent any confusion or delays in payment for services delivered. Also, you should direct the participant back to IBH.
Will IBH deduct taxes from payments?	IBH will not withhold taxes from payments. It is the responsibility of the IBH provider to comply with tax laws from IBH payment. IBH will issue a 1099 for payments issued within a calendar year of $600 and greater.
How will I receive payments? Electronic or Paper check	IBH will issue payments via paper check.
How do I bill for authorized EAP sessions?	IBH will generate an authorization billing form for EAP sessions which will require provider to insert date of service of session and sign billing form. Billing forms received by the 10th of the month, check will cut the last business day of the month. You may submit billing form via US Postal service, fax or email direct to billing department.
How do I submit health care claims services rendered?	IBH will generate authorization for accounts that we managed the healthcare portion and the authorization letter will provide electronic payor ID# for claims submissions. All claims for IBH participants should be submitted direct IBH for review of plan compliance and contractual pricing.
If a participants IBH case has been closed or EAP benefits exhausted, should I call for another authorization?	If a participant is returning for additional services, you should direct the participant to contact an IBH care manager for review of eligible benefits.
What number should I call after hours/weekends for consultations on high risk cases?	Please call 1-800-324-4327 after hours/weekends.

QUESTION	ANSWER
Is it ok if I have direct contact with participant's supervisor?	You should not have contact with the participant's employer. Please feel free to consult with IBH regarding any concerns of this nature.
If a new problem emerges during the course of EAP counseling, may I obtain a new set of authorizations based on the new problem?	EAP counseling includes assessment of problems that an individual may be experiencing if the assessment determines a new problem refer the participant to IBH to discuss the benefit of a new referral. It is IBH's policy that participants are not eligible to receive counseling from the same provider, for different problem in the same benefit year. Also, the same provider is not eligible for counseling multiple family members in the same benefit year under individual cases.
What is the process for adding additional providers to my contract?	IBH will require a completed provider application for each provider that meets panel criteria in order to credential and add to an existing group contract.
What is the process for changing my practice address, phone, fax and email information?	You may contact IBH provider relations department for complete details or you may submit the new information in writing along with a W9 and the information will be updated.
Who has access to my personal information?	IBH is committed to safeguarding your personal information. Only authorized personnel have access to your information, and only the minimum necessary to fulfill their job functions.
Does IBH pay for EAP no-shows?	You may contact the provider relations department regarding the no-show benefit.
Can I bill the member for a no-show	No, you are not eligible to bill or charge participants for any authorized EAP sessions.
Who do I contact for outstanding payments beyond 45 days since I submitted the EAP billing form?	You may contact IBH billing department at 1-800-324-4327. Please have available PHI elements to identify your EAP billing form.
I am seeing a couple for counseling, and the EAP authorization billing form does not include both names, should I have a billing form with both participants name listed?	No, both participants will be covered under the same authorization billing form. You may also see them separately under the same authorization just be mindful that you may not exceed the number of sessions from the combination of both together and individual.
I am seeing a family of 3 for family counseling in a 6-session model program. Is the family eligible for 18 sessions (3 individuals x 6 sessions) for family counseling?	No, in a six-session model program, this family is eligible for up to six sessions. If more than 6 sessions are clinically necessary participant should be referred for treatment. Each family member is eligible for individual counseling under their own EAP case for issues different than family, however, generally not with the same provider.
What should I do if I don't receive the EAP authorization billing form for a participant who has been referred by IBH?	Contact an IBH care manager. If you have not received an authorization billing form or phone call from IBH care manager with the verbal authorization, that is an indicator that participant did not obtain authorization and self-referral should be directed to IBH care manager immediately.