



HORIZON
HEALTH

Improving Health
for **People** and
Organizations



PRACTITIONER MANUAL
EAP AND OUTPATIENT SERVICES

Presented By
Horizon Health EAP Services, Inc.



EAP/OUTPATIENT SERVICES

Release of Information/Confidentiality

1. Your affiliate contract makes you an authorized agent of Horizon Health (HH). Therefore, you do not need to obtain a written release to communicate either verbally or in writing with any HH staff.
2. All EAP/Outpatient providers are required to adhere to Federal and State regulations and laws that pertain to the maintenance of confidential information/records. Should a member ask about or want a copy of the Federal **Protected Health Information** (PHI) requirements, there is a copy of the **Notice of Privacy Practices** (Attachment A) included in this manual. Please make sure that a copy of this statement is available in your office for members. Anyone who divulges or releases confidential information or records concerning any member without proper authorization in accordance with HH policies, state law and local licensing/certification bodies may be terminated from the provider network
3. All communication to any authorized party other than HH is limited to verbal exchanges. The release of verbal information to parties other than the workplace will generally be your responsibility. The Management Referral Consultant (MRC) office is in Denver, Colorado and MRC Consultants will facilitate all communication with the manager/supervisor when there has been a mandatory referral from the member's workplace.
4. Under no circumstances should you provide any written documentation to any party, including letters to the workplace or court. In order to ensure the utmost confidentiality of member records, please direct any inquiries for letters, files and reports to the assigned MRC.
5. All member records must be kept in a secured location at all times.
6. Should a member ask about or want a copy of the **HH Confidentiality Policy**, there is a copy of the agreement included in this manual to give to members upon request (Attachment B).

Documentation

1. You are responsible for ensuring that the following forms are completed when indicated:
 - A. "**Employee Assistance Program Statement of Understanding**": This form serves as informed consent for members seeking EAP services and provides information on client rights and responsibilities (Attachment C).
 - B. "**Release of Information**": Your form serves as authorization for general release of information and should be used when clinically indicated.
2. All member records must be kept in a secure and secluded location at all times.
3. All documentation is subject to clinical review by HH Peer Review Committee. Any relevant findings of this committee will be provided in writing to you for informational purposes and, if indicated, corrective action.

The Americans with Disabilities Act

HH expects all Providers to comply with all provisions of The Americans with Disabilities Act (ADA) applicable to EAP services provided to members.

Non-Discrimination

HH expects all Providers to provide members with EAP/Outpatient and brief counseling services that are free from discrimination regardless of race, gender, culture, disability or sexual orientation.

Member Rights and Responsibilities

All Providers should be fully aware of **HH's Members Rights and Responsibilities** (Attachment D). Please make sure that a copy of this statement is available in your office for members.

Clinical Practice Guidelines

HH has adopted the following clinical practice guidelines developed by the American Psychiatric Association: Treating Major Depressive Disorder, Treating Substance Use Disorders, and Assessing and Treating Suicidal Behaviors. These clinical practice guidelines can be obtained at: www.psych.org/psych_pract/treatg/pg/prac_guide.cfm. HH expects network practitioners to follow these guidelines when treating HH members. Additionally, HH reserves the right, as part of the continuous quality improvement process, to assess provider adherence to these guidelines.

EAP SERVICES

EAP Provider Role

1. Your role as an EAP provider differs somewhat from that generally found within a private practice setting. The primary distinction relates to your need to frequently serve more in the capacity of assessor, advisor, advocate and facilitator of any needed referrals within the confines of a member's session limitations. It is therefore necessary for you to provide timely clinical assessments, implement solution-oriented treatment plans and assist with resource linkage.
 - A. **ASSESSMENT:** The varied nature of presenting problems that EAP members may manifest requires completion of a comprehensive assessment at the onset of services. This assessment must be largely completed in the initial session in order to maximize utilization of the EAP benefit.
 - B. **BRIEF INTERVENTION:** Based on the outcome of the assessment, rapid transition must be made toward implementation of a solution-oriented treatment plan. Interventions need to be carefully constructed to promote either primary mitigation of the members' presenting issues within the session limits or supportive efforts to promote understanding and acceptance of a referral.
 - C. **REFERRAL:** In the event that the nature or severity of the member's issues cannot be fully addressed within the limits of the EAP relationship, assistance with locating referrals, either through their health insurance or community resources, is essential. Communication of any relevant information to other professionals and confirmation of member linkage is also considered a vital component of the EAP.
2. As an EAP provider you are required to maintain a **neutral** stance towards all involved parties, including the member's workplace. If the member presents with a workplace issue, find out if they have attempted to resolve this issue with their supervisor or Human Resources. If not please encourage them to do so. They can also sign a workplace release if they choose too. Please **do not** contact the workplace yourself but call the designated Management Resource Consultant (MRC) who will contact the workplace on the member's behalf. Additionally, all documentation should contain **neutral** language and reflect the fact that it is based solely on member report.
3. A third and critical distinction is that your role as an EAP provider precludes you from providing any authorization for medical leave. Members must be referred to a either their primary care physician or a psychiatrist through their health insurance for any determination of their ability to perform their job duties and issuance of any required documentation.
4. Lastly, your role does not allow you to provide court ordered treatment or related legal documentation. However, you should provide the member with assistance locating other practitioners or organizations that are able to meet these needs. If such a request arises, please immediately inform HH staff and recommend that the member contact us if they have any questions or concerns.

Referral Procedure

1. All members must call HH and receive pre-authorization and a **member identification number** prior to delivery of any counseling sessions. Members will be prescreened at that time for eligibility and determination of the acuity rating: routine, urgent, or priority. The referral protocol for each member rating is as follows:
 - A. **ROUTINE:** This rating is utilized when a member presents none of the risk factors described in 1B as reported at the time of telephonic intake. HH will actively assist with the coordination of appointment scheduling for all urgent and emergent members. Providers will be selected and prescreened based on proximity, required specialization and, depending on the clinical urgency, appointment availability within 24 to 72 hours. The member will be given the date and time of the appointment. The member will then be instructed to contact the provider for appointment confirmation, directions and will give the practitioner/provider their member identification number. The practitioner/provider will call the HH Member Advocate Department, provide the member identification number and receive the authorization number.
 - B. **URGENT & EMERGENT:** All members who report risk factors at the time of intake are screened by one of HH mental health counselors. These risk factors include acute emotional distress, severe psychiatric symptoms, risk of harm to self or others, substance abuse/dependence, domestic violence, alleged child/elder abuse and/or a formal workplace referral into the EAP due to job performance issues. Immediate assistance is provided and a determination is made related to the urgency for scheduling an initial face-to-face session.
2. When you agree to see either a routine or an urgent/emergent member, you will receive a “**Referral Confirmation**” form via U.S. Mail, unless specifically requested by fax.
3. HH will relay any relevant clinical and administrative information to you prior to your first session with the member.
4. All members should be offered an appointment the same day for an emergent referral and within 24 hours for an urgent referral.
5. HH standard for proximity of provider:

Urban	-	15 miles or 30 minutes
Rural	-	30 miles or 30 minutes
6. All members should be offered an appointment within a maximum of five (5) days of a routine referral.
7. At no time should a member be required to wait longer than ten (10) minutes beyond their scheduled appointment time without contact being made to indicate the reason for the delay.

Authorization for EAP Services

1. Authorization is only required prior to the first counseling session. Please contact HH before the first session in the event that a “Referral Confirmation” form is not received.
2. Authorization is not required for the provision of subsequent sessions. You are responsible for determining the number of sessions utilized based on the member’s clinical need and the limitations of the EAP benefit. Providing sessions in excess of the benefit maximum is not permitted. Claims submitted for non-authorized sessions will be denied.
3. Per Incident Benefit. The per incident benefit is defined as the following: The member has a separate issue with a separate diagnosis at a separate time. If a member presents with multiple issues at once, and they cannot be resolved within the benefit module, then it is your responsibility to educate the member on need for referral and assist with the referral process.

Member Education

1. When scheduling the initial session, the member should be reminded to arrive about ten (10) minutes early in order to complete the paperwork required by your practice.
2. It is essential that you clearly educate the member in the first session that the intent of the EAP is to serve as a supplement, not a substitute, for their mental health insurance benefit. The EAP's primary role is that of assessment, brief counseling and, if indicated, referral. Short-term EAP intervention should therefore be viewed as appropriate for problems such as V-Codes and Adjustment Disorders that can be successfully addressed within the number of sessions determined by their benefit model. Members with a primary diagnosis of a more acute nature (i.e., Chemical Dependency, Major Depression, etc.) may be more appropriate for assessment and referral for longer-term treatment, or may need several sessions of pre-treatment prior to referral.
3. Please inform the member in the first session that you are the designated representative of HH and your involvement with them will generally be limited to the parameters of the EAP relationship. Therefore, if your assessment determines the need for longer-term treatment than the EAP benefit allows, you will assist them with linkage to another clinician unless the criteria detailed later in the "Self Referral" section is met.
4. The member should be reminded that a twenty-four (24) hour notice is required for any cancellation. Late cancels and failure to show for appointments are deducted from their available sessions.
5. Please reassure members that their relationship with the EAP is confidential. Unless they provide written authorization, their confidentiality will be protected to the full extent allowed by law and no information will be provided to anyone, including their employer. Only aggregate statistics are provided to member companies.

Extended Treatment Referrals

1. When extended treatment is indicated, attempts should be made to select a referral source within the member's mental health insurance coverage. Cost-effective options, such as community resources, may also be utilized based on clinical need, lack of coverage, financial situation or member request.
2. HH staff can provide general information about insurance options provided by contracted companies. It is important to note, however, that this information should be used only as a general framework as the member's individual selection and/or changes in benefit structure may not be known. Whenever possible, it is best to ask the member to verify their own coverage and report the results to you.
3. If the member's insurance requires pre-certification, it is your responsibility to contact the appropriate party and obtain the authorization.
4. Your assistance with the selection of the specific referral source is considered a crucial element of your role as an EAP provider. Therefore, if latitude exists, you should play an active role in helping the member locate an appropriate referral based on your knowledge of local treatment providers with the required clinical expertise and a reputation for providing quality services.
5. It is imperative that you convey relevant clinical information to all clinical referral sources whenever possible. If a referral for clinical services is required, it is your responsibility to request that the member sign a release of information and then verbally communicate any relevant information. Your role in this regard is to assure a smooth transition to the referral source.
6. Confirmation of linkage must be obtained for all clinical referrals in which an imminent risk of harm to self or others exists. The outcome should then be documented on the "EAP Closing Document".
7. Self-Referrals: Continuation of your therapeutic relationship with the member beyond the scope of the EAP is permitted in the event of the following:
 - A. The member specifically asks to continue in treatment after you have presented an unbiased review of their referral options.
 - B. The names of two (2) alternative referral sources are provided, besides you if appropriate, and the

alternative referrals are documented within the member's file using the **Freedom of Choice Affidavit** and instructions (Attachment E).

C. All available EAP sessions are utilized.

Case Consultation

1. HH will ensure that all relevant information and/or special instructions are provided to you prior to the first session via fax or voice mail.
2. You must contact a Member Advocate III (MA III) for a clinical consultation in the event that your assessment determines that the member presents an imminent risk of harm to self or others. However, feel free to contact a MA III at any time if you would like to discuss the management of a case.
3. All administrative inquiries should be directed to Provider Services.

Reimbursement

1. HH is solely responsible for the payment of your professional fees. The rate of your reimbursement is stipulated in your contract and constitutes payment in full for your services.
2. **DO NOT** discuss your fees with members or have them fill out any financial screening forms.
3. Under no circumstances should the member receive any billing statements.
4. You will receive reimbursement for the initial session upon submission of the "**Referral Confirmation**" form with all necessary fields in Part 2 of the form completed. No additional billing is required since these forms serve as your invoice.
5. The remainder of the balance due will be paid upon receipt of the completed "**EAP Closing Document**" form. No additional billing is required since these forms serve as your invoice.
6. If the member cancels or fails to show for a session you will not be reimbursed.
7. Reimbursement checks will be issued no later than thirty (30) working days following the date of receipt of all required and properly completed documentation.

Member Complaints/Grievances

1. HH is committed to ensuring high quality care and customer service. If at any time members have any concerns, complaints or grievances, they should be directed to contact HH.
2. Upon receipt of a complaint or grievance HH researches and investigates the matter in question and works quickly to correct or resolve the problem.

Claims Dispute Process

In the event that you have a question or concern regarding the payment of your professional fees, HH Claims Department should be contacted immediately by telephone, mail, fax or email. Claims Department Representative(s) will investigate and attempt to resolve the issue promptly.

If the Claims Department Representative(s) is unable to answer the questions or resolve claims and/or billing issues, then question / concern will be sent to the Claims Manager. The Manager will investigate and resolve the issue. Regardless of the manner in which the issue is addressed, all disputes will be resolved within 30 days of initial receipt. If it is determined at resolution that a balance is due, HH will provide payment in full plus interest, if applicable. Interest is paid in the event that full reimbursement was not provided within thirty (30) days of receipt of the original claim and is accrued at an annual percentage rate of fifteen (15) percent.

OUTPATIENT SERVICES

Patient Assessment and Referral for Outpatient Services

Timely and appropriate patient assessment and referral are essential components of HH's managed care programs. When a member calls for a referral our Member Advocates collect demographic data, reason for the referral, and ask questions related to member risk and chief complaints. The Member Advocates verify the member's coverage for the requested routine services and provide eligibility and benefit information.

Every effort is made to match the member's clinical, psychological, cultural and linguistic needs and preferences with the abilities and geographic accessibility of the practitioners/providers.

A **practitioner** is a licensed physician, clinical social worker, psychologist or other licensed and/or credentialed behavioral healthcare professional or health care provider who has entered into an agreement with HH to provide behavioral health care services to covered persons.

A **provider** is a licensed or accredited behavioral healthcare organization, hospital, community mental health center or agency which is capable of providing emergency, acute care inpatient, residential, outpatient or partial hospitalization services.

Accessibility

HH accessibility standards are based upon NCQA guidelines and are an important component of our practitioner selection process. Practitioners should be accessible for emergency matters 24 hours a day, seven days a week.

Appointment standards are as follows:

- **Emergent:** Members with non-life threatening emergent needs should have access to the appropriate level of care the **same day** of the request. Members with life-threatening emergent needs should have access to care immediately (emergency provider evaluation); or as requested by client contract.
- **Urgent:** Members with urgent needs should have access to outpatient care within **twenty-four (24) hours** of the request; or as required by state law or as requested by client contract.
- **Routine office visits:** Members should have access to routine outpatient care within three (3) to five (5) business days of the request.

Timely post-hospitalization follow-up appointments must be in accordance to HEDIS® guidelines which states appointments must be available within seven (7) calendar days and are critical to ensure a successful transition.

You may obtain help by phoning HH Member Advocates to facilitate appointments for urgent/emergent psychiatric evaluations when necessary. It may also be useful to identify an "emergency hour" or a "clinician on call" to handle emergencies and ensure a member has access to care based upon the urgency of the situation. If your office cannot comply with these standards at any time, or if you cannot take referrals for whatever reason, please call **Network Services Department** so the system can be updated and we will not continue to ask you to accept referrals.

Having a "live" person answer the telephone during business hours is preferable to voice mail or an answering service, in the event the member is in crisis. Preference will be given to groups who have appropriate administrative support.

Cell phones should not be used as a method to accept referrals.

Member work schedules may cause conflict with their ability to come to therapy during regular business hours. Therefore, scheduling flexibility increases the ease with which appointments are scheduled and kept.

Obtaining Initial Authorization

Members who have requested care through HH are given a **member identification number** and a referral for evaluation and/or treatment. The member must provide this identification number to the practitioner/provider at the time the first appointment is scheduled. If an member calls to schedule a routine appointment without the identification number, they should be referred back to HH to obtain the identification number **prior to being seen**.

If the case appears more urgent, you may schedule the appointment and then call HH as soon as possible to obtain authorization. For members who present in a true emergency (i.e., danger to self or others, psychotic symptoms) the practitioner/provider should immediately render service, and then call Member Services Department within 24 hours to obtain authorization.

Initial Evaluation

When a member is referred for outpatient treatment, a full biopsychosocial history is to be conducted by the practitioner to determine the member's need for continuing care, clarify current available resources, and develop the treatment plan, if necessary. HH manages benefits utilizing established medical necessity criteria, which are defined in the *Horizon Utilization Review Criteria* (available upon request from the Quality Management Department, 888-482-2733). If the initial evaluation leads you to determine that continued outpatient services are not medically necessary, the member should be referred to an appropriate support group or available community resources.

Prevention and Mental Health Maintenance

HH is committed to collaborating with members, practitioners, and providers to identify, design, and implement preventive behavioral healthcare programs to benefit the populations we serve. One of HH's goals is to enhance behavioral health care programs for our members based upon demographic, cultural, clinical, and risk characteristics of the covered population. HH welcomes recommendations from members, practitioners, and providers regarding the design and implementation of these prevention programs. Please contact the Quality Management Department if you have any recommendations and/or wish to participate. Practitioners, providers, and members will be notified, via newsletters and "Practitioner/Provider Alerts," of preventive programs, as they become available.

Members should be encouraged to pursue continual mental health maintenance measures to help ensure compliance and overall health. HH promotes and supports the use of mental health wellness programs available through community resources and practitioners/ providers are encouraged to utilize community resources to promote member overall wellness and to supplement clinical interventions. Such programs may include, but not be limited to, nutrition, exercise, anger management, and stress management programs.

Prevention services should also be encouraged for members in treatment and their family members. Identified biological indicators may predispose them to conditions that, given adequate education and support, may be preventable. HH prevention programs focus on member and family education for these at-risk populations. These programs, support groups, and available community resources should be utilized, when appropriate, for additional support while members are involved in treatment and for aftercare.

Outpatient Treatment Planning and Monitoring

If the member requires continued treatment, multiple sessions per week or extended sessions (i.e. 90808) practitioners/providers must obtain prior authorization by phoning the Member Services Department. The **Outpatient Treatment Plan for Continuation of Treatment** (Attachment F) should be completed for those members who are re-accessing outpatient services for a new episode of care. **The Outpatient Treatment Plan for Continuation of Treatment is also used to monitor member progress and to request further visits.** All treatment plans must be completed in their entirety. If an item does not apply to the member, choose "NONE." By completing all items, we can be assured that the item has not been overlooked.

Please FAX (972-315-1866) the Interval Outpatient Treatment Plan to Member Services as soon as you determine that additional visits are medically necessary, preferably four (4) sessions before the end of the prior authorization. HH follows parity and catastrophic guidelines according to federal and state regulations, as appropriate.

If there are several practitioners involved in the treatment of a particular member, each practitioner must complete a separate Outpatient Treatment Plan for Continuation of Treatment. Each Outpatient Treatment Plan for Continuation of Treatment requesting additional visits will be reviewed for medical necessity. If approved, each practitioner will receive a separate authorization number.

Clinical Case Management

1. Outpatient Services Authorizations

For **ALL** authorizations, you will receive an “**Authorization Letter**” which includes the number of sessions authorized, an authorization number, type of service(s) authorized, and an expiration date.

The member will phone HH to register, speak to the Member Advocate Department and will receive a **member identification number**. When an appointment is made, the member will give the practitioner/provider their member identification number. The practitioner/provider will call the HH Member Advocate Department, provide the member identification number and receive the authorization number. *Services are to be rendered within the stated time period and the authorization number must be included on all claims.* Authorizations do not carry over. If they are not used during the given time frame, you must request an authorization extension by phoning the Member Advocate Department.

2. Denials

When a request for authorization has been denied, you will be sent a “Denial Notice,” informing you of the reason why further authorizations have been denied and how the member can appeal the decision (*please refer to Claims Section “How to Appeal a Claims(s) Denial”*).

Denials are based on the clinical information provided on the treatment plans submitted to HH or obtained telephonically from the treating practitioner. Denials may occur when the treatment requested could be more appropriately provided at a lesser level of care and/or does not meet criteria for medical necessity.

Other reasons may include:

- Insufficient clinical information;
- Member’s benefit plan does not cover the service;
- Type of treatment being requested does not meet medical necessity or appropriate treatment intensity;
- Member’s benefits have been exhausted;
- Failure to contact HH for authorization.

The final decision concerning treatment remains with the member and the practitioner.

3. Referral for Psychological Testing

Psychological testing **MUST** be pre-authorized through Member Services. Please be prepared to discuss the test(s) being requested, number of hours for each test and the clinical rationale. Psychological testing is approved on a limited basis to assist in determining accurate diagnosis and treatment and you may be asked to complete an **Outpatient Services and Special Requests Form** (Attachment G). Educational, academic, and IQ testing are **EXCLUDED**. Report writing is not covered. Your request will be reviewed with HH’s Psychologist Reviewer and Physician Advisor, and a Member Advocate will notify you of the decision.

4. Referral for Court Ordered Treatment

Court Ordered Treatment is not covered unless clinically indicated. If approved, only the counseling services are reimbursable.

5. Referral for Psychiatric Evaluation

A practitioner who identifies a need for a psychiatric evaluation needs to phone a HH Member Advocate to expedite a referral to a psychiatrist.

A separate authorization is needed for EACH practitioner providing services, even if the practitioners are in the same provider group. HH mental health professionals are required to refer members for a psychiatric evaluation if the member:

- Has a history of hospitalization(s)
- Has a history of suicide attempts
- Has a history of significant self-mutilation, significant/imminent risk-taking, or other-self endangering behavior
- Is taking psychotropic medication(s)
- Exhibits psychotic symptoms, including: delusions, prominent hallucinations, disorganized speech/behavior, decreased reactivity to the environment, psychomotor disturbances, flat or inappropriate affect, poverty of speech, inability to initiate and persist in goal-directed activities
- Exhibits active suicidal ruminations
- Exhibits/threatens violent behavior
- Exhibits active intoxication or withdrawal symptoms
- Exhibits symptoms that indicate a mental or psychotic disorder best treated by a psychiatrist
- Has a medical condition that appears to be contributing to present psychiatric symptoms
- Has demonstrated minimal to no progress in therapy.

For comprehensive medical management and to facilitate quality and safety, psychiatric evaluations are recommended through HH Member Services in accordance with the *Horizon Utilization Review Criteria* (available upon request from the Quality Management Department).

6. Communication with Other Treating Professionals

Communication among the various treating professionals is encouraged to ensure consistent and agreed-upon treatment goals, interventions, and follow-up. Some members may be treated either simultaneously or in succession in several different levels of care. It is critical that the psychiatrist, outpatient practitioner, and/or a representative from a more intensive level of care share information and progress. Behavioral and medical care should also be coordinated to ensure accurate diagnosis and optimal progress.

The primary care physician, with member consent, should be aware of psychiatric medications, substance abuse, psychiatric diagnoses, and other issues, particularly in the event of co-existing medical and behavioral health disorders.

HH monitors communication with Primary Care Physicians (PCPs) through the following where indicated:

- As part of HH Quality Management process, treatment records are reviewed to assess documentation of patient care coordination with the primary care physicians.
- HH Outpatient Treatment Plan of Continuation of Treatment Forms submitted to HH by network practitioners are monitored for the presence of documentation indicating that communication with the PCP has occurred.

7. Emergencies

Referrals to more intensive levels of care are discussed with Member Services. HH Member Advocates are available 24 hours a day, 7 days a week, including holidays. If the member has been evaluated and is determined to be medically appropriate for an inpatient admission, a referral is made to a network provider. Please call HH at any time

during this process to obtain information about what facilities are participating or to inform us of the progress on a case. The network inpatient provider will call the Member Services Department to pre-certify the admission.

Payment/No Shows

Practitioners/Providers are responsible for collecting the specified co-payment, co-insurance and/or deductible payments from the member. Co-payment amounts may be verified through the Member Services Department or the identified Third Party Administrator (TPA) and must be paid by the member or as indicated by the Health Plan.

Medical and behavioral health co-payments are not always the same and vary greatly by contract. **HH does not pay for missed appointments/no shows.**

Utilization Management Guidelines

Practitioners/providers must be willing to work within the guidelines of medical necessity criteria and benefit availability. Services that are not medically necessary are not part of an acute care benefit and will not be authorized.

It is the practitioner's/provider's responsibility to verify benefits through HH Member Services Department or another entity as stated on the membership card. If benefits are exhausted, proper transition to a community

provider should be coordinated between HH, the primary mental health practitioner, and the primary care physician, with patient consent.

Practitioners should be aware that mental health and chemical dependency benefits vary greatly. For example, some plans allow no services for ADHD, other than initial evaluation by a psychiatrist. Many companies offer Employee Assistance Program (EAP) services, which can be of great help to those members seeking help with financial or job concerns, but who do not present with a diagnosable mental disorder. Members should be encouraged to become familiar with their benefit availability, to read their particular plan, and to ask questions if they do not understand any aspect of the information they have received. Members with benefits concerns may be referred to HH Member Advocate Department or their benefits administrator.

HH allows open practitioner-patient communication regarding appropriate treatment alternatives and without penalizing practitioners for discussing medically necessary or appropriate care for the patient.

Medical Necessity/Levels of Care Guidelines

Decisions regarding medical necessity are based upon clinical information supplied by the practitioner. Treatment is deemed to be medically necessary when there is a diagnosable mental condition that affects social, familial, educational, occupational, or physical functioning. In order for a diagnosis to be made, appropriate historical information is a necessary, as well as objective description of symptoms and the degree of impairment. Treatment for a readily diagnosable condition must have a reasonable expectation either for improvement or preventing further decline. In reviewing inpatient and outpatient treatment plans, the *Horizon Utilization Review Criteria* (available upon request from Quality Management Department) is used as a basis for decision-making.

"Medically necessary" evaluation and treatment is defined as all forms of treatment which are generally accepted by peers, carried out in an ethical climate, and based upon effective diagnostic evaluative procedures. The problems should be sufficiently severe to meet established criteria for the diagnosis of psychiatric illness, according to standard nomenclature in the *DSM-IV Statistical Manual of Mental Disorders*. Medical necessity should be based on the member's disability and symptomatic clinical condition and should be paired to the appropriate level of care. Medical necessity, available benefits, the needs of the member, and the therapeutic capabilities of available resources in the behavioral healthcare treatment continuum assist in determining the appropriate level of care.

It is important to maximize the use of community-based resources, support groups, and educational programs.

HH recognizes the following levels of care:

Outpatient: Least restrictive therapeutic setting, clinic or private practice.

Intensive Outpatient: Medically supervised treatment program at least 3 days a week, 3 hours a day.

Partial Hospitalization: Medically monitored day treatment setting at least twenty (20) hours per week; primarily an alternative to or step-down from inpatient hospitalization.

Inpatient Hospital: Acute care provider providing 24-hour medical supervision for stabilization until patient can be moved to a less restrictive setting. A HH Network psychiatrist must follow up with the member daily.

Residential: Highly structured therapeutic environment for long-term care of chronic conditions.

QUALITY IMPROVEMENT

Quality Management

HH is committed to continuous quality improvement in behavioral health care and service delivery. As part of its managed care services, HH provides credentialing of practitioners/providers, 24-hour telephone triage, Member Services, utilization review for both outpatient and inpatient services, claims processing, outcomes studies, member and practitioner satisfaction surveys, and treatment record reviews.

The HH Quality Management (QM) Program monitors all aspects of care and care delivery, which includes clinical and administrative services. HH's philosophy is that the key to effective management of behavioral health care lies in the monitoring and continuous improvement of services of appropriate clinical intensity and the monitoring of adherence to established HH guidelines.

Components of care that are being measured include accessibility, availability, acceptability, appropriateness, continuity, effectiveness, efficacy, efficiency, member perspective issues, safety of care environment, and timeliness. Specific, timely, and quantitative indicators are utilized to evaluate all services provided through a systematic, planned method of data collection, analysis, evaluation, intervention, periodic re-evaluation, and action, if necessary.

HH conducts QM activities on an ongoing basis to assess and improve the delivery of clinical care, service, and prevention programs. HH invites practitioners/providers and members to participate in the development, design, and evaluation of these quality improvement activities.

Practitioners/providers and members are informed of the planning, design, implementation, and results of quality improvement activities via mailings, newsletters, HH "Provider Alert" and telephonically. HH encourages practitioners/providers and members to provide input, via return mailings, by contacting the Quality Management Department. If you have an interest in actively participating in quality improvement activities, please make this interest known to our Quality Management Department.

Reportable events are reviewed by HH for the purpose of evaluating the clinical care and the safety of HH patients and to assess through the quality of care review process the prevention of possible compensatory events. Network practitioners/providers are to report the following events to the HH Member Services department:

- Improper medication administration or medication reaction
- Death from any cause
- Suicide attempt while inpatient or in partial hospitalization
- Against Medical Advice discharges
- Elopement from the treatment provider
- Any inappropriate sexual interaction between treatment staff and patient or between patients
- Threat, by patient or patient's family member, to do bodily harm against treatment practitioners, employer/employee, or HH staff member(s)

- Failure of in-network provider to admit a patient in crisis, who meets criteria for services, because benefits cannot be verified or “pre-cert” cannot be obtained
- Alleged, actual or seriously attempted homicides or actions causing serious harm to another
- Injury/fall accident
- Inappropriate decision by facility and or practitioner/provider
- Other

Treatment Record Review and Site Visits

1. Treatment Records

Consistent and complete documentation in the treatment record is an essential component of quality patient care. HH treatment record documentation standards utilize the Guidelines for Treatment Record Review identified in the NCQA Accreditation Guidelines for MBHO. Results will be communicated to you within 30 days of the review. For those practitioners below threshold, a written improvement plan must be submitted to HH within 30 days. Practitioner treatment record-keeping practices are reviewed, through the HH Quality Management Committee and the Credentialing Committee, for compliance with standards.

Laws governing psychiatric advance directive statutes vary by state. Consult your state regulations. As a practitioner/provider one of the best risk management tools you can have is a well-documented record.

Outpatient Claims

1. Claims Filing Procedures

As a practitioner/provider in the HH Network, you have agreed to bill HH directly for services provided to our members, accept our contracted rates, and submit claims within (90) days of the date of service. “Clean Claim” shall mean a claim submitted by Provider or a Designated Practitioner to HH in writing that is proper, complete and contains all information required by HH in order to process the claim. You may bill the member for applicable co-payment, co-insurance, or deductibles only (not applicable for Medicaid patients). You may not bill the member for any balance above your contracted rate.

In order to promptly and accurately process your claim(s), you must complete an original HCFA-1500 claim form for outpatient services and a UB-92 Claim form (with attached itemization) for inpatient services. Please use the following, if necessary, when billing on the HCFA-1500 claim form:

2. Required Information

HCFA-1500 Field

- | | |
|--|--------|
| • Member’s full name | 2 |
| • Insurers Social Security Number without suffix | 1a |
| • Address and telephone number | 5 |
| • Date of birth | 3 |
| • Insured name (Last, First, MI) | 4 |
| • Relationship to the insured | 6 |
| • Insured group policy number | 11 |
| • Insurance plan name | 11c |
| • Signature or Signature on File (SOF) | 12,13* |
| • Name of referring physician | 17 |
| • ICD-9 diagnosis code(s) (required) | 21 |
| • Authorization number (required) | 23 |
| • Dates of service(s) | 24 |
| • Type of service CPT code(s) | 24d |
| • Place of service. Use the following codes: | 24b |
| 11 = Office | |
| 21 = Inpatient Hospital | |
| 22 = Outpatient Hospital | |

52 = Psychiatric Provider Partial Hospitalization

- Billing Charges and Units or Days 24f/ 24g
- Federal tax I.D. number 25
- Treating physician, including degrees credentials,
and name of supervisor, if applicable 31
- Name and address of provider where services were rendered 32
- Physician's/supplier's billing name, address, zip code (Last, First, MI) 33

Authorization must be obtained for all services for which you intend to be reimbursed. This includes consultations, follow-up visits, psychological testing, etc. HH administered plans provide benefits for only one professional service per day, except for the following, if authorized:

- Outpatient psychotherapy with a participating non-psychiatrist and medication management with a participating psychiatrist
- Outpatient psychotherapy and psychological testing
- Medication management and Intensive Outpatient services

When medical intervention is required while a patient is in a psychiatric inpatient unit, authorization must be obtained from the medical carrier. HH Member Services can assist you in determining whom to contact. HH is not responsible for these services. Authorization does not carry over from one benefit year to another. **Claims will not be paid using authorization from the previous benefit year or previous authorization period.**

"Clean" claims are processed in the order in which they are received. Clean claims are processed and paid within 30 days from the date stamped upon receipt or as specified by state law. "Clean" claims are those received within 90 days of the service and include all the accurate and necessary information, including valid authorization number.

Missing Information on Claims Forms

Please review your claim forms for accuracy and completeness to prevent delays in claims processing, which ultimately results in delay or denial of payment. Some common problems that cause delays:

- Assigned authorization number does not appear on claim form (HCFA 1500)
- No prior authorization was obtained.
- The date of service is before or after the authorized treatment period.
- Billing multiple days on one line.
- Visits or days billed exceed the number of visits or days authorized.
- Charges are not itemized.
- Member has exceeded yearly inpatient or outpatient benefit maximums.
- Service(s) or diagnoses are excluded under the plan.
- Explanation of Benefits (EOB) from the primary carrier is not attached to the claim when secondary coverage is requested.
- Services rendered by a practitioner who was not authorized to treat the patient.
- Pre-existing condition is not covered, as specified by the plan.
- Claims submitted that are too light or not legible will also be returned.
- Claims submitted after 90 days from date of service.

*** Important Note:**

Claims missing any of the above information will be returned to you for completion and will result in additional delay in processing.

How to Appeal a Claim(s) Denial

HH will submit to the practitioner an Explanation of Benefits (EOB) when claims are denied for:

- Services performed that were not authorized by HH.
- Services excluded by the client benefit plan.
- Services performed prior to the effective date or after the patient termination date.
- Claim(s) for services which fall outside the required time frame for submission.
- Member's benefits have been exhausted.
- Insufficient clinical information from the practitioner within the appropriate period of time.

The request to reconsider this denial must be submitted in writing with supporting documentation (HH denial, EOB, proof of the member's eligibility, authorization, etc.). **HH must receive this request within 60 days of the EOB notification of denial.**

Your claim(s) forms or written inquiries should be mailed to the following address:

**P.O. Box 292580
Lewisville, TX 75029-2428**

All other correspondence should be directed to the appropriate department under separate mailing.

The request will be processed through the Claims Service department (1-888-482-2733). Written notification of the result of the review will be sent to you within 30 days from the date of receipt of the appeal.

NETWORK SERVICES

It is very important that practitioners keep HH Provider Services updated on changes in status (address, tax identification number, name changes) and additional areas of specialization. This will allow us to update our systems and provide appropriate referral to most efficiently meet the needs of our members. HH requires practitioners to be both credentialed and contracted with HH in order to assess/evaluate/treat a member. Benefits should be verified prior to the member being seen, if possible. If subsequently it is found that the member was ineligible for services, the member may be billed for services rendered during the period they were ineligible. Any feedback you may be able to provide HH regarding general member needs and concerns is welcomed and particularly useful to us in developing quality monitors and future areas of study. Please do not hesitate to call our Provider Services Department to discuss such issues and trends.

Communication

Provider Services will be amending this manual from time to time when policy and procedure changes on new regulations are approved. You will be receiving this information via practitioner/provider alerts and newsletters.

**Compliance with all policies and procedures is required
to ensure additional referrals.**

If you have any questions, please contact HH at:

Phone: (800) 872-7322

Fax: (214) 626-6462

Attachment A
Horizon Health EAP Services, Inc.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The federal government has enacted a new law, requiring Horizon Health EAP Services, Inc. (HH) to maintain the privacy of information created or collected to manage or make payment for care, including care provided under an Employee Assistance Program (EAP). This information is now called **Protected Health Information (PHI)**, and includes any information that could reasonably identify a member, relating to the member's past, present or future physical or mental health.

HH is required to provide you and all other members with this notice. It describes how HH may collect, use and disclose your PHI, our legal duties to you with respect to it, and your rights in this information. We are required to follow the practices outlined here, effective April 14, 2003, until the notice is replaced, modified or amended.

Uses and Disclosures for Payment, Health Care Operations and Treatment: HH is allowed to use and disclose PHI to support and assist with treatment, to pay for healthcare services, to make decisions about payment for healthcare, and for health care operations, without first getting your written authorization.

Treatment: We may disclose PHI to health care providers to coordinate and manage your healthcare. We also may contact you with treatment alternatives and appointment reminders, and to provide information about other health-related benefits and services that may be of interest to you.

Payment: We use and disclose your PHI to administer your health benefits policy or contract. Administrative functions include eligibility and benefit determination; claims payment; utilization review and care management; medical necessity review; coordination of care, complaint and appeal resolution, and the processing of external review requests. PHI may be disclosed to another plan in order to coordinate benefits, or to another entity that adjudicates or subrogates health claims. PHI may also be disclosed to plans for premium billing, underwriting, and so the plan may determine premium rates, co-payments, deductibles, co-insurance and other cost sharing amounts.

Health Care Operations: This is the name given to healthcare business activities other than those involving payment or treatment. These include:

- Quality assessment and improvement, including peer review and provider credentialing, and efforts to obtain and maintain accreditation by independent organizations such as the National Committee for Quality Assurance (NCQA) and the American Accreditation HealthCare Commission
- Performance measurement, outcomes assessment and health claims analysis
- Operation of preventative health services research, and preventive health, early detection, care management, and coordination of care programs in plans that offer these
- Conducting or arranging for medical review
- Underwriting, premium determination, and reinsurance administration
- Risk management, legal services, auditing, detection and investigation of fraud and other unlawful conduct
- Transfer of eligibility and plan information to business associates in order to administer a plan benefit.
- General administrative activities, including business planning and development, data and information systems management and customer service.
- Potential due diligence activities, in the event of a sale, transfer, merger, or consolidation of all or part of HH occur.

In connection with payment, health care operations, and treatment, we may collect the following types of information about you:

- Information we receive directly or indirectly from you, your employer, your benefits plan sponsor, or one of its business associates. Your name, address, social security number, date of birth, marital status, dependent information, employment information and medical history may be supplied by applications, surveys, or other forms.
- Information about other insurance coverage and health care transactions with another entity, provided in order to coordinate benefits or to properly process an appeal or resolve a complaint.

PHI may be shared with third parties that perform various activities on our behalf. These arrangements are governed by a written contract with terms to protect PHI-privacy. PHI obtained for underwriting when the policy or health insurance or health benefits contract is not written with us, is not used or disclosed for any other purpose, unless required by law.

PHI is not destroyed when a contract for services by HH ends, because it may still be needed for the purposes described in this notice, and is subject to legal retention requirements, but the policies and procedures that protect against improper use or disclosure remain in force.

Some of the uses and disclosures described in this notice may be limited, in certain cases, by applicable state laws that are more stringent than the federal standards.

OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES OF PHI

We may use or disclose your PHI in the following additional situations without your authorization:

Employers: There are restrictions on what can be disclosed to your employer. If your employer “sponsors” or provides your health plan, we may disclose your name, identification number, and family coverage status, so that your employer can pay monthly premiums. We are also allowed to disclose enrollment and disenrollment, and may share PHI with the plan sponsor that summarizes claims history, expenses, and claim-types made by those enrolled in the plan. This information is also provided to your plan sponsor so that the sponsor can obtain premium bids from other health insurance companies or make decisions about modifying, amending, or terminating your health plan. We may also share limited PHI with your plan sponsor if the sponsor specifically requests PHI to administer your health plan, and agrees in writing not to use your PHI for employment-related actions or decisions.

Others Involved in Your Healthcare: Unless you request a *Restriction or Confidential Communication*, we may disclose to a member of your family, a relative, a close friend or any other person you identify, the PHI directly relevant to that person’s involvement in your health care or payment for health care. If you are present for such a disclosure (whether in person or on a telephone call), we will either seek your verbal agreement to the disclosure or provide you an opportunity to object to it. We may also make such disclosures to the persons described above when you are not present or are unable to agree or object to the disclosure, if we determine that the disclosure is in your best interest. We may also disclose your PHI to an authorized public or private entity to assist with disaster relief and to coordinate uses and disclosures to family or other individuals involved in your health care. Unless we are given an alternative address, we will mail explanation of benefits forms and other PHI-containing mailings to the address we have for the health benefits plan subscriber. We will not make separate mailings for enrolled dependents, unless Confidential Communications, described below, are requested. If you would like for us not to share information in any of the ways we have described within this paragraph, please contact the HH Privacy Office for additional information or instructions.

Required by Law: We may use or disclose your PHI to the extent that we are required to do so by law.

Public Health: We may disclose your PHI to a public health authority for purposes of public health activities, in order to control disease, injury or disability. We may also make disclosures to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems; to track products to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance.

Abuse or Neglect: We may make disclosures to government authorities concerning abuse, neglect or domestic violence.

Health Oversight: We may disclose your PHI to a government agency authorized to oversee the health care system, government programs or contractors (e.g., state insurance department, U.S. Department of Labor), for licensure and for legally authorized audits, examinations, investigations and inspections.

Legal Proceedings: We may disclose your PHI in the course of any legal proceeding in response to a court or administrative tribunal order and, in certain cases, in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose your PHI under limited circumstances to law enforcement officials. For example, disclosure may be made in response to a warrant or subpoena; for the purpose of identifying or locating a suspect, witness or missing persons; or to provide information concerning victims of crimes.

Coroners, Funeral Directors and Organ Donation: We may disclose your PHI in certain instances to coroners, funeral directors, and for organ donation.

Threat to Health or Safety: We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety or to the health or safety of others.

Military Activity and National Security: We may disclose your PHI to Armed Forces personnel, under certain circumstances, and to federal officials authorized to conduct national security and intelligence activities.

Correctional Institutions: If you are correctional facility inmate, your PHI may be disclosed to the facility for certain purposes, including to provide for your health care and for the health and safety of you and others.

Workers' Compensation: We may disclose your PHI to the extent required by workers' compensation laws.

Uses and Disclosures of PHI with an Authorization: Other uses and disclosures of PHI are made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization, at any time, in writing, except to the extent that we have acted in reliance on the authorization being revoked.

Some members ask us to disclose their PHI to third parties for reasons not described in this notice. For example, elderly members often ask us to make their records available to caregivers. To authorize us to disclose any of your PHI to a person or organization for reasons other than those described in this notice, please call the HH Privacy Office and you will be provided with the appropriate authorization. You should send the completed form to the address provided under "Contact Information for Exercising Member Rights" below. You may revoke the authorization at any time by sending a letter to the same address. Please include your name, address, member identification and a telephone number where we can reach you.

YOUR INDIVIDUAL RIGHTS

The following is a brief statement of other rights you have with respect to your PHI. In some cases, your health plan or HMO, rather than HH, must assist you with regard to accessing these rights. In either case, you may first contact us at the address below.

Right to Request Restrictions: You have the right to ask us to restrict the way we use or disclose your PHI for treatment, payment of healthcare operations, or as described in the section of this notice entitled "Others Involved in Your Healthcare." We are not required to agree to your request, but if we do, we may not use or disclose your PHI in violation of the restriction, unless necessary due to an emergency.

Confidential Communications: We will accommodate reasonable requests to communicate with you about your PHI by alternative means or at alternative locations. For example, if you are covered under a health plan as an adult dependent (e.g., a spouse or a child attending college) and you want us to send correspondence that contains PHI to a different address from the subscriber we can accommodate that request. We may ask you to make your request in writing.

Access to PHI: You have the right to receive a copy of PHI about you that is contained in a "designated record set" with some specified exceptions. A "designated record set," is a group of records that we use to make decisions about you including enrollment, payment, claims adjudication and case or medical management records. We may ask you to make your request in writing and to provide us the specific information we need to fulfill your request.

We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. More information on our fee structure is available by contacting us at the address provided below.

Amendment of PHI: You have the right to ask us to amend any PHI about you that is contained in a “designated record set” (see above). All requests for amendment must be in writing. In certain cases, we may deny your request. For example, we may deny a request if we did not create the information, as is often the case for medical information in our records. All denials will be made in writing. You may respond by filing a written statement of disagreement with us, and we will have the right to rebut that statement. If you believe someone has received inaccurate PHI from us, you should inform us at the time of the request if you want that person to be informed of the amendment.

Accounting of Certain Disclosures: You have the right to request an accounting of times we have disclosed your PHI for any purpose other than for: (i) treatment, payment, or health care operations; (ii) as described in the section of this notice entitled “Others Involved in Your Healthcare;” (iii) disclosures that you or your personal representative have authorized; or (iv) certain other disclosures, such as disclosures for national security purposes. All requests must be in writing. We will require that you provide us the specific information we need to fulfill your request. This accounting requirement applies for six years from the date of the disclosure, beginning with disclosures occurring after April 14, 2003. If you request accounting more than once in a 12-month period, we may charge you a reasonable fee. More information is available on our fee structure by contacting us at the address provided below.

CHANGES TO PRIVACY PRACTICES

We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain. We will distribute a new Notice of Privacy Practices whenever we make a material change in the privacy practices described here and you may obtain a new notice by contacting the HH Privacy Office below.

QUESTIONS AND COMPLAINTS

If you have questions about this notice or would like an additional copy of the notice, please contact the HH Privacy Office at the address below.

CONTACT INFORMATION FOR EXERCISING MEMBER RIGHTS

If you are concerned that your privacy rights may have been violated, please follow the complaint procedures described in your plan documents. You also have the right to complain to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint. If you have any questions about the complaint process, including the address of the Secretary of Health and Human Services, please call the HH Privacy Office at the telephone number listed below.

You may contact the HH Privacy Office at 1-800-820-1305, or by sending a letter to:

Horizon Health EAP Services, Inc.
9370 Sky Park Court, Suite 140
San Diego CA 92123

Attachment B

Horizon Health EAP Services, Inc.

Confidentiality Policy

Horizon Health's (HH's) comprehensive confidentiality policy is designed to protect access to member medical information. Integrated Insights protects access to confidential information in the following ways:

- HH maintains a strict policy to not sell or share any lists or identifying patient information for any purpose whatsoever.
- HH requires staff, employees and visitors to sign statements concerning confidentiality, release of information and communication requirements.
- Communicating expectations regarding confidentiality to providers via the provider manual and provider agreements.
- Monitoring provider adherence to confidentiality policies and procedures during site visits, quality reviews and routine contact.
- Monitoring member feedback on policy adherence through the complaint process, member satisfaction results and internal quality audits.
- Compliance with all applicable state and federal laws pertaining to confidentiality and the security of any identifying patient information.

In addition, HH providers are required to:

- Utilize Release of Information and consent for treatment forms that comply with applicable state and federal laws and member-specific requirements such as EAP workplace releases.
- Establish office procedures that safeguard communication with members (i.e. telephone and cell phone use, access to appointment books or computers etc).
- Inform and/or make available the HH's Member's Rights and Responsibility Statement, Complaints Process as well as how to request a copy of HH's Confidentiality Policy.
- Participate in and comply with HH's quality review, site visit process and contract obligations.

Attachment C

Horizon Health EAP Services, Inc.

Statement of Understanding

Welcome

Horizon Health (HH) offers assessment, short-term counseling, and referral services to the employees of our client organizations and their eligible family members. Services provided within the EAP counseling benefit are provided at no direct cost to the employee or family member. It is the responsibility of the client to pay for any services outside of the EAP counseling benefit.

Client Rights

Information that you provide to HH Health will not be released without your prior knowledge and written consent except under the following circumstances: HH Health counselors may be required to and will report threats of imminent physical violence or of suicidal intent as well as suspicion of child/elder abuse or neglect. Furthermore, your HH Health counselor may consult or share clinical information with other HH Health counselors or their contracted mental health professionals when necessary to provide you with quality clinical services.

Upon request, you are entitled to information about the methods of counseling, the techniques used, the duration of counseling, information regarding educational degrees, clinical training and experience, licenses and credentials of your counselor. When requested in writing, a treatment summary can be provided at your expense. You may terminate counseling at any time. In a professional counseling relationship, sexual intimacy is never appropriate and should be reported to your Regulatory Agency. Contact information for the Regulatory Agencies is available from our call center. Any time you have questions or comments about HH Health services, please call 1-888-482-2733 (if in the U.S. or Canada), or via confidential fax at 972-315-1866.

If you wish to file a complaint about HH Health, you may do so by telephone at 1-888-482-2733, by fax at 972-315-1866. If you speak a language other than English or Spanish, or require assistance due to a visual or hearing problem, your counselor will contact HH Health to assist you with the Grievance Procedure. If you need an interpreter to assist in filing a complaint, one will be provided, and will contact you to obtain the information about your grievance.

Client Responsibilities

You must cancel 24 hours in advance when you are unable to keep an appointment, or the missed session will "count" toward your EAP counseling benefit for that year.

It is HH Health's policy not to participate in clients' legal actions such as custody suits, divorce proceedings, personal injury suits, etc. If you are considering or are involved in such actions, your HH Health counselor can refer you to a mental health professional that is experienced in legal matters. Because such services are beyond your EAP benefit, costs for these services will be your responsibility.

I understand that HH Health may review my clinician's file regarding my treatment or my dependent's treatment as part of HH Health's Quality Assurance Program. I understand that my records may be transferred electronically. I understand that my participation in EAP counseling is voluntary and that all my records are protected by confidentiality regulations. I have read this form and understand my rights and responsibilities as a client of HH Health. I hereby give my permission to have HH Health follow-up with me upon completion of treatment to make sure that I am satisfied with the services rendered.

Client's Signature
(Parent if client is minor)

Client's PRINTED NAME

Date

Employee's PRINTED NAME

Employee's SSN
(US Citizen only)

Employee's DOB
(Non US Citizen)

Please keep this signed form in Client's Record - Please DO NOT mail back to Horizon Health EAP Services, Inc.

Attachment D

Horizon Health EAP Services, Inc.

Statement of Members' Rights and Responsibilities

Members' Rights

- Members have the right to receive EAP and brief counseling services in their primary language and in a culturally appropriate environment.
- Members have the right to receive EAP and brief counseling services that are free from discrimination regardless of race, gender, culture, disability, or sexual orientation.
- Members have the right to be treated with respect and dignity by all HH staff and contracted providers.
- Members have the right to receive appropriate EAP and brief counseling services.
- Members have the right to obtain information about Integrated Insights services and providers.
- Members have the right to receive information about HH's Quality Improvement Program, Confidentiality Policies and Complaints process.
- Members have the right to make recommendations regarding HH's members' rights and responsibilities.
- Members have the right to participate in the planning of their treatment.
- Members have the right to confidential private EAP and brief counseling in accordance with all applicable laws governing confidentiality. This includes your right to approve or refuse the release of information to your employer or any other third party.
- Members have the right to the confidential treatment and security of your medical record as provided by law. This includes your right to approve or refuse the release of your medical record to any third party.
- Members have the right to inspect your medical record unless it is determined that doing so would cause you harm.
- Members have the right to add an addendum to your medical record if you believe information contained in the record to be in error.
- Members have the right to voice complaints or make recommendations about Integrated Insights customer service or the clinical care you have received.
- Members have the responsibility to provide to the best of your ability, the information your provider needs in order to care for you.

Members' Responsibilities

- Members have the responsibility to follow the treatment plan and instructions for care that you and your provider have agreed upon.
- Members have the responsibility to participate in understanding your identified problems and in developing mutually agreed upon treatment goals with your provider.
- Members have the responsibility to treat those giving them care with dignity and respect.
- Members have the responsibility to keep their appointments. Members should call their providers as soon as possible if they need to cancel visits.
- Members have the responsibility to let their provider know when their treatment plan no longer works for them.
- Members have the responsibility to not take actions that could harm others.
- Members have the responsibility to report abuse.
- Members have the responsibility to report fraud.
- Members have the responsibility to openly report concerns about quality of care.

Attachment E
Horizon Health EAP Services, Inc.
Freedom of Choice Affidavit

Must be signed by any EAP member who wishes to continue in care with the assessing provider after EAP services are completed.

I, _____, verify that after my consultation with
Member Name

_____, _____, _____, an affiliate of
Provider Name City State

Horizon Health EAP Services, Inc. I have freely decided to enter on-going care with this service provider. My signature below signifies that I understand and agree to the following:

- I understand that the EAP is a short-term counseling benefit and that the care required is not EAP-appropriate.
- I verify that I have been offered a referral to at least two other treatment resources that are listed below, but have decided to continue care, beyond the services covered by the EAP, with this provider.
- I understand that I have entered into a direct payment relationship with this provider and that the EAP is no longer responsible for payment of services provided by this provider.
- I also understand that I am solely responsible for determining if the services of this provider are covered under my medical/behavioral insurance plan.

Member's Signature/ Guardian's Signature

Date

Witness

Date

NOTE TO PROVIDER:

Please list the two alternate treatment options that have been offered to this member. These alternate options must be outside of your practice and not affiliated with any facility or group in which you have a financial interest. Please include at least one participating provider under the member's insurance.

1) _____

2) _____

Horizon Health EAP Services, Inc., Fax: 972.315.1866

Attachment E

Horizon Health EAP Services, Inc.

Instructions for Freedom of Choice Affidavit

Introduction:

This form documents a member's choice to continue to see the EAP counselor after it has been determined that the problem or condition is not amenable to the short-term counseling available under the member's EAP benefit.

If the service cannot be provided under the EAP benefit, the member has the right to see the provider of his/her choice. In order to make an informed choice, the member needs specific information. This information includes:

- Why the recommended care cannot be provided under the EAP benefit.
- Names and locations of at least two providers, not including the EAP provider, from which to choose. At least one of these providers should be a participating provider in the network offered under the member's insurance.
- It is the member's responsibility to determine if the services of the chosen provider are covered under the member's insurance. Many members, however, can benefit from the expertise of the EAP counselor in navigating through the insurance coverage to determine:
 - Network status of available providers, if applicable, and
 - Financial implication of the choices, such as out-of-pocket costs.

Procedures:

1. Upon determination that a member's needs cannot best be served under the EAP benefit and that a referral is necessary, contact HH at **1.888.482.2733** to give disposition of the assessment and discuss the possibility of a self-referral.
2. If the member decides to continue with long-term care and expresses a desire to stay with the EAP counselor for this care, review with the member the Freedom of Choice Affidavit and alternative choices for care. Secure the member's signature.
3. Maintain the signed Freedom of Choice Affidavit in the member's file.
4. If the member is covered by a company for which HH is the gatekeeper to the insurance, **fax** a signed copy to HH at **1.972.315.1866** so that the referral may be given.

Attachment F
Horizon Health EAP Services, Inc.
Outpatient Treatment Plan for Continuation of Treatment

FAX: 1.972.459.6255

Received: _____
 Auth Date: _____
 Reviewer: _____

Form Instructions: Please print or type. All fields must be complete for authorization.
 Authorizations are contingent upon eligibility and benefits at the time services are rendered and are not a guarantee of payment.

ADMINISTRATIVE

Authorization Number:		Account Number:	
Member Name (last/first: required):			
Date of Birth: / /		Employer Group:	
State:			
Practitioner Name:			
Practitioner Address:			
Practitioner Tax ID# or SS#			
Phone:		Fax:	
Initial Visit:		Total Visits To Date:	

DIAGNOSTIC

Axis I:		
Axis II:		
Axis III:		
Axis IV:		
Axis V:	Current GAF:	Last Reported GAF:

TREATMENT GOALS AND PROGRESS (Refer to initial assessment)

Targeted Symptoms (Required)	Initial Frequency	Current Frequency
e.g. Suicidal Thinking / Sleep Disturbance / AV Hallucination	e.g. 3X/Week	e.g. 1X/Week
e.g. Panic Attacks / Intrusive Thoughts / Delusions	e.g. 2X/Day	e.g. 1X/Day
1.	/	/
2.	/	/
3.	/	/
4.	/	/

Attachment F

Horizon Health EAP Services, Inc.

Outpatient Treatment Plan for Continuation of Treatment

Member Name:		Authorization or Account #:			
Substance Abuse	<input type="checkbox"/> Denied	<input type="checkbox"/> Unknown	<input type="checkbox"/> None		
	Current	Abstinent	Current	Abstinent	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturate	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepine	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogen	<input type="checkbox"/>	<input type="checkbox"/>
Opioid:	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine	<input type="checkbox"/>	<input type="checkbox"/>			
Problems noted as it relates to substance abuse:					
Allergies to Medications or Environmental issues:					

CURRENT MEDICATIONS: (Required of prescribing physician)

Medication Name	Dosage / Frequency	Is this a change?
	/ /	Y <input type="checkbox"/> N <input type="checkbox"/>
	/ /	Y <input type="checkbox"/> N <input type="checkbox"/>
	/ /	Y <input type="checkbox"/> N <input type="checkbox"/>
	/ /	Y <input type="checkbox"/> N <input type="checkbox"/>
	/ /	Y <input type="checkbox"/> N <input type="checkbox"/>
Prescribed by:		

Treatment Plan/Intervention/Goals:

AUTHORIZATION REQUEST

Member is currently being seen : <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> PRN	
Number of sessions requested :	
From:	To:
Treatment type(s) requested (CPT Code) :	
Request for referral (Describe) :	
Comments : (Any Improvements) :	
Signature of Provider :	Date :
(Degree / Credentials) :	

Attachment G
Horizon Health EAP, Services, Inc.
Outpatient Services and Special Requests

FORM MUST: HAVE A RECENT MENTAL STATUS EXAM ATTACHED,
BE COMPLETELY FILLED OUT, AND BE LEGIBLE AFTER FAXING

RETURN FAX: 972-459-6255/Attn: Brad Loomis

If you have any questions, please call 888-482-2733, ext. 6245

Date of Request:					
Patient Name:		ID:			
Name of Requesting Practitioner:					
Practitioner Phone / Fax:					
Name of Administering Practitioner:					
Practitioner Phone/Fax:					
Current Diagnosis (DSM-IV): I:		II:	III:	IV:	V:

<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Mental Status Exam (copy attached)
Specific Psychological Tests Requested:
Purpose of Testing:
Estimated time required:
<input type="checkbox"/> <u>OUTPATIENT ECT</u>
<input type="checkbox"/> Psychiatric Evaluation (copy attached)
<input type="checkbox"/> Second Opinion (copy attached)
Outpatient Site:
<input type="checkbox"/> OTHER SPECIAL SERVICE REQUEST