WASATCH BEHAVIORAL HEALTH
SPECIAL SERVICE DISTRICT

CLIENT ACCESS TO TREATMENT – PERFORMANCE STANDARDS – C – 3.06

Purpose:

The purpose of this policy is to establish access standards for responding to clients' requests for services based on their expressed level of need, and to document adherence to those standards established by Division of Medicaid and Health Financing (Medicaid), and the Office of Substance Use and Mental Health (OSUMH)

Definitions:

Medicaid level of care standards: *

Emergent Care: Situations requiring immediate treatment telephone intervention within 30 minutes and face-to-face intervention within 60 minutes if the emergency condition persists.

Criteria: Individuals require immediate intervention. They may appear to be psychotic (experiencing hallucinations or delusions) expressing suicidal or homicidal thoughts.

Examples:

- Individual has made verbal suicidal/homicidal threats.
- Individual has made suicidal gestures (walking in front of car, cutting wrists).
- Individual reports or it is known that he/she has attempted suicide in the past.
- Individual was recently discharged from the inpatient psychiatric unit or is being referred by the hospital in an acute crisis that does not meet hospital admission criteria.

  Emergent Initial Contacts are defined as those made during normal business hours and include only enrollees who are not currently enrolled in services and who are Medicaid enrollees in the community (NOT at a hospital).

Urgent Care: Situations of a serious nature requiring treatment interventions within 5 business days of the initial contact.

Examples:

- Individuals identified by a crisis worker to be in need of urgent care.
- Individuals moving to Wasatch Behavioral Health Special Service District (WBH) catchment area who are identified by their current provider to be in need for urgent care.

Non-urgent Care: Situations requiring treatment interventions within 15 business days of the initial contact.

Criteria: Individuals requesting services who do not meet emergent or urgent criteria.

OSUMH established service priorities:

High Service Priority:

1. Individuals with an acute mental health crisis requiring immediate intervention or evaluation for an application of civil commitment as defined by mental health commitment criteria (i.e. “pink”, “blue”, or “white” sheets).
2. Individuals classified as a Seriously and Persistently Mentally Ill adult (SPMI) - or classified as a Seriously and Emotionally Disturbed child (SED) - and are indigent or Medicaid eligible.
3. Individuals classified as SPMI or SED who require two or more mental health statute mandated services.

Medium Service Priority:

1. SPMI and SED individuals who require only one mental health statute mandated service.
2. Non-SPMI/SED indigent individuals in need of services.

Low Service Priority:

1. Non-SPMI/SED individuals needing or requesting services and are not indigent.
2. General consultation, prevention, and public education services.

SUD Service Priority

In Rule R523-2-3. Priorities for Treatment Services, OSUMH requires substance use disorder treatment services provided with public funds (federal, state, and local match) to provide priority admission to the following populations (in order of priority):

(a) Pregnant females who use drugs by injection;
(b) Pregnant females who use substances;
(c) Other persons who use drugs by injection;
(d) Substance using females with dependent children and their families, including women who are attempting to regain custody of their children; and
(e) All other clients with a substance use disorder, regardless of gender or route of use.

Policy:

A. Medicaid Enrollees requesting treatment services with WBH shall be screened prior to admission in accordance with WBH’s current Medicaid Contract, Utah State involuntary commitment laws (State statute 62A-15-713), and Utah State Mental Health Board Policy 01-04, requiring community mental health centers prioritize services to potential clients based on defined service priorities and levels of care determination.
B. WBH accepts eligible Enrollees in the order in which they apply, without discrimination on the basis of race, color, national origin, age, sex, sexual orientation, gender identity, or disability, and without restriction to the members free choice of services and providers, pursuant to the terms in the contract.
C. Non-Medicaid individuals requesting services may be refused services, receive limited services, or referred elsewhere based on level of service priorities, levels of care determination and the availability of non-Medicaid funds.

   WBH shall:

   1. Maintain a database on Medicaid clients’ initial contact data for all enrollees regardless of the initial referral source, and

2. Provide timely access to evaluation services and document these services including the following:
    - Date and time of all initial contact.
    - Type of contact.
    - Date and time of 30-minute follow-up screening for emergencies.
    - Date and time of face-to-face contacts for emergent, urgent and non-urgent care.
    - When time frames are exceeded, and documentation of the clients' agreement or disagreement to a later time.
    - Reason for exceeding time frames.
3. WBH shall use the database to evaluate the quality of timely access to treatment for Medicaid enrollees.
4. Document the status of scheduled first face-to-face in the clients' electronic record. (See Initial Contact System).
5. Send the enrollee a Notice of Adverse Benefit Determination (ABD) when WBH cannot offer the first face-to-face service within the required time frame. (See policy C – 3.08B Medicaid Adverse Benefit Determination (ABD)s and Appeals)
6. Submit its performance on the timely access standards for provision of first face-to-face services to Medicaid and Medicaid's contracted external quality review organization when requested.
7. Patients under the age of 18 requiring insulin to manage diabetes mellitus may participate in Wasatch Behavioral Health day and residential programs if they are able to independently execute orders by their treating provider or if a written care plan is created and signed by parents and the Program Supervisor. This may include, but is not limited to, monitoring of blood glucose levels, dietary needs and insulin administration. Orders from the treating provider must be available prior to starting the WBH program. Emergency admissions are exempted from this policy.

Procedure:

A. Initial Telephone Contacts:

1. The care team assistant shall promptly answer and respond to all initial requests for services phone calls.
2. The care team assistant shall gather basic information about the service needs of the person calling, or about the person for whom the person is calling. When the caller is requesting general information, the care team assistant shall provide what the caller requests.
3. When more than basic information is requested, the care team assistant shall transfer the call to the appropriate staff or to a crisis worker for further evaluation.
4. Should a caller report being in crisis or in circumstances that are emergent, the crisis worker shall respond to the enrollee within 30 minutes. If the caller states the situation is life threatening, the care team assistant shall instruct the caller to call 911.
5. When it is determined that the enrollee has a Crisis/Emergency, the crisis worker shall offer face-to-face Crisis/Emergency Services within one hour or within a time frame mutually agreed on by the enrollee or his or her agent and WBH. The care

team assistant or crisis worker shall ensure appointments for clinical follow-up shall be scheduled, within the required level of care standards.

6. When the enrollee is not contacted with in the 30-minute standard, the crisis worker must document the reason.
7. When it is determined during the Initial Contact that the enrollee requires Urgent Care, WBH shall offer face-to-face Covered Services within a maximum of 5 working days of the Initial Contact.
8. When it is determined during the Initial Contact that the enrollee requires Non-urgent Care, WBH shall offer face-to-face Covered Services within 15 working days of the Initial Contact.
9. The care team assistant or crisis worker shall provide important information regarding Crisis/Emergency Services to the enrollee with instructions to contact WBH if more immediate services are needed. The care team assistant or crisis worker shall document in the pre admit database whether enrollees receiving urgent services were provided with information about Crisis/Emergency Services.
10. When an enrollee cannot be offered the first face-to-face service within the required time frame, WBH shall follow Medicaid Clients - Failure to Meet Performance Standards for First Face-to-Face Services procedures. (See policy C – 3.08B Medicaid Clients - Failure to Meet Performance Standards for First Face-to-Face Services procedures).
11. Based on the assessment of service priorities and level of care standards, referrals to other appropriate service agency providers may be made, as clinically indicated.
12. When requested by an enrollee, or when WBH determines it is necessary to ensure provision of appropriate Covered Services, WBH shall provide for a second opinion from a qualified provider within the network, or arrange for the enrollee to obtain a second opinion outside the network, and no cost to the enrollee.

B. Initial Walk-in Contacts:
   1. The care team assistant shall greet the person and gathers basic information about the service needs of the person.
   2. The care team assistant shall refer the person immediately to a crisis/intake clinician who shall determine access to services using acuity based level of care criteria.
   3. The crisis/intake clinician shall complete an initial clinical screening/ evaluation. If the person presents with an acute mental health crisis, immediate stabilization services shall be offered.
   4. An initial intake evaluation shall be provided at the time of screening when necessary; otherwise a follow-up appointment shall be made with an appropriate service provider.
   5. Based on the assessment of service priorities and level of care standards, referrals to other appropriate service providers shall be made, when clinically indicated.

C. Outside Provider: When an enrollee, who is already in treatment with WBH, request to see an outside provider, the care team assistant shall notify the program manager of

the request and inform the enrollee that the program manager shall review the enrollee's request with the enrollee. The program manager shall notify the enrollee of the decision within 14 calendar days of their request. (See related policy C – 4.31 Intake, Recovery Planning and Discharge Services for Medicaid Clients by Outside Providers). When the program manger authorizes the request, the date and time of 30-minute follow-up screenings for emergencies shall not be required to be documented because the standard has already met for the initial contact.

When an enrollee initially contact an outside provider without being seen by a WBH provider, the outside provider shall follow the performance standard, which are:

(a) If based on the Initial Contact it appears the Enrollee requires Emergency Services, the Contractor shall conduct a clinical screening by telephone within 30 minutes. If the Contractor determines that the Enrollee has an emergency, the Contractor shall offer outpatient face-to-face Emergency Services within one hour of completion of the telephone clinical screening, as appropriate. If an Initial Contact requiring outpatient Emergency Services is made on a walk-in basis, the Contractor shall offer face-to-face outpatient Emergency Services within one hour.

(b) If it is determined during the Initial Contact that the Enrollee requires Urgent Care, the Contractor shall offer a face-to-face Covered Service within five business days of the Initial Contact. The Contractor shall also provide appropriate information regarding Emergency Services to the Enrollee with instructions to contact the Contractor if more immediate services are needed.

(c) If it is determined during the Initial Contact that the Enrollee requires Non-Urgent Care, the Contractor shall offer a face-to-face Covered Service within 15 business days of the Initial Contact.

If a new enrollee who isn't receiving treatment with WBH requests an outside provider, the outside providers will complete the initial intake within the required Medicaid guidelines for the 30-minute follow-up screenings for emergencies. The outside provider may refer them to the Utah Crisis Line or WBH crisis services.

D. Coordination and Continuity of Care with Outside Providers:

WBH will coordinate service:

a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;
b. With the services the client receives from any other managed care plan;
c. With the services the enrollee receives in Fee for Service Medicaid;
d. With the services the client receives from community and social support providers; and
e. Ensuring that in the process of coordinating care, each client's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]) and

42 CFR part II, if appropriately needed.

f. All outside providers' hours of operation and performance standards will adhere to the Medicaid standards.

E. Medicaid Client Level of Care Determination Required Interventions:

1. If based on the Initial Contact it appears the enrollee has Crisis/Emergency, WBH shall respond to the enrollee within 30 minutes. If WBH determines that the enrollee has a Crisis/Emergency, WBH shall offer face-to-face Crisis/Emergency Services within one hour or within a time frame mutually agreed on by the enrollee or his or her agent and WBH.
2. If it is determined during the initial contact that the enrollee requires Urgent Care, WBH shall offer face-to-face covered services within a maximum of 5 working days of the initial contact.
3. The WBH Intake Worker shall also provide important information regarding Crisis/Emergency Services to the enrollee with instructions to contact WBH if more immediate services are needed. The WBH Intake Worker shall document in the clinical record (Junction) whether enrollees receiving urgent services were provided with information about Crisis/Emergency Services.
4. If it is determined during the initial contact that the enrollee requires Non-urgent Care, WBH shall offer face-to-face covered services within 15 working days of the initial contact.
5. When an enrollee seeks services from an outside provider, and WBH authorizes the request, the date and time of 30-minute follow-up screenings for emergencies are not required to be documented.

F. Intake Process for Urgent and Non Urgent Standards: (See flow chart attachments A-D for point of entry).

At the intake appointment, the intake specialist shall:

1. Assist enrollee or parent/guardian in completing the intake information.
2. Provide enrollee or parent/guardian with the appropriate tool(s) (i.e. electronic device or paper and pencil) to complete state required surveys.
3. Highlight for the enrollee that the following can be found on WBH's website:
   - Medicaid Handbook
   - HIPAA Privacy Brochure
   - WBH brochure of services
   - Enrollee may request hard copies of these at anytime.
4. Offer alternative formant of the Medicaid Member Handbook. The alternative formats are translated versions of the handbook and other enrollee information in English and Spanish, large print or audio/CD for visually or hearing impaired enrollees. Offer to obtain an interpreter to give assistance in the explanation. Provide responses to any questions the enrollee or parent/guardian may have about their rights.

G. Assessment Process:

The Intake Therapist shall:

1. Construct an Assessment (Intake Assessment, SPMI/SED, Diagnosis, Initial Recovery Plan).
2. Schedule appointment with doctor/therapist.

H. Client "Timely Access to Services" Data Analysis and Reporting:

1. The Information Technology Department (IT) Program Manager shall provide a report quarterly to the QAPI Committee of adherence to Medicaid enrollee timely access standards required by the Medicaid PMHP contract. The IT program manager shall report to this committee whether or not WBH is in compliance, and if not, the reasons and recommendations for achieving compliance. The Committee shall document compliance issues in its meeting minutes and generate reports documenting non-compliance findings and recommendations from monitoring activities. The Committee may take corrective action if there is a failure to comply with set standards.

   The IT program manager shall use WBH's behavioral health care database (Junction) to track compliance with enrollee access to treatment standards. The program manager shall be responsible for ensuring the integrity of the database, that all required pre-admit intake data is obtained and correctly entered into the database, and the information is up to date and accurate for reporting purposes to PMHP Medicaid. (See related policy C-3.07 QAPI).

I. Medicaid Client Waiting List Requirements:

1. Placement on waiting lists pertains only to enrollees requiring Non-urgent Care. WBH may place an enrollee on a waiting list only after providing an initial mental health evaluation and if there is agreement between the enrollee (or their representatives) and WBH that the need for general outpatient services is non-urgent.
2. Enrollees, regardless of diagnosis or treatment needs, shall be given a follow-up appointment not to exceed 20 working days from the date of placement on the waiting list.
3. If enrollees are placed on waiting lists for specialty services (e.g. specialized therapy groups, psychosocial rehabilitation groups or programs, etc.), or for services with a specific provider, WBH shall offer or provide other needed outpatient services in the interim. Enrollees may remain on waiting lists for specialty services or for services with specific providers until openings become available, as long as other appropriate outpatient services are offered or provided in the interim. If enrollees (or their representatives) do not want other outpatient services in the interim, WBH shall document the services that were offered and the enrollee (or his/her representative's) decision.

J. First Face-To-Face Initial Contact Data Collection:

1. **Documentation:** WBH's first face-to-face initial contact data is captured, monitored, and calculated in WBH's Behavioral Health Care Database "Junction". At admissions, clients are screened and a level of care based on pre-determined criteria is selected for each client. The urgency level triggers a timer in Junction that alerts the staff member associated with the client about the minimum required

time frames in which to resolve the client's initial contact. The Scheduling System in Junction displays the date by which clients must be seen and allows staff members to identify specific reasons as to why appointments fall outside these time frames.

2. **Data Collections:** WBH's IT department shall be responsible for data audits and calculation. The IT department shall conduct a monthly audit of the existing Initial Contact data for analysis purposes. Data shall be extracted from Junction using an SQL script (see the file "ICReport.sql"). Junction is equipped with a date algorithm that determines compliant and non-compliant initial contacts. The data is then aggregated to show any unresolved initial contacts. Junction will automatically alert staff members of any unresolved initial contacts. Staff member shall be responsible for any unresolved initial contacts. The IT department shall also audit any outliers to verify aggregated totals.
3. **Reporting:** WBH's IT department shall be responsible for conducting audits of first face-to-face initial contact data to ensure clients were offered appointments within then required time frame. Any discrepancy found, that constitutes an Adverse Benefit Determination (ABD), shall be reported to the Care Management Director. The IT department shall also be responsible for generating and submitting first face-to f ace initial contact data to the Utah State Department of Health (Medicaid) when requested.

K. Safeguarding:

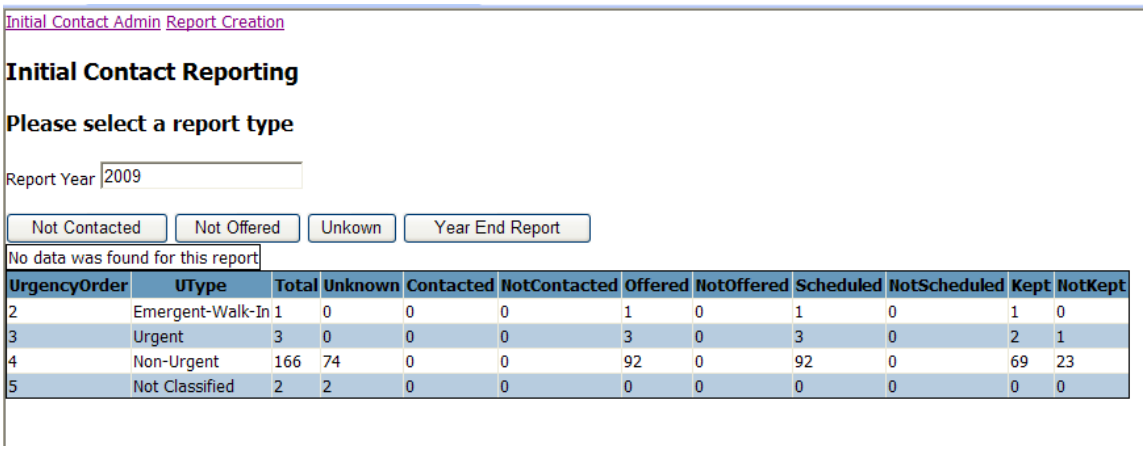
Security of Files: All files are stored in a highly secured area where only members of the Information Technology (IT) staff have access. Only members of the IT staff have direct access to servers and data located on the Junction database.

Data back-up: All data is backed up via two methods. The first method is a nightly tape backup. Files are backed up on a nightly, weekly and monthly basis. The second back up takes place through redundant servers located at the WBH Parkview campus about 3 miles away from the main WBH Westpark building. The redundancy allows for the quick reconstruction of user accounts and data required to ensure business can continue as normal in the event servers at WBH Westpark are damaged.

Cross training: Information Services (IS) staff have been cross trained to ensure continuity of workflow in the event staff leave WBH or become incapacitated.

File retention: Files are retained indefinitely.

Snapshot: The Junction electronic health record allows IS staff members to pull up a snapshot as seen in the image below:



Initial Contact Admin Report Creation

Initial Contact Reporting

Please select a report type

Report Year 2009

Not Contacted | Not Offered | Unkown | Year End Report

No data was found for this report

UrgencyOrder	UType	Total	Unknown	Contacted	NotContacted	Offered	NotOffered	Scheduled	NotScheduled	Kept	NotKept
2	Emergent-Walk-In	1	0	0	0	1	0	1	0	1	0
3	Urgent	3	0	0	0	3	0	3	0	2	1
4	Non-Urgent	166	74	0	0	92	0	92	0	69	23
5	Not Classified	2	2	0	0	0	0	0	0	0	0

Version control: To ensure accuracy of versions of the data that are sent to Medicaid, files are labeled with the following format, "CY08 WBH PERFORMANCE MEASURES REPORT v1.xls" To maintain historical data in the event of modification of files, subsequent files are labeled v2, v3, etc. The completed files are located at S:\Shared.Care Management\Medicaid\Performance Standards.

Logging and monitoring state deliverables: Upon creation of file to be submitted to Department of Health (Medicaid), the report that has been created is logged into an Excel spreadsheet titled, "Performance Measures Submission Tracking.xls.

L. Disenrollment:

Medicaid Enrollees may disenroll at any time by contacting the Utah Department of Health (Medicaid). Situations in which the health plan my request disenrollment of an enrollee include incarceration of an enrollee, admission to the Utah State Hospital, admission to a long term custodial care, enrollees residing outside of the service area, and enrolled by error.

A Medicaid Specialist with the Utah Department of Health will conduct periodic reviews of cases that have been placed on hold to determine if program termination is warranted. The specialist will review cases that are non-routine in nature and involve circumstances that are specific to the member involved.

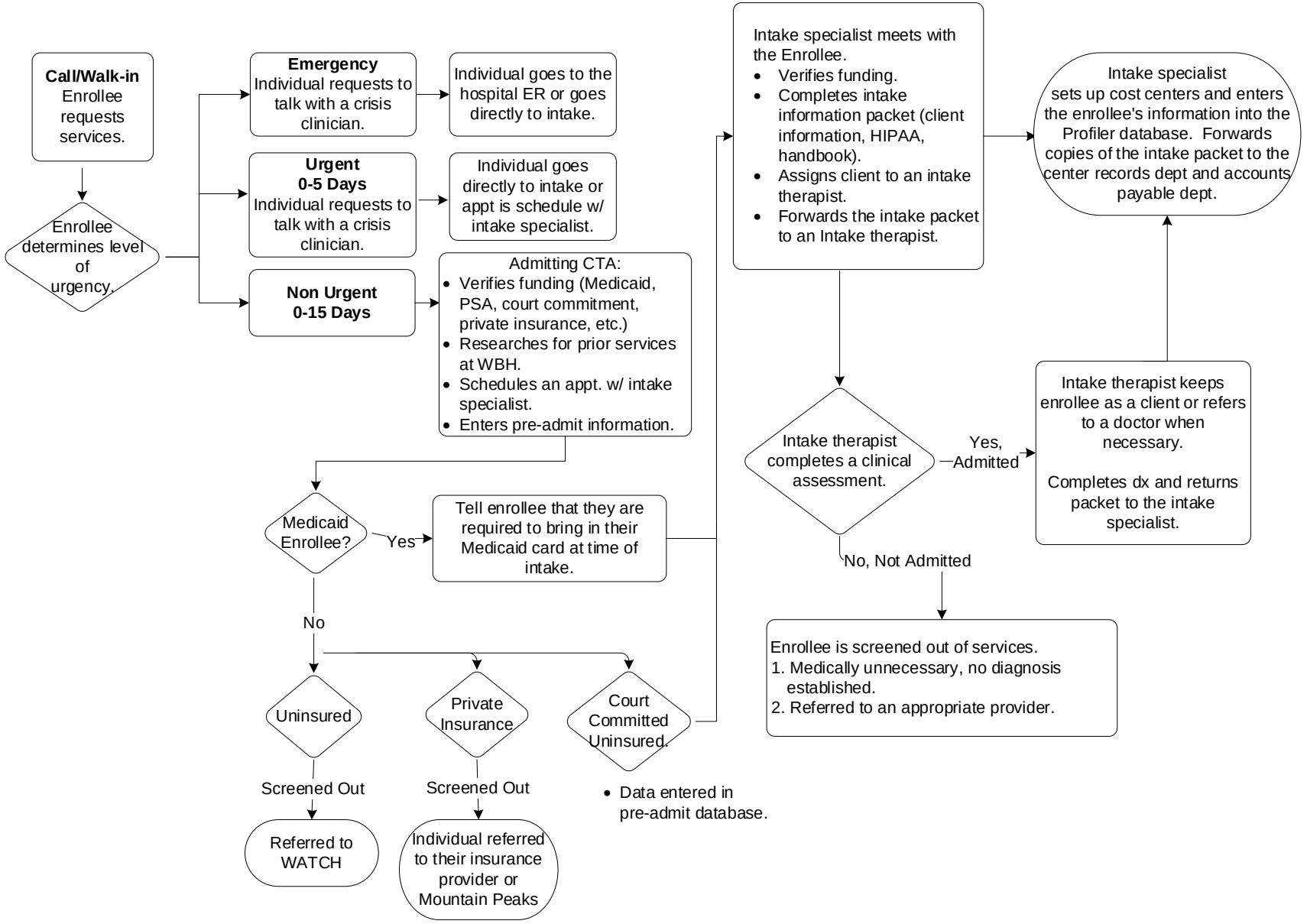
If an individual is disenrolled from Medicaid for more than 90 days, the individual must complete a new application and complete the enrollment process as if they were a new applicant.

WBH may not request disenrollment of an Enrollee because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from special needs (except when continued enrollment in the PMHP seriously impairs the WBH's ability to furnish services to either this particular Enrollee or other Enrollees).

Right to Change and/or Terminate Policy:

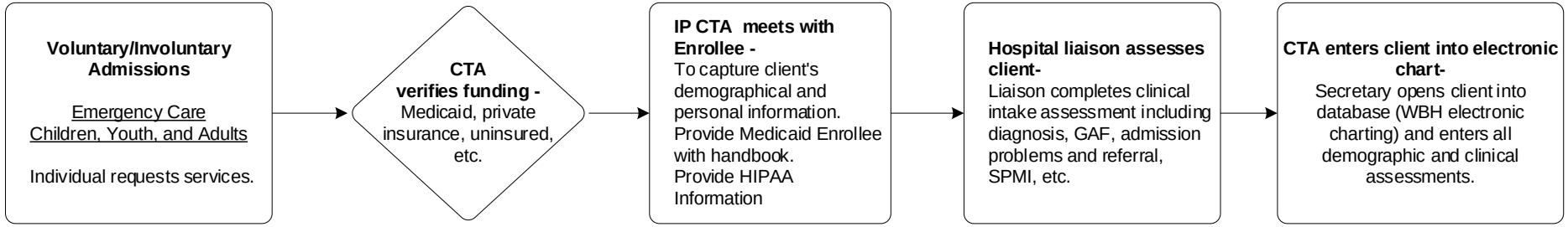
Reasonable efforts shall be made to keep employees informed of any changes in the policy; however, WBH reserves the right, in its sole discretion, to amend, replace, and/or terminate this policy at any time.

Attachment A
Adult Intake Process

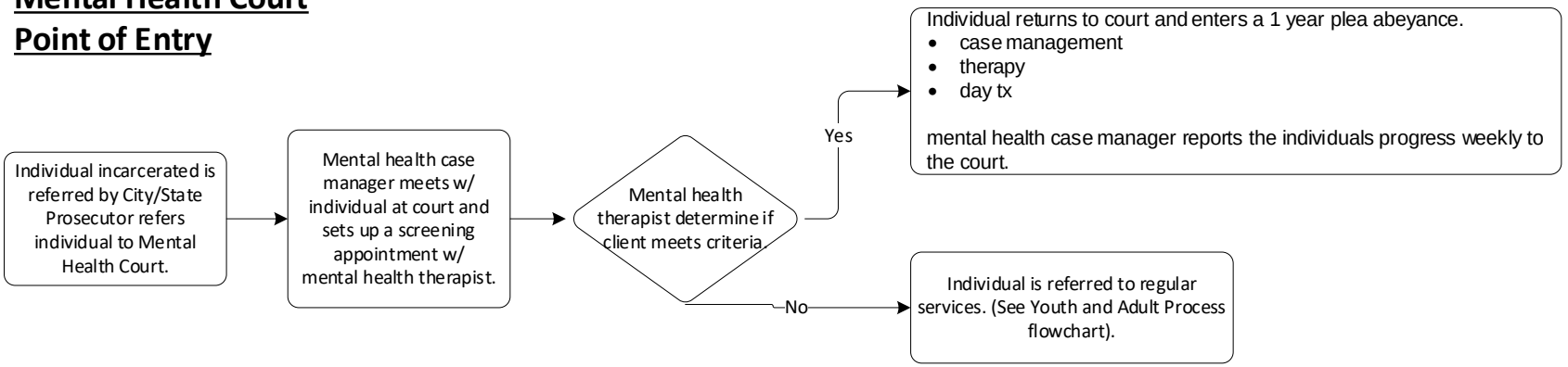


Attachment B
Inpatient and Mental Health Court Services

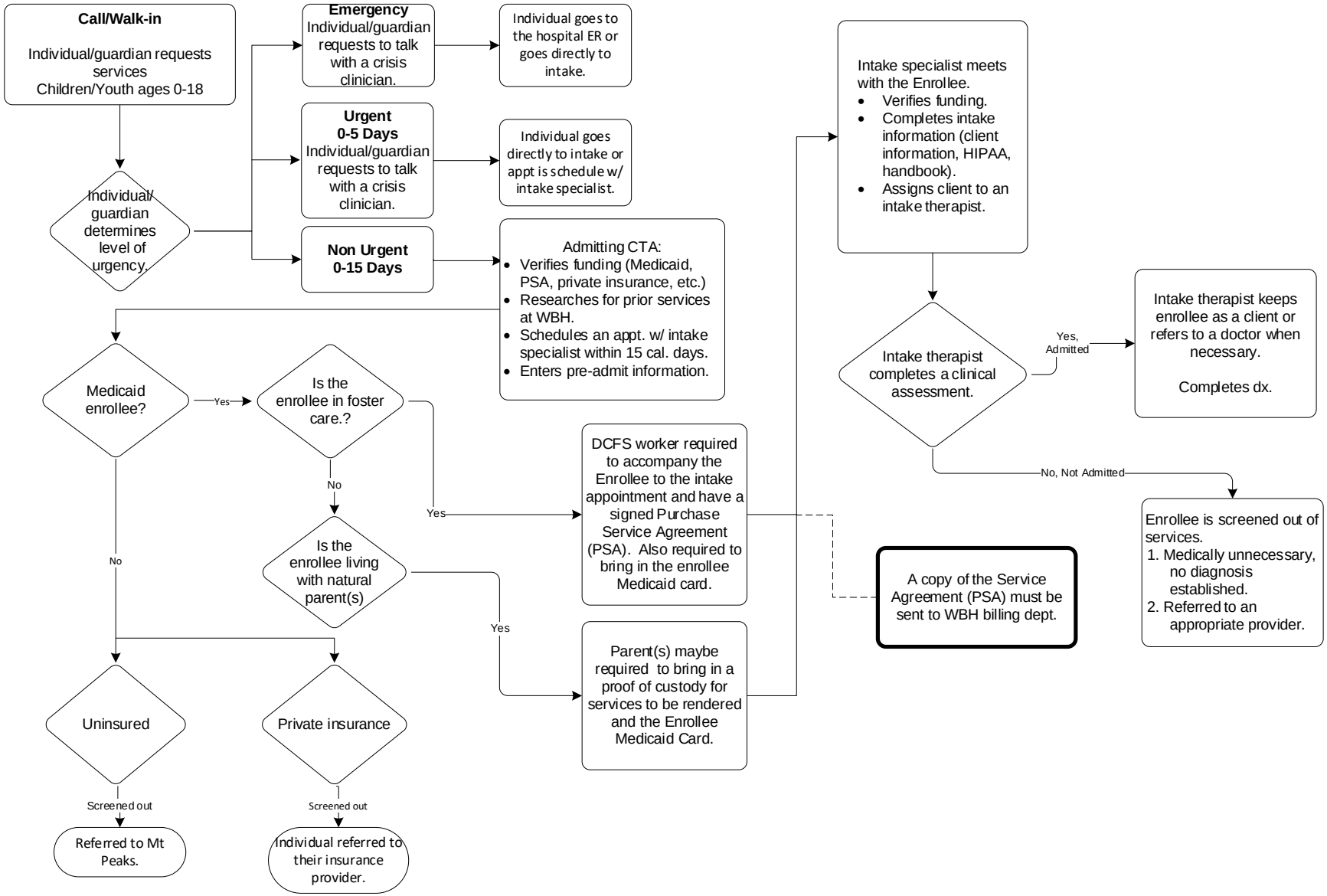
Inpatient Services Point of Entry



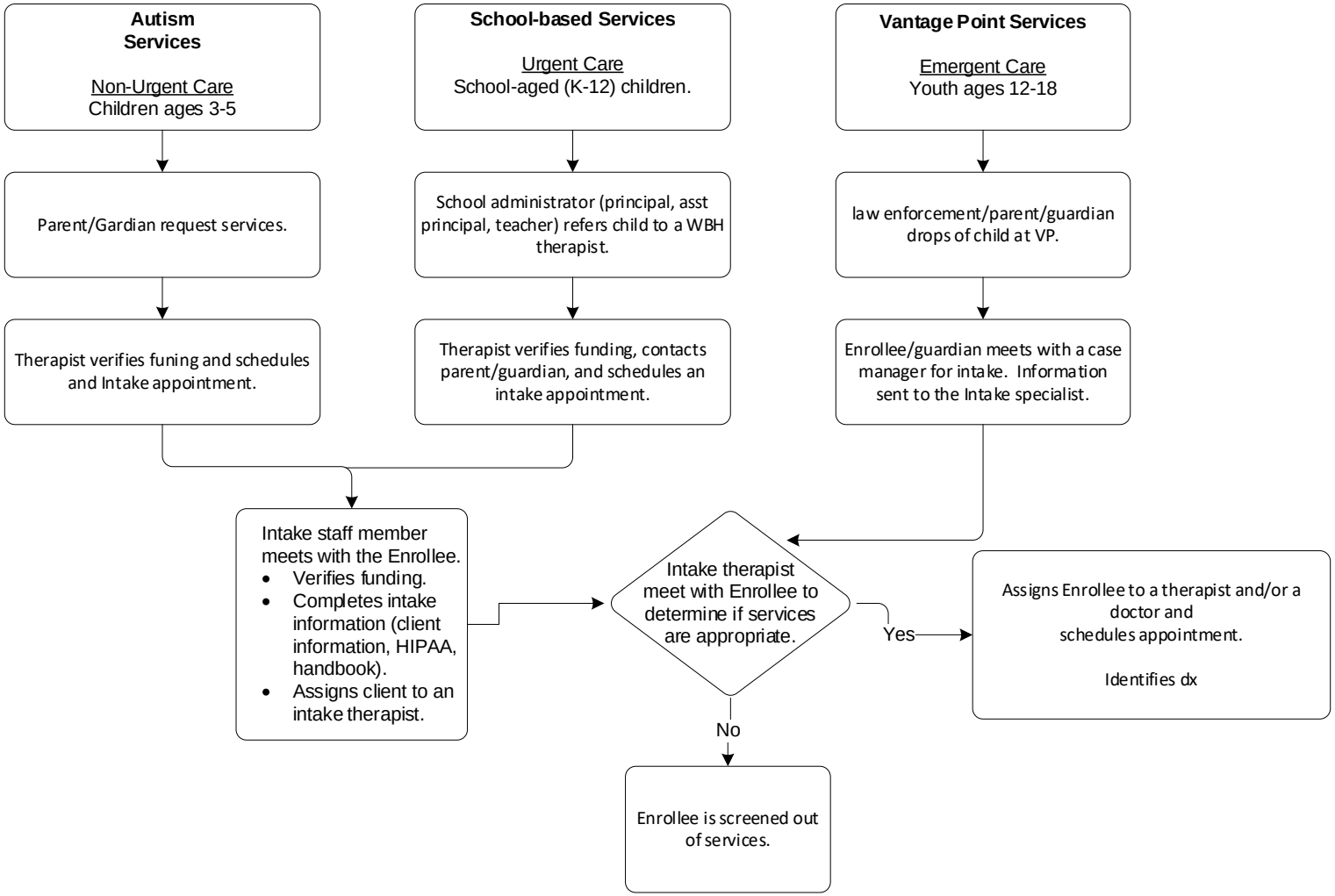
Mental Health Court Point of Entry



Attachment C
Youth Intake Process
Point of Entry



Attachment D
Youth Services Process
Point of Entry

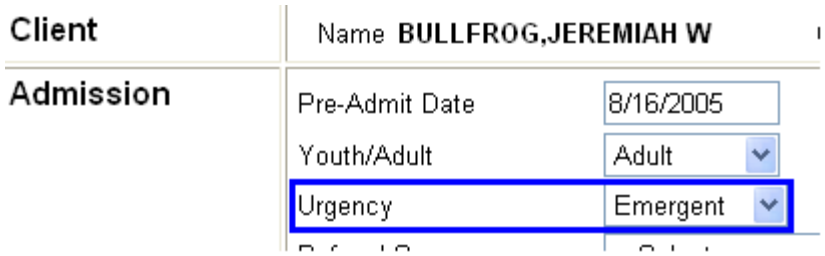


Initial Contact System

As part of the Medicaid Performance Improvement Project we are required to track the delay between the time a client requests service and their first face-to-face visit. The Initial Contact System is designed to help with this requirement.

Clients in Tracking

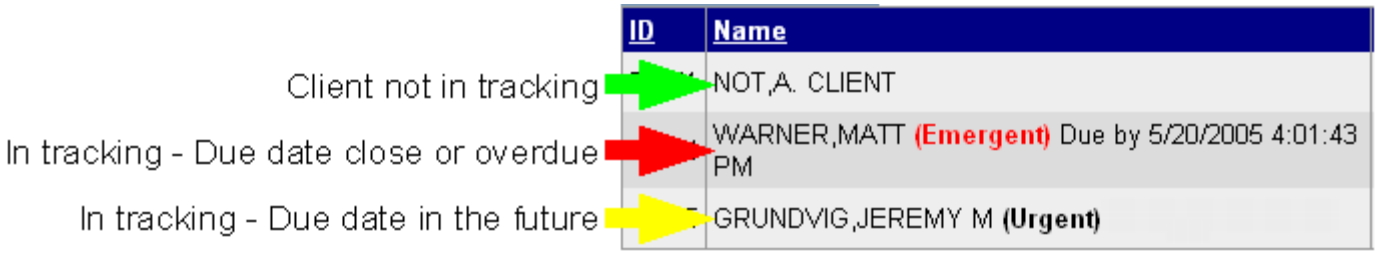
At intake, each Client is assigned an Urgency level (Emergent, Urgent, Non-Urgent). For more information, see Admission.



Based on this Urgency level, a Contact Due Date is assigned to the Client.

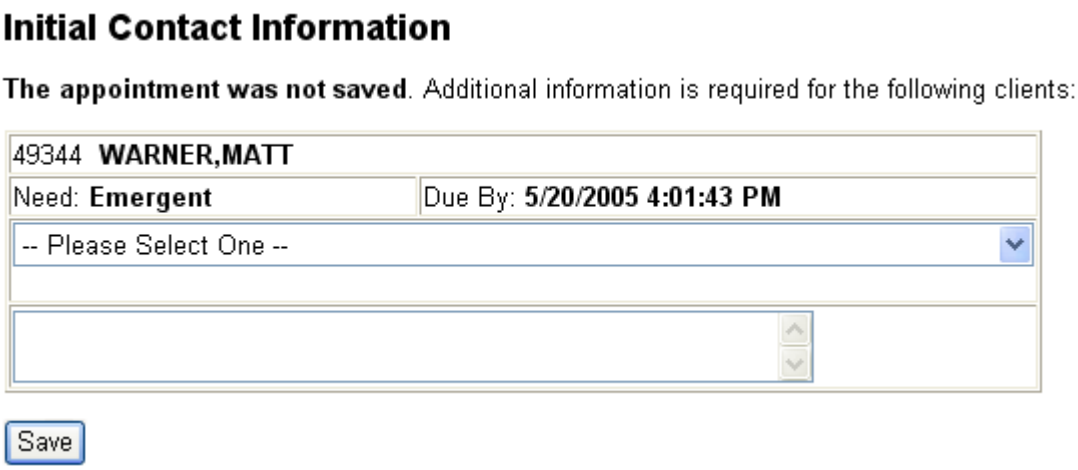
Urgency Level	Due Date	Definition
Emergent	One hour after Admission	**Emergency (Requiring telephone intervention within 30 minutes and face-to-face intervention within 60 minutes if the emergency condition persists):** Individuals who appear to be psychotic (experiencing hallucinations or delusions) or are expressing suicidal or homicidal thoughts. Examples: • Individual has made verbal suicidal/homicidal threats. • Individual has made suicidal gestures (walking in front of car, cutting wrists). • Individual reports or it is know that he/she has attempted suicide in the past. • Individual was recently discharged from the inpatient psychiatric unit or is being referred by the hospital in an acute crisis that does not meet hospital admission criteria.
Urgent	5 business days after Admission	**Urgent (Requiring an appointment within five working days):** • Individuals referred by the hospital who are not in an acute crisis and are not appropriate for admission to the psychiatric unit. • Individuals identified by a crisis worker to be in need of urgent care. • Individuals moving to WBH catchment area who are identified by their current center provider to be in need of urgent care.
Non-Urgent	15 business days after Admission	**Non - Urgent:** Individuals requesting services who do not meet emergent or urgent criteria should be scheduled an initial appointment within fifteen (15) working days.

You will be able to identify Clients in tracking in the Appointment Detail screen. Any Client in tracking will display the Urgency need. If the current date is close to or after the Initial Contact Due Date, the Due Date will be listed after the Client's Urgency. Emergent clients will also display the time due.



Initial Contact Information screen

The Initial Contact Information screen is used to collect information about Clients in tracking. You will be taken to this screen when you add a Client in tracking to an Appointment scheduled after the Initial Contact Due Date or when you change the status of a Client in tracking to anything but No Show. For example: If you change the status of a Client in tracking from No Show to Active, you will be taken to the Initial Contact Information screen.



You must specify a reason why the Appointment is being scheduled after the Contact Due Date or why the Client status is being changed. Select an appropriate reason from the drop-down box and click **Save** to save the Information and the Appointment.

Timely Appointment Offered

Select a reason from this group when we offered an Appointment within the Initial Contact time frame but the Appointment was not scheduled. Select the reason that best describes the situation

Timely Appointment Not Offered

Select a reason from this group when we were did not offer an Appointment within the Initial Contact time frame.

Other – Explain

Select this reason if there is no other option available that matches the situation. Be sure to enter comments as to why you are selecting Other.

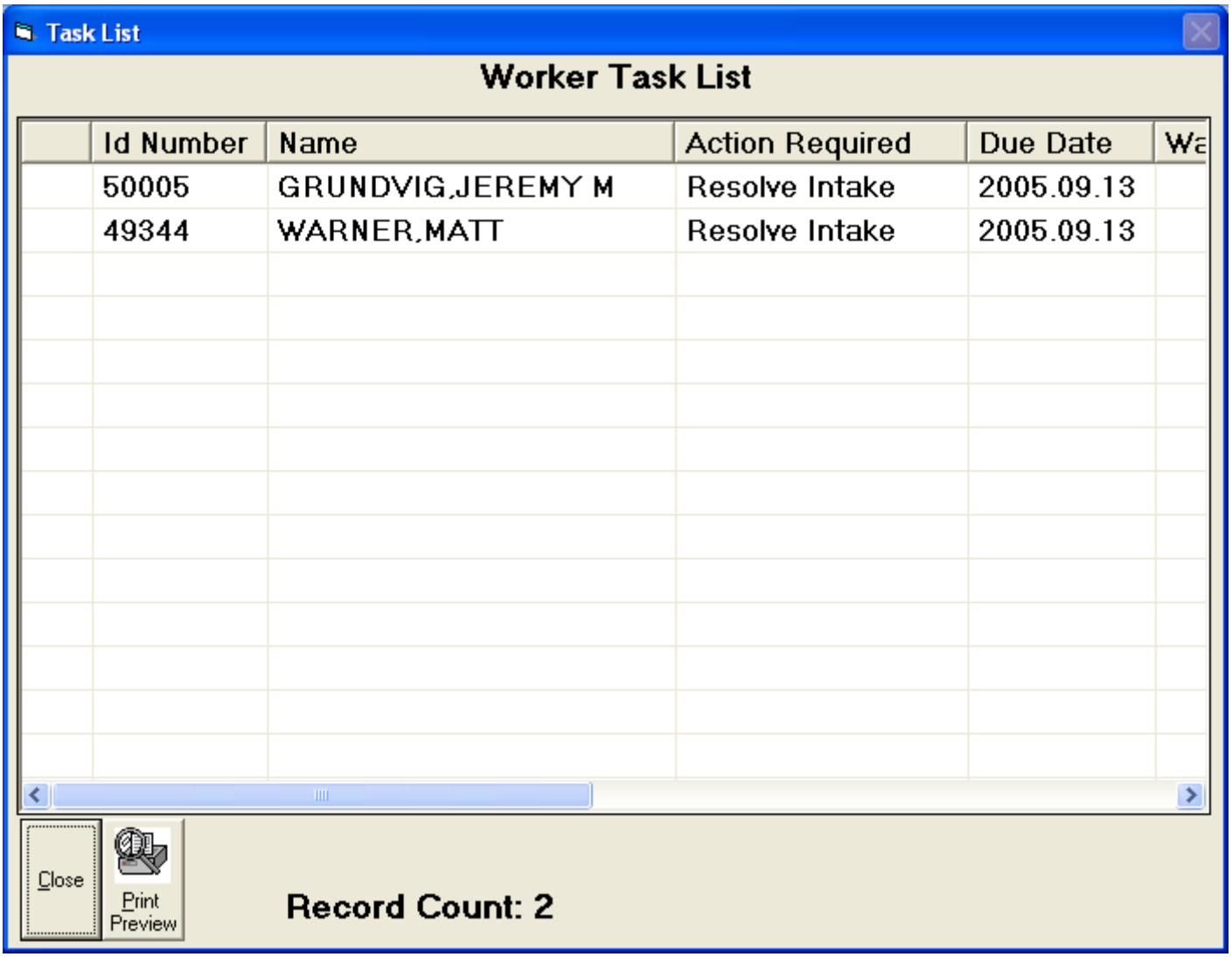
Task List Item

Each night the system will generate Task List Items for any Clients in tracking without resolved Appointments after the Contact Due Date. For more information on Unresolved Appointments, see Scheduling System Views. Each Client that meets this criteria will display with a Resolve Intake Task List Item.

Why do Task List Items appear?

There are several reasons why the system will create an Initial Contact Task List Item.

1. The Client has no Appointments scheduled in the system and no billable documentation. This means that the Client has no documentation anywhere in the system, other than his/her admission. Remember, an Appointment is added to the Schedule when you create a Note in CWS.
2. The Client's first Appointment is not reconciled with a clinical document and the Client's status is not No Show. Other Appointments may exist with clinical documents or where the client status is No Show; however, the system only looks at the First or Initial Appointment.
3. All of the Client's Appointments have a Client Status of Cancelled by Client or Cancelled by Worker and no billable documentation exists. This means that no Appointments exist for the Client that can be resolved for the Initial Contact system.
4. The Client's first Appointment is after the Initial Contact Due Date, the Appointment Date is in the future, and the Client requested an earlier Appointment. This information is documented when you save the Appointment with a date after the Due Date. See the Initial Contact Information screen.



When you click on a Resolve Intake Task List item or when you click on the Task List - Initial Contact link from the Scheduling System, you will be taken to the following screen. Each Client that has a Task List item will be displayed.

The Appointment Date, Time, Duration, Client Status, and Appointment comments will be listed. Links are available to navigate to specific Appointments or to Resolve the Appointment.

View Schedule

Click the **View Schedule** link to open the Scheduling System to the Client's Schedule on his/her Admission Date.

View Apt

Click the **View Apt** link to open the Scheduling System to the Appointment Detail screen for the selected Appointment.

Add Doc

Click the **Add Doc** link to Add a Note to the selected Appointment. This is the same as clicking the Add PNI, Add NUR, or Add DRN link in the Scheduling System. For more information see, Reconciling Documents with the Scheduling System.

No Show

Click the **No Show** link to change the Client status to No Show for the selected Appointment. This is the same as clicking the No Show Cancellation Shortcut in the Scheduling System. For more information, see Canceling an Appointment.

Past Due

If the Appointment is scheduled after the Contact Due Date, Past Due will be displayed after the Appointment date and time.

Group

If the Appointment contained multiple clients, Group will be displayed after the Appointment date and time. The Add Doc and No Show links will be disabled.

Back

Click **Back** to return to CWS or the Scheduling System.

Resolving Initial Contact Task List Items

To resolve an Initial Contact Task List Item, the Client must have either a Clinical Document in their chart or have a No-Show Appointment. From the Initial Contact Task List screen you can add a Note to a specific Appointment or change the Client status to No-Show for a specific Appointment. Knowing which Appointment to create the Note for or which Appointment was a No Show is up to you.

The resolution process may take some detective work on your part. It is up to you to remember when a Client No Shows and put this information into the Scheduling System. If a No Show is not documented in the Scheduling System, there is no one other than you who will know this.

After you have resolved the Appointment by either creating a Note or marking the Client as No-Show, the Task List item will remain in your list until the next day. All resolved items are cleared out of the list each night. Also, after a Client has been resolved, they will be removed from the Initial Contact tracking.

If a Client is resolved with a No-Show for their first Appointment and receives no services for 30 days, the Client will automatically be discharged.

View Resolution Examples

Medicaid Clients - Failure to Meet Performance Standards for First Face-to-Face Services

1. When WBH cannot offer the first face-to-face service within the required time frame, this constitutes an Adverse Benefit Determination (ABD). If there is not satisfied with waiting beyond the required time frame, the Intake Program Manager shall:
2. Review flow chart Adverse Benefit Determination (ABD) #4: Failure to Meet Performance Standards For First Face-to-Face Service.
3. Notify the Customer Service Representative (CSR).
4. Send the enrollee, and all affected parties, a written Notice of Adverse Benefit Determination (ABD) letter explaining the reason why WBH could not offer an appointment within the performance standard, the enrollee's right to appeal, and explain that they may receive reasonable assistance with the appeal process from staff (See policy C – 3.08B attachment form 7.59b-N2a Notice of Adverse Benefit Determination (ABD) and Appeal Rights).
5. The CSR shall log information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance/Adverse Benefit Determination (ABD)/Appeal spreadsheet and maintain a copy of the Notice of Adverse Benefit Determination (ABD).
6. Should the enrollee or other affected parties decide to Appeal the Adverse Benefit Determination (ABD). (See Policy C-3.08B Medicaid Adverse Benefit Determination (ABD)s and Appeals).

NOTE: It does not constitute failure to provide Covered Services in a timely manner, and therefore is <u>not</u> an Adverse Benefit Determination (ABD) if:

- The enrollee agrees to and is not dissatisfied with waiting beyond the required time frame,
- WBH determines the enrollee should not be at risk as a result of waiting and the enrollee is told to contact WBH if his or her situation changes
- An initial appointment is offered to the enrollee within the timeframe, but the enrollee is not able to meet the offered appointment time.