KEPRO
INTELLIGENT VALUE

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Maine ASO

Behavioral Health Services
Utilization Review Program

Member Handbook

Photograph by Marc Dionne, LCSW

KEPRO and Maine Department of Health and Human Services

Member Handbook

July 2016

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Office Location

KEPRO
400 Technology Way
Scarborough, Maine 04074

Office Hours

KEPRO offices are open Monday – Friday from 8 am to 6 pm.

Member Services

1-866-521-0027, Option 3
1-866-325-4752 (fax)
207-239-3252 (TTY/TDD), or Sorenson VRS

Maine Statewide Crisis Hotline

Toll free – **1-888-568-1112**
24 hours a day, 7 days a week
Intentional Warm Line
Toll free – 1-866-771-9276

KEPRO Website

www.qualitycareforME.com

If you want a paper copy of this Handbook, please call **KEPRO Member Services** at **1-866-521-0027**, **Option 3**

PART ONE: KEPRO and Me

Why Do I Need This Handbook?

The purpose of this handbook is to have a clear, easy to read guide on how KEPRO (APS) works. We want you to know how we do things at APS. This knowledge will help you advocate for yourself with APS and your providers (agencies who provide behavioral health services). These are your services and you have the right to know how they work.

What Is KEPRO?

KEPRO is an Administrative Services Organization (ASO). We were hired by the Department of Health and Human Services (DHHS) to review most behavioral health (mental health), intellectual disabilities, and substance abuse services. We do not provide services like a mental health agency. APS does not refer you for services. We look at information your provider gives us. We look over the information to make sure you receive the best services, for the right amount of time, with the least amount of restrictions.

Do I Still Pick My Provider?

Yes. APS does not pick out providers for you. You choose the provider that best fits your needs.

What If I'm In Crisis?

You do not need to call APS if you are in crisis. We want you to be safe so please call the **Maine Statewide Crisis Hotline** at **1-888-568-1112.** They are open 24 hours, 7 days a week, and 365 days a year. You can also go to your nearest hospital's emergency department.

KEPRO Member Services Department

The KEPRO Member Services Department is the part of APS that supports members. The Member Services Department includes the Clinical Manager and the Member Liaison. The Member Liaison serves as a bridge between you and APS. They can do this because they have personal experience with Maine's behavioral healthcare, intellectual disabilities, and/or substance abuse system. They may also have family members who receive services or have received services in the past. The experience of having used services gives the Member Liaison a unique understanding of members and their needs.

What Does the Member Liaison Do?

The Member Liaison;

- Answers your calls if you have questions or comments about APS.
- Takes your calls with ideas to improve APS.

- Recruits members for the APS Member Advisory Council.
- Explains your options to you if you get a Denial or Partial Approval letter.
- Looks over all member paperwork like newsletters, handbooks, presentations, to make sure they are clear and easy to understand.
- Does outreach for APS to member groups who want to learn more about APS.
- Helps you file an appeal if your services are denied.
- Helps you with a formal complaint against APS or someone who works for APS.

Contacting the Member Liaison

To contact the Member Liaison call **1-866-521-0027, Option 3**. You can contact the Member Liaison with any questions you may have about this handbook. We encourage you to ask questions about APS and how we do things.

The Member Advisory Council

The KEPRO Member Advisory Council (MAC) is made up of MaineCare members and their families or guardians. It is a group of individuals who gather together a minimum of four times a year to review APS

paperwork as needed. They review presentations, handbooks, to make sure they are clear and easy to read. The members also help us make improvements in how we deliver our services to you. They will also suggest trainings that can be done to help APS better serve MaineCare members. MAC members do all these things by listening to MaineCare members and their families. Then they bring these ideas and suggestions back to the quarterly meetings.

Who Can Be On the Member Advisory Council?

If the MAC sounds like something you would like to be involved with, then we want you. A member must be using behavioral health, intellectual disabilities and/or substance abuse services paid for by MaineCare or have used services in the past two years. Members may be:

- Youths
- Adults
- Parent or guardians of members

Do MAC Members Get Paid?

Yes. APS will pay you a $25.00 stipend for attending the meeting. You must show up at the meeting to get the stipend. We will

reimburse you for mileage or for your bus ticket or cab fare. We serve food at the meetings. If you choose to stay over in a hotel before or after the meeting we **will not** reimburse you for your stay.

How Many MAC Members Can There Be?

The most members that the MAC can have at one time is 16. When the MAC is full the council will rotate members at the end of the year. The Member Liaison keeps a list of people who want to be MAC members. New members will replace the oldest members and it will keep rotating out until everyone who wants to be a member has had a turn.

How Do I find Out More about APS?

- Go to our website www.qualitycareforme.com. You do not need a password and you can read anything posted on the website.
- Call **Member Services** at **1-866-521-0027**, **Option 3**. We can answer your questions by phone or send you copies of APS materials by mail.

PART TWO: UTILIZATION REVIEWS

Will APS Keep My Information Confidential?

Yes. APS is very concerned with keeping members information private and confidential. We follow all federal, state laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA).

Who Can APS Talk With?

APS can talk to your providers without a release of information because APS is a representative of DHHS. This means that we have access to the same information about you that DHHS has. Your information is kept private. APS needs written permission (Release of Information) to talk to anyone else. If you would like a Release of Information from APS, please call the **Member Liaison** at **1**- **866-521-0027**, **Option 3.**

How Does APS Review Services?

APS Care Managers look at clinical information given by providers to APS. The providers give this information when they request services for members. Clinical information includes your diagnosis, LOCUS, and CAFAS/CHAT or CANS (if you are a child) scores. We will also receive a shortened version of your treatment plan and a discharge plan. Care managers look at that

information along with the MaineCare Rules to make their decision. This whole process is called a “utilization review”.

What Does Utilization Review Mean?

The word Utilization means to make use of. The word Review means to look over. When we put those two words together “Utilization Review” then means making use of the information that we are given to look over. APS does this by using the clinical information that we are given along with the MaineCare Rules to make a decision about your services**.**

What Kinds of Services Does APS Review?

APS reviews most behavioral health, intellectual disabilities and substance abuse services. In order to receive these services your provider may have to do either a prior authorization or an initial registration.

A prior authorization is an approval that is needed before you can start services. Not every service needs a prior authorization.

An initial registration tells APS that a person has started services with a provider. They are usually approved for a pre-set amount of time and number of units.

What Is a Unit?

A unit is a measure of time that a provider can bill for. A unit can be different amounts for different services. For example, in Community Integration (Case Management) one unit is equal to fifteen minutes (one unit = 15 minutes). While in Residential Services one unit is equal to one day (one unit = one day). Your provider will ask APS for the number of units needed for your services.

Does APS Do Any Other Reviews?

Yes. APS does Continued Stay Reviews (CSR). To continue your services, your provider will submit a CSR. Your provider can submit clinical information about you to APS ten days before the date that your services are set to expire. CSRs are then looked over by our Care Managers. They can make one of three possible decisions when they look at a CSR:

- **Approve**: The services asked for by the provider are approved as requested.

- **Approve with changes**: This means the Care Manager has approved the service for a shorter length of time. You will receive the same level of service.
- **Ask one of APS' doctors to review the request**: The doctor may decide to approve, approve with changes, partially approve, or deny the services.

The provider does a discharge review. A discharge review lets APS know that a member is no longer receiving services from a provider.

What Do Care Managers Look for in Reviews?

Care Managers use the DHHS MaineCare Benefits Manual (MBM) when they look at a review. The DHHS MBM describes all the services MaineCare members are eligible to receive. It outlines the clinical information that is required for a service. These requirements include eligibility information and standards about the service. When a Care Manager approves your review they are making sure your clinical information meets MaineCare Rules. Care Managers focus on these five things when looking at a review:

- Eligibility
- Medical Necessity
- Progress
- Clinically appropriate amount of time

- Services delivered in the least restrictive setting

Eligibility

Eligibility refers to the established MaineCare criteria needed for the member to qualify for the given service. The Care Manager first reviews each case to match the information submitted with the necessary criteria. All elements of the stated criteria must be met in order for the member to be determined eligible to receive the service.

Medical Necessity

Medical necessity means that a service is medically necessary or needed. Every case that a Care Manager reviews has to be medically needed in order for you to receive the services.

The service has to be what most providers would choose to treat your symptoms. The service has to be consistent with the accepted standards of practice. The amount of care needs to be the right amount to treat your symptoms.

Progress

When you begin any service with a provider you are asked what your goals are or what you want to get out of the service. Sometimes these are called Individual Service Plans (ISP) or Treatment Plans. They are a way of measuring the progress you are making towards your goals. When Care Managers review services they can tell how much progress you are making by looking at a shortened version of your treatment plan. When you meet your goals your services may be decreased. If you are not making progress in your treatment then you and your provider will need to come up with a different way to help you meet your goals.

Least Restrictive Setting

Your services should be provided in a place that fits your needs and your symptoms. If your symptoms are very serious you may need to be in a hospital or in a crisis unit. If your symptoms are less severe then you can meet with your provider in your home, the community, or their office.

Clinically Appropriate Amount of Time

Care Managers approve services for specific amounts of time. It depends on the service. Some services like Outpatient Therapy are initially approved for a year. Other services are approved for three or six months. Care Managers and providers use a grid from DHHS that tells them the amount of time they can request with each service APS reviews. Care Managers or APS doctors can shorten this amount of time if they use “authorized with changes” in a review. This means they are looking to see how much progress you are making. They will review the services more often. If your services are still medically needed then you will keep your services. When you have made progress then your services might be partially authorized (approved) or denied.

PART THREE: DECISIONS

As we discussed before there are three decisions a Care Manager can make:

- Approve the service
- Approve with changes
- Ask one of APS’ doctors to review the request

In this section we are going to look at what an APS doctor can do with your service review.

What Decisions Can An APS Doctor Make?

When a case goes to a doctor for review the doctor can make four decisions about the services:

- Approve the service
- Approve with changes
- Partially approve the service
- Deny the services

The doctor is following the MaineCare Benefits Manual (MBM) and is still looking at eligibility, medical necessity, progress, clinically appropriate amount of time, and services delivered in the least restrictive setting.

Who Are the APS Doctors?

APS hires adult psychiatrists and child psychiatrists from Maine to review cases. We also have a few psychiatrists that live out of state and are familiar with Maine's behavioral health and substance abuse system working with us to review cases. Our Medical Director and physician advisors will handle most first level

reviews and our network of physician advisors handles all our second level reviews or reconsiderations.

What Is a Partial Approval?

A partial approval is when part but not all of your services have been approved by APS. This means some of your services that were requested have been denied. APS will put a letter in the U.S. mail within 24 hours of the doctor's decision explaining why your services have been partially approved.

What Is a Denial?

A denial is when the services were not approved by APS. The clinical information submitted did not meet the MBM rules or medical necessity. You may also be denied because your provider did not submit some needed clinical information. APS will put a letter in the U.S. mail within 24 hours of the doctor's decision explaining why you have been denied services.

What Is a Second Level Review (Reconsideration)?

A second level review (reconsideration) is when you can request that your provider ask for a reconsideration. This is where a second doctor will look over the first doctor's decision. The second doctor

can change the decision or agree with the first doctor's decision. A doctor has three business days to reach a decision. If the decision is a denial, partial approval or a renegotiation of services, APS will put a letter in the U.S. mail within 24 hours notifying you of the decision. Providers can call the Appeals and Grievances Specialist to request a second level review.

The Review Process

These are the steps a case goes through in the review process;

- Clinical information is sent to APS by your provider.
- An APS Care Manager reviews the information to see if it meets the MBM Rules.
- If the case meets the MBM Rules, then the Care Manager will approve the case.
- If the Care Manager has any questions about the case, they will send it to the Medical Director for review.
- The Medical Director can approve, approve with changes, partially approve or deny the case.
- If the case is partially approved or denied your provider can ask for a second level review.
- If the case is partially approved, you can also wait for the end date. Your provider can submit another continued stay review.

- You can also ask to appeal a partially approved or denied case.

PART FOUR: APPEALS

The appeals process can take place any time you get a partial approval or denial letter. We encourage you to try to work things out with APS first, before it comes to an appeal. When you get a partial approval or denial letter, please call the **Member Liaison** at **1- 866 - 521- 0027, Option 3**.

Partial Approvals

When you receive a partial approval letter from APS there are several things that you can do:

- You can wait and have your provider put in another Continued Stay Review when your services are near their end date or when you run out of units. Remember, your services are approved for a period of time.
- You can ask for a second level review. A second doctor will look over the denied part of your services. They will make a decision on whether to approve the denied part of your services.
- You can appeal the decision.

Denials

When you receive a denial letter from APS you can:

- Ask your provider to request a second level review from APS. A second doctor will look over your case and make a decision on whether to return your services to you.
- You can appeal the decision by contacting the Member Service Liaison directly. You, the member, always has the right to appeal cases that have been denied.

- **Important Note: It is recommended, but not required, that every case going to appeal have a reconsideration completed first. Your existing services will be authorized for as long as the appeal process takes if you call APS within 10 days of receiving the first partial approval or denial letter.**
- **You can file the appeal while waiting for the second level review to be completed. If you do not call APS within the first 10 days of receiving the first partial approval or denial letter you may still appeal but your services will not be authorized during the appeals process.**
- **The exception to this rule is with a prior authorization. If you haven't received any services yet no new services can be approved during the appeals process. You have 60 days from**

receiving the first partial approval or denial letter to appeal the decision. If you receive a partial approval or denial letter from APS, please call the Member Liaison at 1- 866-521-0027, Option 3.

The Appeals Process

The appeals process can take several months to complete. These are the steps that an average appeal will go through.

- The member receives a partial approval or denial letter from APS.
- The member calls the APS Member Liaison at **1-866 – 521-0027, Option 3** and requests an appeal within the first 10 days of receiving the partial approval or denial letter.
- The APS Member Liaison tells the member that they can initiate the appeal or work with their provider to request a second level review (reconsideration). The Member Liaison takes down all the information and sends it to a doctor for review.
- If the doctor reviews the case and disagrees with the first doctor, they will approve the case. At this point there would be no appeal because your services have been approved. There can only be an appeal when services have been denied.

- If the second level review (reconsideration) was done and the doctor does not change the decision, the member can initiate an appeal by contacting the Member Liaison.
- For additional support/assistance through the process please contact the Member Liaison.
- The Appeals & Grievance Specialist makes up an appeals packet. This contains:
    - Appeal Cover Letter
    - Order of Reference – which is a list that tells you what is in the appeals packet.
    - DHHS Fair Hearing Report
    - MaineCare Benefit Manual Chapter 1 Sec. 1.17.1 - Authorized Agent Rule
    - MaineCare Benefit Manual Chapter 1 Sec. 1.02 – 4D - Medical Necessity Rule
    - Confirmation of Appeal Letter within 10 Days – This confirms that your services are being authorized for the length of the appeal.
    - Confirmation of Appeal Letter not in 10 Days – This is the letter that confirms that you have appealed but not within the first 10 days. Your services will not be authorized during your appeal.
    - Copies of Previous Letters APS has sent

- Care Connection Reviewer Notes – This will include all the clinical information, provider notes, and APS notes.

- Once the Division of Administrative Hearings has received the appeals packet they will schedule the hearing at the DHHS office closest to the member's home. They will send a letter to the member and to APS notifying them of the date of the hearing.
- When we authorize services, you are approved for the start date, end date, and number of units that your provider originally asked for in their service request. At your end date, APS will approve your services for another month and prorate (adjusted proportionately) the units accordingly. During the appeals process your provider cannot ask for more units for the same type of service. We will continue to approve your services every month with prorated units until we receive the final decision from the DHHS Commissioner.
- You can withdraw from a hearing at any time. It will not be held against you by the Division of Administrative Hearings or APS if you want to withdraw from your hearing. It is better to withdraw then to not show up on the day of the hearing.
- At the hearing you may present any information that you think will help your case. You must send copies of any information you wish to present to the Division of Administrative Hearings and APS. You can choose to have a lawyer represent you at the

hearing. You may also call Disability Rights Center (DRC) for assistance with this representation.

- You or your representative must participate at the hearing unless you are a child.
- Please let the Appeals & Grievance Specialist know if you need an interpreter when you ask for an appeal. One will be provided for you at no cost. Although friends and family members cannot be interpreters, they can be present for the hearing.
- On the day of the hearing, a representative of APS will be at the hearing via the telephone. They will tell the hearing officer why the case was partially approved or denied. You will then get to tell the hearing officer why your services should be approved. The hearing officer will ask questions of both sides. The hearing officer works for the State. Their rulings are independent and fair and based upon the MaineCare Benefits Manual.
- The hearing officer will make a decision and send it to both the member and APS. This decision is final.

Other Ways to Appeal

If you prefer, you can file an appeal through **MaineCare Member Services**. You can contact them by phone at **1-800-977-6740 or**

TTY/TDD 1-800-977-6741 (or use Sorenson, the video relay service) or you can write them;

DHHS Office of MaineCare Services

Member Services

P.O. Box 709

Augusta, ME 04332

When you call or write to MaineCare Member Services, please tell them that you are appealing an KEPRO decision. Please request an Administrative Fair Hearing. MaineCare Member Services will fill out the Fair Hearing report and send it to the Division of Administrative Hearings.

You can also call the **Division of Administrative Hearings at (207) 287-3610.** Again, please tell them you are appealing a decision from KEPRO. Please request a Fair Hearing. They will fill out the Fair Hearing report and schedule a hearing date.

PART FIVE: DISAGREEMENTS

There may be times where you disagree with APS and the way we do things. At some point, you may have a disagreement with one of our employees. APS takes these disagreements very seriously. You are always free to talk with someone's supervisor if the disagreement is

with an employee. If you cannot work it out on that level then you can file a formal complaint.

The Complaint Process

- Call the **Member Liaison at 866-521-0027, Option 3**. They will send you an KEPRO Complaint Form. This can be mailed, e-mailed, or faxed to you. If you have any trouble filling out this form, the Member Liaison will help you.
- Send the completed complaint form back to APS. We have five (5) working days to respond in writing to your complaint. If we need more time it may take an additional five (5) working days to respond to your complaint. If that happens, we will notify you in writing.
- APS will send you a written report explaining what we found out. We will also tell you how we are going to fix the problem. This letter will include information about your right to appeal this decision. This will be sent to you through the U.S. Mail.
- If you don't feel comfortable working with the Member Liaison, you can also talk to the Appeals Department who will help you with reporting a complaint.

Other Ways to File a Complaint

ADULT SERVICES

For adult services you can file a complaint directly with DHHS.

You can write to them at:

Substance Abuse and Mental Health Services
State House Station #11
41 Anthony Avenue
Augusta, Maine 04333-0011
Phone: (207) 287-2595
Fax: (207) 287-4334
TTY: Maine relay 711

http://www.maine.gov/dhhs/mh/GrievanceMH/index.html

CHILDREN'S SERVICES

If you have a complaint about children's services, please contact:

Department of
Health and Human Services 221 State Street
Augusta, Maine 04333-0040
Phone: (207) 287-3707
FAX: (207)287-3005
TTY: Maine relay 711

If you have any questions about filing a complaint please call the

KEPRO Member Liaison at 866 -521-0027, Option 3.