

ACCOUNTABLE BEHAVIORAL HEALTH ALLIANCE

*Serving the Oregon Counties of
Benton, Crook, Deschutes, Jefferson and Lincoln*



UTILIZATION MANAGEMENT PLAN

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1.0 CONTEXT

Accountable Behavioral Health Alliance (ABHA) manages all outpatient mental health treatment and all inpatient psychiatric treatment for Accountable Behavioral Health Alliance Oregon Health Plan enrollees.

The utilization Management process is one component of ABHA’s comprehensive Quality Management Program. The primary goals of the QM Program are to determine adherence to standards which define service quality and to ensure continual improvement in the quality of services. Utilization management focuses on the quality of *clinical* services specifically, as well processes designed to monitor and measure the cost-effectiveness of these services. These processes include preauthorization, concurrent review, and retrospective review procedures to implement utilization management.

2.0 PURPOSE AND PRINCIPLES

The purpose of the UM Program for both outpatient and acute care is:

- to ensure that all ABHA members have access to appropriate behavioral health services at times of need, and
- to ensure that the services offered make the most efficient use of the financial resources available to the member.

The specific objectives of the Program are to ensure that:

- members experience no undue impediments in access to services,
- members who receive services demonstrate medical/psychological necessity,
- services provided are likely to lead to an improvement in the condition being treated, and
- services are provided at an appropriate level of intensity in the least restrictive setting.
- OHP Member with Special Health Care needs are assessed in order to identify any ongoing special conditions that require a course of mental health treatment or care management.

The Program utilizes explicit (written) criteria to evaluate the necessity, appropriateness, and efficiency of mental health services (see Appendix 1). These criteria are based on both expert professional opinion and published results of empirical research in behavioral health. Criteria for access are based on best professional opinion, industry-wide benchmarks and standards established by members and purchasers. The charge of the Committee overseeing the UM Program includes both the evaluation of patterns of care and monitoring outcomes of corrective actions.

Procedures for conducting first and second level reviews for mental health services must ensure that:

- Review criteria are applied consistently and correctly
- Reviews are conducted by qualified reviewers
- Reviews are conducted in a timely fashion
- Physicians are involved in all denial determinations of inpatient services

3.0 THE UTILIZATION MANAGEMENT PROGRAM

3.1 SCOPE OF PROGRAM

Activities of the UM Program are intended to ensure the necessity, appropriateness, timeliness of access, and cost effectiveness of services received by ABHA members. The ABHA UM Program addresses the delivery of the full range of mental health services. Its scope is comprehensive and includes, but is not limited to, the following:

- Inpatient care
- Respite care
- Intensive outpatient programs
- Outpatient treatment

- Alternative treatment settings
- Psychological testing
- Emergency care
- Psychiatric Residential Treatment
- Day Treatment

It is noted that the scope of benefits offered is subject to limitations and exclusions specified in the OHP plan of benefits.

ABHA utilizes first and second level review procedures to complete the following types of utilization management activities:

- Prospective review
- Concurrent review
- Retrospective review
- “High Risk” case management

3.2 Structure

ABHA will have a Quality Management Committee (QMC) that will oversee the Utilization Management Program, The Quality Management Committee will meet at least bi-monthly,

UM Responsibilities Of The Quality Management Committee (QMC)

To fulfill its charge of ensuring necessity, appropriateness and efficiency of ABHA services, the Committee is responsible for the:

- the development and monitoring of standards, protocols, or guidelines that are Evidence Based Practice and are consonant with generally accepted standards of care within the behavioral healthcare field
- appropriate utilization of services as evidenced by: provider practice patterns, length of stay by service population, utilization by diagnostic subgroups.
- identification and focused monitoring in populations which historically have been subject to over-utilization or under-utilization.
- appropriateness of service type and usage as evidence by: transfers to higher level of care; dual diagnosis; absence of Axis I diagnosis, other severity indicators.
- appropriateness of services as reflected in adherence to clinical guidelines (e.g., appropriate utilization of psychiatric consultation with bipolar disorder).
- timeliness of:
 - scheduling of services as evidenced by: delays in assessment or testing; practitioner availability.
 - admissions, assessments, and referrals.

- treatment authorizations and denials,
- consistency of utilization managers' application of ABHA clinical guidelines.
- non-utilization of initial authorizations.

4.0 SERVICE MODEL

4.1 Definition of Terms

- Access

Access is the ease with which a member can enter a provider's network at the appropriate level of care. Accuracy of referral, location of services in relation to members' homes, timeliness of response to service requests, availability of services at every level of care, and the ability to serve high acuity and other difficult problems are aspects of access that are measured. Section 5.1 establishes access standards for "Emergent", "Urgent" and "Routine" levels of acuity. These standards are monitored and reviewed by the Quality Management Committee.

- Appropriate and Necessary Services

Appropriate and necessary services are typically understood to be reflected in several criteria; that the services are necessary for treatment of the focus problem, that the services are generally professionally accepted and not considered experimental, and that the problem is likely to be responsive to those particular services.

These services refer to medical, hospital or therapy services and supplies for treatment of an active mental disorder which has been established in accordance with generally accepted professional standards and approved for use by ABHA's Quality Management Committee. They are expected to be:

- rendered for the treatment and diagnosis of a mental disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders
- appropriate for the severity of symptoms, consistent with the diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards;
- not furnished primarily for the convenience of the member, the attending physician, or other provider of service (including the provider making referral to inpatient care); and
- furnished at the least restrictive level which may be provided safely and effectively to the member.

In addition, for the services to be eligible for reimbursement there must be a reasonable expectation that the condition of the member will improve or show improvement. Such an expectation would be based both on empirical evidence about efficacy of the procedure and the probability that the member's particular condition will be responsive to the procedure.

- **Comprehensiveness**

Comprehensiveness of care includes the concepts of appropriateness and continuity.

Appropriateness of care is the degree to which the quality and the intensity of services are delivered in the setting most likely to promote positive clinical outcomes.

Continuity of care is the degree to which the care provided is based on a consistent and comprehensive treatment plan across the range of necessary services.

- **Case Management**

Case management in the context of utilization management involves close tracking and coordination of care for members who require treatment. The case management function of utilization management performed by ABHA involves intensive clinical review. The utilization management clinician works with each member and his or her provider to ensure that the most effective treatment plan is implemented throughout the member's participation in the Oregon Health Plan. In addition, the ABHA Utilization Manager provides assistance in obtaining needed acute care services in a timely manner. This role sometimes requires intensive assistance to high service use members who have problems obtaining appropriate services.

- **Care Coordination**

As defined in the OAR's, "Care coordination" means a process oriented activity that provides ongoing communication and collaboration with children and families with multiple needs. Care coordination includes: facilitating communication between the family, natural supports, community resources, and involved child-serving providers and agencies; organizing, facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older youth to the adult service system.

- **Cost-effectiveness**

Services provided through ABHA are expected to deliver positive outcomes using the most efficient and effective treatment approaches. ABHA will support affiliated providers' efforts by performing ongoing reviews of providers' operations, including their quality improvement program and clinical protocols. ABHA will also assist in the credentialing of providers, consulting regarding needed network development, surveying member satisfaction, performing focused clinical record reviews, and analyzing data to identify trends. ABHA provides a

comprehensive, ongoing external quality review of all providers to ensure that Oregon Health Plan members receive high quality services.

- County sub-contractors

ABHA subcontracts with Benton, Crook, Deschutes, Jefferson, and Lincoln counties to provide outpatient services. Some counties provide outpatient services through clinical staff who are employees of their county's health department. Other counties subcontract with non profit agencies to provide these services.

- Confidentiality

Utilization Management Programs necessarily deal with sensitive information about patients and providers. The documents that are created and reviewed as a part of the utilization management process - electronic and hardcopy case records as well as all oral communication. These records are confidential and privileged information case records and must be treated accordingly.

Medical records or other materials used for utilization management shall be considered strictly confidential and retained in a secure environment. All personnel who have access to records must receive training in and be able to demonstrate an understanding of HIPPA and applicable state laws.

Clinical and other patient data used by the QM Committee in the course of its activities are maintained as confidential in accordance with applicable Federal and State laws and regulations. Summary data may be released to individuals outside of the Committee to the extent that these data do not allow identification of individual members.

ABHA will be comply with HIPAA privacy standards, as well as all related standards developed by the State of Oregon and its regulating agencies,

Clinical services are categorized into two primary levels of care: acute care, and outpatient.

- Members With Special Health Care Needs

Covered members who either 1) have functional disabilities, or 2) live with health or social conditions that place them at risk of developing functional disabilities.

- Service outcomes

Service outcomes are indications of the benefit of treatment to members and their families. ABHA will work with providers and members to develop measures and methodologies which can determine the degree to which a member's:

1. ability to function is maintained or improved,
 2. symptomatology abates,
 3. expectations for service have been met or exceeded and their sense of well-being improved.
- Utilization Review

Utilization review refers to a determination of the need for a level of care necessary for adequate health and function. Utilization review includes prospective (preauthorization or pre-certification) reviews, concurrent reviews, and retrospective reviews. ABHA's utilization review program is designed to match the treatment needs of the individual to the least restrictive and most clinically appropriate setting available.

4.2 Primary Levels Of Care

Acute Care

Inpatient acute care is indicated when a member is unable to maintain a level of functioning in the community that assures the member's own or other's safety, or the member's ability to care for themselves and is due to a mental disease or defect covered by the OHP prioritized list.

- **Inpatient Hospitalization**

Hospitalization is indicated when a member is at significant risk to harm themselves due to suicidal or self destructive acts; member is at significant risk to others due to violence, aggression or impulsive acts; member is in acute psychiatric crisis leading to disorganization or deterioration that is unmanageable in a less restrictive setting; member needs medication or medical management unavailable in a community setting; or member is unable to provide basic self care without 24 hour supervision. Hospitalization may also be necessary if a member meets the criteria for sub-acute/respice but no sub-acute/respice beds are available.

When a member is hospitalized coordination will occur between the hospital, ABHA Utilization Manager and the local CMHP staff to resolve the crisis and move the member to a less restrictive level of care as soon as possible.

- **Sub-Acute**

Sub-Acute Care is indicated when a member meets the criteria for hospitalization but the CMHP assessment shows that the member can be served in a less restrictive setting. Sub-Acute Care is a higher level of care than Crisis Respice in the level of care has more structure, supervision and psychiatric consultation for medication adjustment is available. Sub-Acute is

also available as a step-down from hospitalization. Sub-Acute settings are facility based and available to both children and adults.

- **Crisis Respite**

Crisis Respite Care is indicated when a member meets the criteria for hospitalization but the CMHP assessment shows that the member can be served in a less restrictive setting. Crisis respite is also available as a step-down from hospitalization. Crisis respite is facility based and the options available have a wide variety of structure, supervision and medication management.

- **Psychiatric Residential Treatment**

Psychiatric Residential Treatment Services are services provided in a structured treatment environment with daily 24-hour supervision and active psychiatric treatment. Psychiatric Residential Treatment Services are provided by nationally accredited providers certified under the Oregon Regulations for children who require active treatment for a diagnosed mental disorder in a 24-hour residential setting. Requirements for admission and approval are required later in this document.

- **Intensive Community Treatment and Support Services , (ICTS)**

ICTS services are a specialized set of in-home and community-based supports and mental health treatment services available to clients aged 6 – 18. These services are delivered in the most normative, least restrictive setting. Family and community involvement and coordination are essential. ICTS is available to children who are assessed as meeting a level IV and above on the Child and Adolescent Service Intensity Instrument. The Referral and Determination process is described later in this document.

Outpatient Care

Outpatient care includes assessment and treatment that is provided within the community (non-facility).

Intensive Outpatient Services

Intensive outpatient services for mental health disorders generally provide increased hours of structured treatment each week, consisting of, but not limited to: individual, group and family psychotherapy, medication management, and psycho-educational counseling. Day or evening programs may be offered, before or after work or school, in the evening or on a weekend. IOS differs from partial hospitalization in that the clinical services offered are generally less intensive. Some intensive outpatient services have been developed to treat patients with specific disorders, such as eating or personality disorders

Entrance Criteria

- The patient meets criteria for a non-V-code DSM-IV diagnosis.
- Admission is based on meeting one of the following criteria:
 - A deterioration in the patient's mental status has occurred resulting in symptoms of such severity that there is significant restriction of the patient's usual level of social, occupational and/or educational functioning.
 - The patient has verbalized thoughts of harming self or others or is engaging in sporadic episodes of self-mutilation representing a maladaptive response but no immediate danger to the patient
 - A deterioration in the patient's baseline level of functioning has occurred, which has been unresponsive to an appropriate course of treatment at a lesser level of care, and supervised care is required.
 - The patient will require support for stabilization in the community.
 - The patient requires skilled observation and assessment of psychiatric status.
- Treatment plan also includes clear, time-limited, transition-focused objectives for this treatment phase

Continued Stay

- Patient continues to satisfy entrance criteria, and specific discharge/ transfer plan has been developed
- Patient has improved but has not achieved a degree of clinical stability which would warrant discharge to a lesser level of care
- Treatment plan is appropriate to treat the patient's illness and is expected to result in improvement in patient's functioning

Discharge or Transfer

- Absence of imminent danger to self or others
- Discharge/transfer plan ready for implementation with schedule for ongoing care
- Patient sufficiently stable clinically to transition to a less restrictive level of care
- Maximum clinical benefit has been achieved and it appears unlikely that further clinical benefit is possible
- Patient and/or family have established a pattern of noncompliance with treatment plan, including treatment recommendations for family involvement

Special Considerations

- The intensive involvement of the family and/or care providers (e.g., foster parents, group home staff) in child/adolescent treatment is required, unless there are legal restrictions that prohibit contact with specific family members.

Outpatient Treatment

Entrance Criteria

- Member identifies a behavioral health problem.
- Treatment is being sought on a voluntary basis since court-ordered treatment is excluded unless the medical necessity for care clearly exists.
- Face-to-face participation is required since telephone counseling is excluded.
- Member meets ABHA Medical Necessity Criteria for outpatient care

Continued Stay

- Patient meets criteria for a covered diagnosis according the current DSM and the list of covered mental conditions under the Oregon Health Plan prioritized list.
- A specific treatment plan has been developed to reach focused objectives.
- Treatment plan is appropriate to treat the patient's illness and is expected to result in improvement in patient's functioning.
- Referrals for medication evaluations are made in a timely manner when warranted by diagnosis and clinical symptomatology.

Discharge or Transfer

- Focused treatment objectives have been met
- Maximum clinical benefit has been achieved and it appears unlikely that further clinical benefit is possible
- Patient and/or family have established a pattern of noncompliance with treatment plan, including treatment recommendations for family involvement
- Transfer to a higher level of care whenever there is imminent risk to self or others.

- Member no longer meets ABHA Medical Necessity Criteria for outpatient care

Special Considerations

- Outpatient treatment is expected to be time-sensitive, problem-focused and goal-oriented

5.0 CARE MANAGEMENT

5.1 Overview

Care Management initiates the utilization management process at the individual case (episode of service) level, for ABHA. The principal objectives of care management are to ensure that:

Clients are referred in a timely manner to clinicians or programs offering services appropriate to their needs

- Emergency Care-Member shall be seen within 24 hours or as indicated in initial screening;
- Urgent Care-Member shall be seen within 48 hours or as indicated in initial screening;
- Non-Urgent Care-Member shall be seen for an intake assessment within 2 weeks from date of request.
- services provided throughout the course of the treatment episode are Medically Necessary and appropriate to patient condition, and
- discharge plans are appropriate and are developed by the provider in collaboration with the patient.

ABHA will employ an approach to managed care which recognizes the importance of Evidence Based Practice in determining appropriate levels of care. ABHA's Utilization Manager or the County clinic Utilization Manager will always authorize a more intensive level of care if a less intensive, appropriate level is not available. Inadequate access and gaps in the continuum of care will be identified and tracked as systems problems. Such systems problems will be reported to the Quality Management Committee, which will be responsible for the development and monitoring of corrective action plans.

As noted in the definition of medically appropriate services, treatment provided to ABHA members must be active, individualized and goal-focused. Active intervention must address members' diagnosis, symptoms and functional capacity in such a way as to prepare them for independence or treatment at less intensive levels of care.

Member's have a right to a second opinion. A request for a second opinion is not a request for an appeal; It is a request for a second provider to independently assess the clinical needs of the

member and the clinical conclusions of the clinician were clinicians formulated the first opinion. The MHO Agreement says:

Contractor shall Provide for a second opinion from a qualified mental Health Care Professional within the Provider Panel, or arrange for the ability of the OHP Member to obtain one outside the Provider Panel, at no cost to the OHP Member

5.2 Review Criteria

Before certifying medically necessary treatment under the Oregon Health Plan, a Utilization Manager must ascertain that treatment meets the ABHA Medical Necessity Criteria (see appendix) as well as the additional criteria defined below.

Service Provided To ABHA Members Must Be Adequate and Essential for the Evaluation/Treatment of a Mental Disorder

- [i] Services must be an adequate and essential therapeutic response for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for the specific Member's illness, disease or condition as defined by standard diagnostic nomenclatures (current DSM- or its equivalent in ICD-)

To be considered medically necessary, services which are provided or proposed must be those services (e.g., psychotherapy, psychopharmacology) which the patient clinically requires--no more and no less.

The adequacy of treatment refers to its clinical appropriateness, completeness, and timeliness. Essential treatment means treatment that is neither more nor less than what is clinically appropriate for the patient at a specific point in time.

Treatment may be **adequate** but not essential if a more restrictive and costly alternative is used than the patient clinically requires. On the other hand, treatment may be **essential** but inadequate, if, for example, a patient is hospitalized for a severe mental disorder but is not given appropriate medication in a timely manner.

To be considered medically necessary, treatment must address a mental disorder. Treatment intended solely for self-improvement or for normal life stress, reactions or a court order is not medically necessary. Treatment must address a recognized current DSM- diagnosis (qualified by all five axes) -- with the exception of certain DSM- diagnoses for which medical/psychiatric intervention is generally not appropriate or for diagnoses not covered under the Oregon Health Plan.

A provider's rationale for treatment should reflect clinical indications and symptoms which have been appropriately interpreted as a diagnosis consistent

with one of the categories to be found in the current Diagnostic and Statistical Manual of Mental Disorders, or current ICD.

Services must be provided at the appropriate level of care relative to the severity of the patient's illness and capacity to respond to professionally-provided psychotherapy (ies) and services by a provider capable of rendering effective treatment for the patient's clinical condition.

A Service Must Meet National Standards for Mental Health Professional Practice

[i] Services provided to ABHA members should be safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications

- ABHA clinical review policies and criteria have been developed by drawing upon the resources of national standards for mental health professional practice. To be considered medically necessary, treatment must be rendered by appropriately licensed and qualified (e.g., credentials, experience) mental health professionals. Treatment facilities and programs must be appropriately licensed and qualified to provide the appropriate level of care.

A Service Must Be Provided at the Most Cost Effective Level of Care

[i] Services should be provided at the appropriate and most cost effective level of care that can safely be provided for the specific Member's diagnosed condition in accordance with the professional and technical standards adopted by ABHA

As outlined in (i) above, treatment must be "adequate and essential." Treatment at the most appropriate level of care is care that is provided to meet a specific beneficiary's clinical needs (structure, process, outcome) at the most reasonable cost.

5.3 Preauthorization

ABHA or subcontractors will perform utilization review functions for those mental health services requiring prior authorization. Inpatient, sub-acute, Psychiatric Residential, respite, Day Treatment, ICTS and outpatient treatment require prior authorization from ABHA or County Mental Health Programs.

Medical Emergencies

Definition:

A Medical Emergency occurs when, due to Mental Illness is of such a nature that failure to get immediate medical care could put the person's life in danger or cause serious harm to self or others.

Some examples of a Medical Emergency are: hallucinations and delusions which result in irrational acts that subject the person or others to danger; active plans for committing suicide; inability to provide self-care which threatens the life of the person.

Some examples of conditions that are not usually Medical Emergencies are: thoughts of committing suicide with no credible plan; serious parent-child conflict; acute mourning and grief; emotional reactions to a trauma or personal loss.

ABHA will make the final determination on what constitutes a Medical Emergency, and when the Medical Emergency will be considered to begin and to end.

ABHA managed care operations are fully equipped to identify and handle mental health and substance abuse emergency calls, seven days-per-week, 24 hours-per-day. Clinical staff are experienced and trained in crisis management.

- Detailed clinical information is gathered to assess if the situation is emergent, urgent, or routine
- If a clinical emergency exists, the local crisis staff is called and intervenes including transportation for evaluation, police intervention or other emergency services. Only local County Mental Health Crisis Staff or ABHA Utilization Manager can authorize after hours admissions.
- If a ABHA member must be transferred out of area for mental health treatment services, the provider initiating the transfer will:
 - a) Notify the member's primary care physician of impending transfer (if such transfer is not an emergency).
 - b) Notify the member's physical health plan (FCHP) prior to transfer (if such transfer is not an emergency).
 - c) In an emergency situation, both FCHP and PCP shall be notified the next business day.
- If the evaluation does not indicate the need for an inpatient admission, the patient is referred to the appropriate level of care and provider
- A follow-up call is made to ensure that the referral appointment is kept.

6.0 Inpatient Care Management

6.1 Prospective Review Inpatient

Prospective review is defined as an evaluation of a provider's request for treatment of a member before any treatment for a distinct level of care has been delivered. Prospective review is conducted for all non-emergency mental health treatment for inpatient, sub-acute/respite admissions. Psychological testing, and electroconvulsive therapy are also subject to prospective review. Prospective review activities may be completed on site or telephonically.

When a member is admitted to an acute care facility in a true clinical emergency, ABHA does require preauthorization by the member's local County Mental Health Clinic crisis team which can be contacted through the ABHA Crisis Line at 1-888-232-7192.

All admissions to acute care settings will be reviewed by the standards stated in the first level prospective review for inpatient stays. The primary route to admission is through the member's local County Crisis Team with the ABHA Utilization Manager only as a backup or to confirm benefits are available and authorized. Any admission not pre-screened by the member's local County Crisis Team will be referred back to them by the ABHA Utilization Manager. Should there be question between the screening hospital and the local County Crisis Team then the ABHA Utilization Manager and Consulting Physician can be brought in for a Second Level Prospective Review.

First Level Prospective Review for Inpatient Stays

When providers or facilities call to request prospective authorization for a non-emergency inpatient, sub-acute/respite admission, they are connected to the ABHA Utilization Manager for completion of a clinical review. During a clinical review the Utilization Manager:

- Gathers comprehensive clinical data from the provider/facility
 - requests for information will be limited to the information that is pertinent to rendering a utilization management decision and managing care
- Verifies and substantiates a diagnosis per current DSM- criteria
- Reviews the proposed treatment plan which:
 1. integrates measurable goals and objectives
 2. is individualized to address the specific problems presented by the member at admission
 3. contains an individualized plan for the involvement of family members unless therapeutically contraindicated
 4. includes a comprehensive, individualized discharge plan.
- Utilizes ABHA review criteria to determine if the proposed care is needed an appropriate.
- When indicated, makes use of network (or non-network providers if clinically appropriate) to refer the member to a less restrictive level of care.

- Determines the number of days to certify. If unable to approve the provider's request, refers the case to the ABHA Physician Advisor for second level review.

Second Level Prospective Review

When the ABHA Utilization Manager is unable to authorize a request for care the case is referred to a Physician Advisor for second level review. During a second level review the Physician Advisor:

- Reviews all available clinical materials
- If additional clinical information is needed, the case will be discussed directly with the attending physician or other providers of care who have been recently involved in either evaluating or providing services to the member and can reasonably be expected to have clinical knowledge that will be helpful to making a decision regarding appropriate certification of care and treatment planning.
- Makes and documents a precertification decision and refers the case back to the ABHA Utilization Manager for follow-up

6.2 Continued Stay Review Inpatient

Following an authorized admission, the member's provider must call the ABHA Utilization Manager within 1 business day. The first continued stay review is done within 1 business day of admission. The ABHA Utilization Manager and provider discuss the initial treatment plan, goals of treatment, and the initial discharge plan. Additional days are authorized as needed. Continued Stay Reviews are completed throughout the authorization time frame, at intervals deemed clinically appropriate and necessary by the ABHA Utilization Manager. Such deemed intervals are based on the clinical presentation and ongoing treatment needs of the member during the episode of care. The ABHA Utilization Manager will notify the provider of the dates of the Continued Stay reviews.

Inpatient Continued Stay Review Criteria

Inpatient psychiatric care should be used to treat a mentally ill person who requires a 24 hour (round the clock), medically structured and supervised facility. ABHA criteria for admission and continued stay at an inpatient facility assume that the patient's illness is so severe that alternative treatment (sub acute, respite, or outpatient treatment) would be unsafe or ineffective.

Continued Stay review is an evaluation of:

- A member's continued need for treatment
- The appropriateness of the current and proposed treatment
- The appropriateness of the setting in which the treatment is being rendered or proposed

All continued stay review activities are completed by the ABHA Utilization Manager who may choose from the following methods to conduct their review activities:

Telephonic Continued Stay Review. Information is generally gathered either from the provider directly involved in rendering services to the member, or the UR staff at a facility.

On-site Clinical Review. In locations where ABHA has contracted with local providers for this service, continued stay reviews of facility-based treatment may be completed on-site in order to obtain first-hand clinical data. Such reviews are generally conducted when the member:

- Has a highly complex clinical presentation
- Has a history of readmissions, or
- Is being treated in a facility for an extended period without measurable progress

On-site review may include a review of all pertinent medical records, discussion of the case with the treatment team and/or a face-to-face meeting with the member and/or family. All on-site review activities are clearly documented in the member's electronic clinical record

Medical Chart Review. ABHA may request the attending provider or facility utilization review staff send some or all of the member's medical record via facsimile or overnight express mail. This information will be used to review and/or validate the report of the member's condition and clinical progress. The chart may be requested when:

- The Utilization Manager is provided conflicting data regarding the continued clinical need and appropriateness for the current level of care, e.g., despite a description of continuing suicidal behavior, a member is allowed a weekend pass with a family member.
- The diagnosis is not supported by information reported during telephonic review.
- The treatment plan seems inappropriate for the clinical presentation of the member, e.g., the member is experiencing visual and auditory hallucinations, yet no medications are considered or prescribed.
- Clinical data furnished by the provider is insufficient and does not permit the reviewer to make a well-informed decision.

First Level, Continued Stay Review for Facility Based Treatment

- Gathers comprehensive clinical data from the provider/facility

- requests for information will be limited to the information that is pertinent to rendering a utilization management decision and managing care
- Re-verifies and substantiates the diagnosis per DSM criteria
- Reviews progress made in relation to all active treatment goals included in the master treatment plan, discusses goals added to the treatment plan and also discusses appropriate level of care required to treat remaining problems
- Identifies and investigates possible quality of care concerns
- When appropriate, reviews progress made in family treatment and evaluates indicators for continued intervention
- The outpt Discusses discharge plans, timelines and possible obstacles to successful implementation
- Utilizes review criteria to determine clinical need and appropriateness for continued stay
- Makes determination of number of additional days to certify. If unable to certify further days, refers to Physician Advisor for second level review.

6.3 Retrospective Review Inpatient

ABHA conducts retrospective reviews of inpatient care to evaluate care which has already been delivered. The purpose of this type of review is to determine if such services were clinically needed and appropriate, prior to releasing any or part of the claim payment requested.

When an inpatient, residential or partial hospital claim is received:

- The ABHA Utilization Managers pends claims which are eligible for retrospective review and notifies the provider/facility of which records are required to complete a prepayment review for clinical need and appropriateness.
- When all records required for the review have been received, the ABHA Utilization Manager reviews for:
 - Completes a clinical review of the record utilizing ABHA review criteria
 - Make a first level review decision, authorizing all, part or none of the treatment episode
 - Documents the results of the review

If the first level review does not support clinical need and appropriateness for any or all of the facility stay the case is forwarded for review by an ABHA Physician Advisor. If the second level reviewer issues a determination to deny any or all of the care, the member, provider and facility are notified in writing and informed of the appeal process, in Section 10.0. A final determination is issued on all prepayment reviews within 30 days of receipt of all necessary clinical materials.

6.4 Discharge Planning Inpatient

Discharge planning is an essential component of ABHA's utilization management program. It is a process which focuses on facilitating appropriate and timely discharge from facility-based treatment and ensures that members are linked to comprehensive aftercare services.

ABHA's clinical review standards require that discharge planning activities be documented during the first review of a case and be monitored closely during subsequent reviews throughout the treatment episode.

Upon initial pre-certification, the Utilization Manager clarifies the anticipated length of stay and criteria for discharge.

6.5 Out-of-Network Management Inpatient

ABHA applies the same utilization management program to treatment delivered both in-network and out-of-network.

6.6 Review Timelines

The ABHA Utilization Manager is required to complete and document prospective and concurrent clinical review activities and authorizations in a timely fashion. The standards are:

- Completion of authorization for inpatient treatment within 24 hours of completing necessary clinical reviews

7.0 Psychiatric Residential Treatment

Psychiatric Residential Treatment is a level of care within the continuum of services provided to Children receiving mental health services. Psychiatric Residential Treatment Services are services provided in a structured treatment environment with daily 24-hour supervision and active psychiatric treatment. Psychiatric Residential Treatment Services are provided by nationally accredited providers certified under the Oregon Regulations for children who require active treatment for a diagnosed mental disorder in a 24-hour residential setting.

7.1 Prospective Review

The Regional Care Coordination committee, in consultation with the Regional Care Coordinator and the Child and Family Team/Wraparound Team will approve admissions to Psychiatric

Residential Facilities. When this approval process is complete, the Regional Care Coordinator notifies the ABHA Child and Family System of Care Manager who:

- Reviews the clinical data reported by the Regional Care Coordinator
- Verifies and substantiates that the client meets Admission Requirements
- Supports Child and Family Team/Wraparound Team and Care Coordinator and in Determining the number of days to certify
- Enters an authorization into the CSCI database
- Supports Child and Family Team/Wraparound Team and Care Coordinator in assuring that needs and corresponding goals and objectives of the residential placement identified by the Child and Family Team/Wraparound Team are addressed in Psych Res facilities and goals of treatment.

7.2 Admission Requirements are described in Appendix 5 of UM Plan

7.3 Continued Stay Review, Including Discharge Planning

Continued Stay Reviews are defined and completed as described in 6.2 of the UM Plan for Continued Stay Review for Facility Based Treatment. In doing a Continued Stay Review, the ABHA Child and Family System of Care Manager:

- Gathers comprehensive clinical data from the provider/facility - requests for information will be limited to the information that is pertinent to rendering a utilization management decision and managing care
- Re-verifies and substantiates the diagnosis per DSM criteria
- Clarifies with Child and Family Team/Wraparound Team, Care Coordinator and Psych Res facilities the planned length of stay and criteria for discharge; discusses discharge plans, timelines and possible obstacles to the successful implementation and addressing of the needs identified by the Child and Family Team/Wraparound Team.
- Reviews progress made in relation to all active treatment goals included in the Child and Family Team/Wraparound Team's Service Coordination Plan and the provider's master treatment plan, discusses goals added to the treatment plan and also discusses appropriate level of care required to treat needs. Ensures that services are provided as outlined in the Service Coordination Plan.
- Identifies and investigates possible quality of care concerns
- Reviews progress made in family treatment and evaluates indicators for continued intervention
- Maintains link between Psychiatric Residential facility, Child and Family Team/Wraparound Team, local Care Coordinator and Community Care Coordination Committee to support the identification of needs and development of post-discharge resources

- Utilizes review criteria to determine clinical need and appropriateness for continued stay. Continued stay shall be approved at a maximum of 30 day intervals.
- Makes determination of number of additional days to certify only after consultation with Care Coordinator representing the Child and Family Team/Wraparound Team. If unable to certify further days, refers to Physician Advisor for second level review.

8.0 Psychiatric Day Treatment

Psychiatric Day Treatment is a level of care within the continuum of services delivered as part of the Intensive Service Array for children who have serious mental health issues. Admitted children are referred in conjunction with the local school district, providers, family members, or childcare/preschool programs and have received assessments and planning as required by the Department of Education and/or mental health. This service is delivered by providers certified by Oregon's Department of Human Services/Addiction and Mental Health Division under OAR 309-032-1150(9) and may be provided as an integrated program in a public school setting or as a separate program at an independent site. Psychiatric Day Treatment services are available to children who are living in the community with a parent, guardian or foster parent. Day treatment services are provided by qualified mental health professionals and qualified mental health associates in consultation with a psychiatrist. An education program is provided by a teacher and aides as a part of this service.

The child's Wraparound Team recommends day treatment as a service to meet identified needs. Authorization for day treatment is made by the County Mental Health Program's ICTS representative upon recommendation from the care coordination team and verification that the child meets admission criteria.

The County Mental Health Program conducts on-going utilization management for clients who participate in Psychiatric Day Treatment.

8.1 Admission Requirements are described in Appendix 4

9.0 INTENSIVE COMMUNITY TREATMENT SERVICES AND SUPPORTS, (ICTS) AND DAY TREATMENT SERVICES

Intensive Community Treatment Services and Supports is a level of care within the continuum of services provided to Children receiving mental health services. Our goal is to increase the availability and quality of individualized, intensive, and culturally competent home and community based services so that children can be served in the most natural environment possible and so that the use of institutional care is minimized. The standards set forth within this policy

statement are intended to represent the minimal requirements established by the state. ABHA counties have separate policies and service standards to enhance and individualize policies set forth in this document. County specific policies are designed to make them relevant to the uniqueness of their organizations and client population. The standards prescribed by the state through the ABHA contract and the Oregon Administrative Rules are included in this document as Addendums.

9.1 Philosophy and Approach

It is the mission of Accountable Behavioral Health Alliance to effectively and efficiently manage the behavioral health benefits for Oregon Health Plan Members. It is a natural extension of our mission to collaborate with partner agencies to provide a broad array of intensive community based and family focused services to children and their families with a goal of providing the most effective and cost efficient services to meet the individual needs of the child and their family.

ABHA recognizes the value and importance of maintaining children in their communities. We value children and their families as experts in the understanding of their needs. We promote the identification and utilization of a child and families unique strengths as critical components of an individualized plan of care.

ICTS is included as part of a continuum of care within the ABHA UM Plan. This continuum extends from education and prevention programs and community support and outreach provided by or coordinated through county mental health programs to acute levels of service provided by hospitals. ABHA and our partner counties will use a Wraparound Model in planning for the needs of children and family clients. The children and their families will work with a Care Coordinator to identify family strengths and needs. A Child and Family Team will be convened jointly by the Care Coordinator and identified family and will develop a strength based Service Coordination Plan identifying resources, (both informal community supports and formal professional supports), to address the needs identified.

ABHA will use “transition” to describe the mechanism by which a client moves within the service continuum. The word “discharge” will be used only when necessary to satisfy the state requirements as it promotes an artificial boundary reflecting poorly on the implementation of a continuum of care.

9.2 ROLES AND RESPONSIBILITIES

ABHA

- Conducts on-going UM for clients approved for admission to Psych Res and other levels of acute care by regional coordinators.
- Conducts Reviews as previously stated in section 6.0 of this document.
- Provides consultation and support for community care coordinator cases where child requires hospital level of care.
- Will be available as resource in identifying Residential services when this level of care is recommended and not locally available.

- Provides consultation and technical assistance to Community Care Coordinators and ICTS providers.
- Insures that training and consultation about community-based planning and ICTS are provided to Community Care Coordinators and ICTS providers.
- Supports the development and monitoring of a data management system that is responsive to care planning where children needing ICTS can access a referral and screening at multiple entry points.
- Promotes member access to care and services that are family-driven, strengths-based, and culturally sensitive.
- Monitors implementation of guidelines and standards that enhance and promote quality, community-based service delivery.
- Tracks ICTS children to ensure continuous enrollment with the MHO.
- Tracks quality indicators and works with County Child Serving Agencies to determine and develop actions plans when appropriate.

Community Mental Health Program, (CMHP)

- Conducts on-going utilization management for clients who participate in treatment within their communities, inclusive of Day Treatment.
- Makes referrals to panel providers and authorizes services when agency staff lack the clinical expertise to provide the services needed of a member or, when agency staff to not time available to see clients within contractually determined access standards
- Responsible for providing Care Coordination to clients.
- Screens referrals and makes ICTS determination.
- Meets with family to develop a relationship and begin identifying family strengths, needs and goals.
- Works with family to establish the Child and Family Team.
- Jointly coordinates and convenes the Child and Family Team with the family as needed.
- Coordinates with DHS/Child Welfare if family is involved with DHS/Child Welfare. (DHS will facilitate Team Meetings if they are custodians).
- Maintains ICTS case file and disseminates the Service Coordination Plan.
- Maintains regular contact with the child, family, service providers and representatives of other systems in which the child is involved.
- Provides/assures case management services: assessing needs, identifying and coordinating services, monitoring service effectiveness, consultation, advocacy, crisis response, etc.
- Collaborates with Child and Family Team to adjust level of care to meet needs.
- Implements a transition plan to/from services. Maintains involvement during transitions.
- Facilitates the Community Care Coordination Committee.

ABHA/CMHP Cooperation

- The CMHP will contact the ABHA Child and Family Manager when it is determined that a client requires a Residential or Acute level of Care.

- The hand off of UM responsibilities to ABHA will occur after the client has entered into a Psychiatric Residential or Acute Facility.
- The CMHP and ABHA Child and Family Manager will work together to insure that involvement with the CMHP Care Coordinator and Child and Family Team continues.

10.0 OUTPATIENT SERVICES

Responsibility and Scope

ABHA subcontracts with each of its five member counties on a per member per month basis for the provision and utilization management of all outpatient services. This is a delegated activity under the MHO Agreement. A member county may provide such services through employees who work for a county run and operated agency (e.g., Benton County Mental Health), through a subcontract with a non-county agency (e.g., BestCare), or through a contract (held by ABHA) with a panel provider which is an agency (e.g., Old Mill Center) or an individual practitioner.

The policies, procedures, and protocols described below regarding authorizations for treatment; denials of treatment; and grievances for panel providers are applicable the mental health services provided by County Mental Health Clinics as well as panel providers.

ABHA will periodically audit county agencies and high volume providers to determine if clinical services and delegated functions are being provided in a manner that is consistent with the MHO Agreement and all applicable rules and regulations as agreed to in ABHA's contract with its partner agencies.

10.1 General Considerations Related To The Utilization Of Outpatient Services

ABHA has based its criteria for outpatient psychotherapy upon Evidence Based Practice guidelines and upon a consideration of various models of psychotherapeutic change. ABHA does not intend to exclude any model from possible consideration for patient care. The guidelines below reflect ABHA's belief that outpatient treatment must consider time and cost as legitimate parameters of effectiveness. Specific goals for change would be behaviorally referenced. Medical necessity requires treatment be delivered in the most cost-effective manner consistent with quality outcome. (The ABHA outpatient medical necessity criteria are presented in the Appendix.)

When patients do not respond to traditional outpatient services, more intensive care outpatient care, as described above, may be appropriate.

Situations which suggest there should be a *review* regarding whether Outpatient Psychotherapy is Medically Necessary

- The individual's GAF is above 70
- Treatment is not voluntary
- The risk of self harm or harm to others is significant and requires significant observation and control
- The individual lacks the cognitive or expressive capabilities to participate in the behavioral change process
- Data from the Oregon Change Index demonstrates that the member:
 - is functioning well at initial presentation for treatment (total OCI score for questions 1-4 >24).
 - has plateaued in treatment and is likely to achieve no, or only minimal gains with additional services
- Personality disorders or traits not covered under OHP that interfere with treatment and/or behavioral change.

In order to be eligible for outpatient mental health benefits following an initial assessment, the member must be diagnosed by an eligible mental health provider as having a mental disorder using the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*; have an OHP covered condition; and must have a condition that meets ABHA's medical necessity criteria for outpatient services (see Sections 4.2 and 5.2)

Access to Outpatient and Crisis Intervention (emergent and urgent)

Mental health screening and referral services are available 24 hours per day seven days-a-week through a toll-free phone number. No preauthorization is required for initial screening or assessments conducted by the ABHA County clinics. Crisis and Intake assessments are available during the local County clinic's regular business hours. ABHA partners shall assist members in securing access to mental health services that are medically appropriate, but not covered by the Oregon Health Plan.

Crisis intervention is available through Accountable Behavioral Health Alliance during non-business hours and seven days per week via the ABHA crisis phone line, without preauthorization.

10.2 Intensive Case Management

ABHA's case management process is a key element of the Utilization Management Program. Case management is a collaborative process between the member, provider, county utilization manager¹ (when services are authorized to a panel provider) which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet complex health needs. The use of case management strategies, in addition to ongoing utilization review, promotes quality care and preserves the members' benefits.

Some cases are determined to be "high risk" and require intensive case management services.

10.2(a) Identification & Evaluation

Both inpatient (ABHA) and outpatient (county) utilization managers screen for "high risk" cases. In order for a member to be considered "high risk", the member must have had two or more acute care or crisis episodes in the last year and meet two or more of the following criteria:

- Have an Axis I diagnosis of Schizophrenia, Bipolar disorder, Schizoaffective disorder, Major depression, PTSD
- Have current or past history of substance abuse
- Have an Axis II diagnosis of Borderline, Dependent, Paranoid or Schizoid Personality Disorder
- History of non compliance with medication or therapy including multiple changes in providers
- Has a medical condition that complicates their psychiatric status

When a member has been identified as "high risk", the case is evaluated for appropriateness of updating the member's treatment plan. This evaluation should include a review of:

- The member's clinical history
- Utilization patterns
- Social and family supports
- Treatment and resource deficits that have the potential for being positively impacted by high risk case management services

This evaluation, as well as treatment recommendations, is documented in the member's clinical record.

10.2(b) Intensive Case Management Treatment Planning

¹ The term, utilization manager, refers to that person or persons in a county agency who makes referrals and authorizes treatment to panel providers and reviews requests for service authorization.

A member may be identified as a candidate for Intensive Case Management (ICM), when receiving acute care services or by intensity of services being required to maintain the member in the community, by the County Mental Health Program hospital liaison, the ABHA Utilization Manager, the County Mental Health Utilization Manager or the County Mental Health Crisis Team in consultation with the member's primary treatment provider. When a member has been identified as needing ICM by the county staff and ABHA Utilization Manager a multi-disciplinary team plan will be developed and implemented within five working days. Plan development will be coordinated by County Mental Health staff

An ICM plan will be a modification of the member's treatment plan and includes:

- A strategy for minimizing use of acute care services
- A listing of specific services to be provided including frequency and duration
- Identification of community resources and a plan to access as necessary and appropriate
- All funding options
- Inclusion of support systems in planning and implementation strategies

The plan will be reviewed as necessary, but at least monthly, and modified according to the member's needs. When the member is discharged from acute care, responsibility for monitoring and continued implementation will pass to county designated staff.

When a member is identified as a candidate for ICM plan while receiving outpatient services, the county staff begins the development and implementation of a multi-disciplinary team plan in consultation with member's support system. The plan will be implemented within five working days of initial identification.

10.2(c) Implementing and Monitoring the Case Management Plan

In implementing the intensive case management plan, the county staff will conduct the following activities:

- Frequenting monitoring of the member's stability, progress in treatment and appropriateness of current level of care
- Referral for specialized consultation (e.g., evaluation by neurologist)
- Referral to appropriate providers for necessary ancillary services (e.g., marital therapy for parents whose problems are impacting a child's progress in treatment)
- Consultation with providers, family, support systems and member
- Identification of and referral to appropriate community services
- Member advocacy, including interfacing with schools, treatment facilities, community agencies and government resources
- Crisis intervention

10.3 Services To ABHA Members With Serious And Persistent Mental Illnesses

ABHA's Counties have primary responsibility for adequate, long-term commitment to treatment of the ABHA members with serious and persistent mental illnesses. The goal of providing services is recovery. Needs vary for each individual depending on the impact of their illness on functioning. At a minimum, the County should provide ongoing medication management for psychiatric medications, case management with at least monthly contact and the availability of a therapist when needed for more in-depth issues. It is important for providers to work with members to monitor their symptoms for prevention of relapse and to provide the higher level of interventions necessary to prevent acute care interventions.

Treatment should be provided in a manner that is consistent with the Recovery . Recovery is not only maintaining the member at the current level of function, or prevention of deterioration, but a philosophy of increased functioning to the maximum possible within the member's ability. Areas to focus on in the recovery model are: independent living skills, vocational/academic skills, socialization, mobility, and independence in managing and seeking treatment for mental illness.

Disease Management

The patient requires scheduled or intermittent contact with a clinical professional to maintain his or her level of functioning and to prevent the use of more intensive levels of care. Patients who require this ongoing contact with a therapist should be considered for the most cost effective approach to chronic disease management, including groups, "as needed" availability of the same therapist as a consistent object during crises, or flexible, discontinuous scheduling which individualizes the patient's need for contact.

10.4 Ancillary Treatment Options

10.4(a) Outpatient Medication Management

Medication Management is the term applied to situations where the sole service rendered by a licensed medical practitioner (LMP) is the evaluation of the patient's need for psychotropic drugs, the provision of a prescription, and ongoing medical monitoring. Interactive psychotherapy is not being rendered at this time by the LMP, but may be provided by another clinician. Medication Management is specifically classified in one of two categories:

- Providing medical supervision and prescribing or evaluating the need for psychotropic drugs to a patient who is in treatment with a non-medical psychotherapist
- or

- Providing medical services, including prescription of psychotropic drugs, to a patient currently not in need of psychotherapy

Following the initiation of a medication strategy, failure to progress on medication alone or some combination of medication/psychotherapy after a 2-3 month trial may require a second opinion regarding the medication.

In certain cases, Medication Management will continue beyond the psychotherapy component of treatment. In other cases, Medication Management will occur in the context of long-term supportive psychotherapy (usually on a monthly basis). In the authorization of Medication Management, consideration should be given to the following: the need to involve the family or social support network in order to evaluate compliance with medication regimes as prescribing the medication is also providing some aspect of supportive therapy on a regular basis. (Generally, with a patient who is psychologically stable, medication alone can be followed on a 15 minute to 30 minute basis; no more than monthly.)

10.4(b) Psychological Testing

All psychological testing is reviewed per case specifications. Based on the diagnostic question posed and the specific tests planned or administered, a Utilization Manager (County UM staff for outpatient service and ABHA UM staff for acute care service) evaluates the appropriateness and clinical need of the testing. . ABHA does not authorize general batteries of tests. Tests are authorized which are appropriate to the specific questions that need to be addressed by psychological testing. When a large battery of tests is proposed, particularly neuropsychological testing, a psychologist or psychiatrist with testing background is always consulted. (See Appendix 2, ABHA Psychological Testing Guidelines, for further details.)

10.4(c) ECT

Electroconvulsive therapy is a covered treatment by the Oregon Health Plan. ECT is a specific treatment procedure requiring clinical justification and clear documentation of the clinical process. ECT can be administered as an inpatient or outpatient service. For inpatient service the ABHA Utilization manager is responsible for authorization and payment. Outpatient ECT will be authorized and paid for by the county of responsibility. ECT treatments must be preauthorized. .

Use of Electroconvulsive Therapy

1. The decision to administer ECT is based on an evaluation of the risks and benefits for the individual member and involves a combination of factors, including psychiatric diagnosis, type and severity of symptoms, prior treatment history and response, identification of possible alternative treatment options and member's preference.
2. Indications for treatment. ECT is to be considered as a secondary treatment when a member has shown insufficient improvement with prescribed treatments which typically

- includes at least three failed pharmacotherapy trials. In addition to lack of substantial clinical response, other reasons to use ECT include intolerance to medication side effects, deterioration in condition and/or increased suicidality, and prior history of favorable response to ECT.
3. The use of ECT is mainly reserved for but is not limited to members with Major Depressive Disorder, Bipolar Disorder and Schizophrenia and subtypes of other psychotic disorders.
 4. ECT is typically counter-indicated for individuals which borderline personality disorder.
 5. ECT should only be done on clients who have informed consent and should not be pressured into such a treatment

As described above, when an appropriate provider is not available in ABHA's panel counties will contact ABHA to arrange a contract with the provider(s) needed for a course of treatment. Note: some of the services required are medical in nature (e.g., anesthesia), but are paid for under the member's mental health plan of benefits. Unless the member is admitted to the hospital, ECT services delivered in a hospital setting are an outpatient service that the responsibility of the member's county.

10.5 Utilization Management

10.51 Adding Panel Providers

As noted in ABHA Policy #37, ABHA county sub-contractors shall annually assess its panel provider needs. Each county will identify staff authorized to submit provider names for inclusion on the ABHA panel. Providers must be appropriately licensed, certified, or registered by the State to be considered for inclusion in the Panel. Reasons to make exception to this rule must be clearly stated by the county requesting the addition of a new provider AND the reasons for agreeing to this exception must be approved and documented, in the minutes of the ABHA Recredentialing Committee and the provider's file.

10.52 Outpatient Concurrent Review

In the sections below, we describe the procedures to be followed when a county subcontractor determines that a referral to a panel provider should be considered. The Utilization Management Plan does not specify *how* a county subcontractor should manage utilization within his/her own agency. That is up to each county. ABHA, however, is required under the MHO Agreement to assess each subcontractor's ability to perform this function and will do so periodically.

Whether services are provided by a county subcontractor or a panel provider, medical necessity criteria are the same, as are the policies that apply to the delivery, management and oversight of outpatient services in general.

Method of County Subcontractor Concurrent Review Of Services Provided By Panel Providers

Following an initial assessment, which could be conducted by either a Panel Provider or the County Subcontractor, the County Utilization Manager determines the need for an authorization for outpatient services to a Panel Provider. To complete an authorization for services, the Utilization Manager, in consultation with the treating provider, will determine:

1. The type of services that are clinically appropriate
2. The frequency and intensity of services that are clinically appropriate
3. A time period for an initial authorization that is clinically appropriate
4. A dollar amount that is sufficient to cover the cost of services the provider is expected to deliver over the course of the authorization

The County Utilization Manager communicates this information to the panel provider and enters a corresponding authorization into the authorization system of ABHA's Third Party Administrator.

Either a new authorization for treatment or a modification of an existing authorization must be made when a member's condition changes, necessitating a modification of the intensity, frequency, or duration of treatment.

Panel providers are responsible to contact the authorizing County Utilization Manager:

- If it is their determination that a client needs additional outpatient services
- If their client's mental health condition has changed, or their assessment of that condition has changed, which would necessitate that a different type or intensity of services be provided to the member.

Routine requests for reauthorization must be submitted 14 calendar days before the last expected day of service or the last day of the current authorization, whichever date comes sooner.

Panel providers will contact their County Utilization Manager immediately if the need for a new, extended, or modified outpatient authorization for services requires a more immediate review.

In emergent situations, Panel Providers should contact the county crisis team to make a determination if a higher level of service needs to be provided to the member..

County Utilization Managers are available by phone to members and outpatient providers to facilitate treatment planning and authorization for services in response to significant, unexpected changes in patient status that require changes in treatment authorizations.

- County Utilization Managers will respond to non-routine requests for new or modified authorizations within two business days
- County Utilization Managers will respond to routine requests for new or modified authorizations within five business days

It is the responsibility of each County Subcontractor to develop forms and county-specific procedures for gathering the clinical information needed to make utilization management decisions. ABHA will provide technical assistance to counties, as requested, to implement and improve these processes.

The clinical information used to make such determinations will include, at a minimum, review of the member's most recently updated assessment and treatment plan. County Utilization Managers will gather routine clinical information regarding clients progress in treatment and may request, at any time, copies of progress notes or other components of the panel providers clinical record.

It is the responsibility of county sub-contractors to enroll every member who receives a service in CPMS. Note: it is not the responsibility of Panel Providers to do this.

Continued Authorizations and Extensions of Service

A change in treatment or an extension of authorization for treatment must be made in when a members condition changes necessitating a modification of the intensity, frequency, or duration of treatment. For member services paid on a case rate basis chart reviews will be completed every 30 to 180 days for continued authorizations.

11.0 DENIALS AND APPEALS

APPEALS:

An appeal is an ABHA Member, member representative, or provider's request for reconsideration of a Notice of Action or Denial of Service Authorization.

1. ABHA members or member representative have the right to appeal a Notice of Action.
2. Appeals to ABHA must be made orally or in writing within a reasonable timeframe that can be no later than 45 calendar days from the date of the Notice of Action or Service Authorization Denial letter. Oral Appeals must be followed with a written Appeal unless the member or member representative requests an expedited process. Members or member representatives may request assistance from ABHA in filing an appeal.
3. ABHA will provide the member or member representative an opportunity to present evidence for an Appeal in person as well as in writing; ABHA will inform the member or member representative of the limited time available for presentation of evidence for an expedited process. Members will be given the opportunity before and during the Appeals process to examine their own clinical records and others documents and records considered during the Appeals process.
4. ABHA will ensure that the decision-makers for appeals were not involved in the previous levels of review or decision-making and are Mental Health professionals with clinical expertise in treating the member's mental Health condition if the Appeal is of a denial based on lack of medical Appropriateness, or the Appeal involves clinical issues.
5. OHP members, member representatives, or providers have the right to request Continuation of Benefits until a decision in an Appeal or Administrative Hearing is rendered. If the final resolution of the Appeal is adverse to the OHP Member, that is, upholds the Action, ABHA may recover from the OHP Member the cost of the Services furnished to the OHP Member while the Appeal was pending.
6. Continuation of benefits pending Administrative Hearing – If, at the OHP Member's, member representatives, or provider's request, ABHA continues or reinstates the OHP Member's benefits while the Appeal is pending and the notice of Appeal resolution is adverse to the OHP Member, the benefits must be continued pending Administrative Hearing pursuant to OAR 410-141-0260 through 410-141-0266.
7. \

NOTICES:

1. ABHA does not delegate the Appeal procedure related to the reduction or denial of service. All such appeals go directly to ABHA; there is no county level appeal.
2. ABHA or its county partners shall issue a written **Notice of Action** to the member and/or member representative in a format that meets the member's special needs each time:
 - A Service or benefit will be terminated, suspended, or reduced without the member's consent (within 10 days before effective date of action)
 - A request for Service authorization is denied in whole or in part (within 14 days of the date of the service authorization request)
 - A claim payment is denied in whole or in part based on a determination of medical necessity (at the time of denial mailed to both member and provider)
3. The Notice shall include:
 - A statement of the action and the effective date of the action; the reasons for the action
 - The member's right to file an Appeal

- The member's right to request an Administrative Hearing with DHS, information on how to obtain an Administrative Hearing, or an Expedited Appeal
- The member's right to request continuation of benefits until a decision is made, notice that the cost of any Services continued may have to be repaid by the member if the issue is resolved in favor of ABHA
- The name and telephone number of the ABHA Quality Manager to contact for additional information

A Notice of Hearing Rights (MHDDSD-OHP-0505-3/98), and Administrative Hearing Request Form AFS 443) will be included with each Notice of Action.

4. ABHA county agencies are responsible for sending Notice of Action letters to affected members or member representatives in the event of significant changes in program or Service sites that impacts the member's ability to access care or services, including contract terminations of panel providers. A copy of each letter will be provided to ABHA (within 10 days of the action).
5. ABHA or county partners will reinstate services if any action to deny, reduce, or discontinue services was made without providing the required notice, or the notice is not provided in the timeframe above and the member or member representative requests a hearing within 10 days of the mailing of the Notice, or the USPS returns mail directed to the member but the member's whereabouts become known during the time the member is eligible for service.

RESOLUTION OF APPEALS:

1. ABHA will resolve each Appeal and provide a written resolution, including the outcome and the date of resolution, to the ABHA member or member representative within the timeframe prescribed by Oregon Administrative Rules (OAR). ABHA may extend this timeframe by up to 14 days if the member or member representative requests an extension or if ABHA shows that there is need for additional information and that the delay is in the member's interest. For extensions not requested by the ABHA member, ABHA will give the member or member representative written notice of the reason for the delay.
2. If the decision is not in the member's favor, written notice of this decision will include the member's right to request an Administrative Hearing as well as information and forms to request such a hearing. A member or member's representative is not prohibited from requesting an Administrative Hearing at any time as a result of this policy.
3. If the mental health status of the member meets the definition of an Emergency Situation or Urgent Situation, the member or member representative may request an Expedited Appeal Process. If an Expedited Appeal is requested and meets the Emergent or Urgent criteria, then The ABHA Utilization Manager presents an immediate report to the ABHA Executive Director who will determine if the mental health condition at issue meets emergency or urgent definition. ABHA will provide the member or member representative a response within 3 working days of receiving the request for an Expedited Appeal. If ABHA denies

the request for an Expedited Appeal, ABHA will follow the timeframe for standard appeals, but will give the member or member representative prompt oral notice and will provide written notice within 2 calendar days.

4. An OHP member or member representative may request that service that have been reduced, or intended to be discontinued, instead be continued by filing a **Request for Continuation of Service** with ABHA. Service will be continued, unless medically contraindicated (e.g., drug reactions), until the appeal is resolved. The appeal must be filed before the date of intended action or within 10 calendar days after the date of the Notice of Action was mailed or given to the member or member representative. If the Complaint or Hearing authority rules against the member or member Representative, the member can be held financially responsible for all service delivered after the date of termination or reduction in the Notice of Intended Action.

DHS ADMINISTRATIVE HEARINGS:

1. At any time, ABHA members or member representatives may request an Administrative Hearing by the Oregon Department of Human Services (DHS) for review of a Notice of Action or written appeal decision. The DHS Administrative Hearing Rules require members or member representatives to request a hearing within 45 days of the date of the Notice of Action or written appeal decision. If the hearing issue involves a Notice of Action and the member or member representative indicates the desire to have Services continued while the hearing issue is resolved, the member or member representative must request a hearing before the effective date of the Notice of Action or within 10 calendar days after the date of the Notice of Action or written appeal decision was mailed or given to the member.
2. Members are entitled to an expedited hearing if the mental status of the member meets the definition of an Emergency Situation or Urgent Situation and the situation cannot wait to be addressed within the regular hearing timeframes. The member or member representative may request an Expedited Hearing by indicating this on the Administrative Hearing Request (form AFS 443) and must explain why a decision is needed right away.
3. Any Administrative Hearing Request received by ABHA or a county partner shall be forwarded along with any documentation related to the hearing issue to AMH. AMH will notify ABHA within 5 working days and review the request to confirm member eligibility and timeliness of the request. If the Member or member representative requests to have benefits continue during resolution of the hearing issue, AMH will notify ABHA to continue services for no more than 90 days from the date of request, or until the current authorization expires, a decision is made, or the member is no longer eligible for Medicaid benefits. ABHA will notify the member or member representative in writing that it is continuing the service and that if the hearing is resolved against the member, the member can be financially responsible for the cost of any services continued after the effective date of the Client Notice.
4. ABHA will cooperate fully with the DHS Administrative Hearing process and comply with and fully implement Hearing decisions.

Inpatient and Sub-Acute/Crisis-Respite, and Residential Services Denials and Appeals

The ABHA Utilization Manager (ABHA UM) conducts all first level review activities using ABHA clinical guidelines. First level reviewers can authorize care but cannot deny services. All cases not meeting the first level screening criteria are submitted for a second level review. All second level reviewers are board certified psychiatrists. All second level reviews are conducted to render clinical need and appropriateness decisions based on the ABHA criteria and medical expertise of the reviewer. If the appropriateness of type or level of care is questioned and a potential denial of benefit may be indicated the case enters the second level review process. ABHA will ensure that no Physician Reviewer previously involved in review or decision-making regarding the case shall be a part of any appeal process.

- Second level review process: The ABHA UM will inform the treating provider that the case requires a second level review. The ABHA UM will provide an oral overview of the second level review process to the treating provider.
 - The case is presented by the ABHA UM to the ABHA Physician Advisor or designee **within one business day** of receipt of all necessary documentation and /or all pertinent clinical data. At that time, a MD to MD consult will be offered by the ABHA UM to the treating provider MD.
 - If an authorization cannot be supported and a **denial will be issued** by the ABHA Physician Advisor or designee, **that decision** will be conveyed by the ABHA Physician Advisor or designee to the treating provider MD **at that time**.
 - The ABHA Physician Advisor or designee will **immediately notify** the ABHA UM of the denial.
 - The ABHA UM will **immediately** telephone the treating provider and inform the provider of the decision to deny (if not already done by the ABHA Physician advisor or designee), that a Notice of Action (NOA) will be sent to the treating provider and OHP member on this same day, and how the treating provider **may request/ initiate an expedited appeal process** on behalf of the OHP member.
 - Per MHO Agreement Exhibit G (4) (a): The **OHP Member is only entitled to an expedited appeal process** if the mental status of the OHP Member meets the definition of an Emergency Situation or Urgent Situation and the situation cannot wait to be addressed within the time frames associated with a regular Appeal.
 - The ABHA UM will generate a Notice of Action(**NOA**) and **mail it and/or hand delivery** the NOA to the treating provider and the OHP member **on the same day, but not later than the next business day** as the decision to deny was made by the ABHA Physician Advisor or designee.
 - The NOA will include all elements and documents as defined by the MHO Agreement Exhibit G (1). The NOA is signed by both the

ABHA UM and the ABHA Physician Advisor or designee. The ABHA UM may sign the NOA for the ABHA Physician Advisor or designee when directed to do so by the ABHA Physician Advisor or designee.

- If the treating provider on behalf of the OHP member and/or the OHP member **requests an expedited appeal of the denial**, and the OHP member meets criteria as set fourth in the MHO Agreement Exhibit G (4)(a), a second level phone review by the ABHA Medical Director or designee will **occur within two working days** of the request. The ABHA UM will coordinate the second level review with the treating provider and ABHA Medical Director or designee within the give timeframe.
 - Per MHO Agreement Exhibit G 4 (c) ABHA resolution and subsequent written and oral notification to the treating provider and OHP member of an **expedited appeal** will occur as expeditiously as the OHP member’s mental health condition requires not to **exceed 3 working days after ABHA receives the request for an expedited appeal**. ABHA **may extend the timeframes by up to 14 calendar days** if the OHP member requests the extension either orally or in writing, or ABHA shows that there is need for additional information and how the delay is in the OHP Member’s interest. For any **extension not requested by the OHP Member, ABHA shall give the OHP member written notice** of the reason for the delay. Such **notice will be mailed/hand delivered** to the treating provider and/or the OHP member on the **same day** such a decision was made but **not later than the next business day**. In addition to the written notice, **ABHA will provide oral notice** to the treating provider and OHP member of ABHA’s decision to extend the time frame on the same day such a decision is made but no later than the next business day.
 - If ABHA **denies the request for an expedited appeal** per MHO Agreement Exhibit G (4) (d): ABHA will follow the timeframe for standard appeals. ABHA shall provide **oral notice** to the treating provider and/or the OHP member on that **same day** as the decision was made to deny, and follow up with a **written notice** to the treating provider and/or the OHP member **within 2 calendar days**.
 - **If the denial of the expedited appeal is upheld** by the ABHA Medical Director or designee, a **written notice** will be issued. The written notice will signed by both the ABHA UM and the ABHA Medical Director or designee **on the same day** such determination is made and/or as expeditiously as the OHP member’s mental health condition requires not to exceed **the 3 working days after** the expedited appeal was requested, or as an extension applies (**not to exceed 14 calendar days** from date the extension was request by the OHP member and/or date ABHA requested extension). The ABHA UM may sign

the notice for the ABHA Medical Director or designee when directed to do so by the ABHA Medical Director or designee.

- ABHA per MHO Agreement Exhibit G (5) (c) will provide written notice of the disposition that includes outcome and date of the Appeal resolution. If the decision is not in the OHP Member's favor, notice must include OHP Member's right to request an administrative hearing and the process to request a hearing, the OHP Member's right to request continuation of services pending a hearing, the process to request continuation of services and that the OHP Member may be held responsible for the cost of continued Services if the hearing is in favor of Contractor (ABHA).
- **There are no other levels of appeal within ABHA should an appeal be expedited, however;** the OHP member has the right to an administrative hearing as defined in the Notice of Hearing Rights enclosed with the both with the NOA and written Notice of Appeal Resolution.
- **Resolution of an appeal** in response to a **retrospective review which yields a denial**, of full or partial payment of the claim, at request of the treating provider will follow the Standard Appeals time frame and not **exceed 45 days from the date ABHA receives the appeal**. ABHA will provide a written notice of its decision to the treating provider on the Notice of Appeal Resolution.
 - ABHA per MHO Agreement Exhibit G (5) (c) will provide a written notice of the disposition which includes outcome and date of the Appeal resolution. Notice will include how the provider may request another level of appeal within ABHA should the denial be based on not meeting medical Necessity criteria.
- All **retrospective reviews that do not meet medical necessity** criteria and are subsequently denied by the ABHA Physician Advisor or designee **can be appealed**. These appeals will be referred to the UM Appeals Subcommittee for a final determination. The treating provide may request such a review through the ABHA UM as indicated on the written notice in response to the appeal of the denial yielded by the retrospective review.
 - Per MHO Contract Exhibit G (2)(a)(1): ABHA shall ensure that no member of the appeals sub-committee have been involved in previous levels of review or decision-making regarding the case that is being appealed. For cases where a denial has been issued on the basis of Medical Appropriateness, Appeals Committee members will be mental health care professionals with clinical expertise that is relevant to the case under consideration. The subcommittee will be composed of: the ABHA Executive Director, the ABHA Medical Director, a Mental Health Director from a county not involved in the case and the ABHA Quality Manager. Staff to the appeal, but not voting is the ABHA

Utilization Manager who has been involved in the case under consideration.

- This **review is completed within 30 calendar days** of receipt of requested documentation. The outcome of this review will be provided to the treating provider via a **written notice**. Such notice will be **postmarked no later than two business days** from the date the decision was made by the Appeals Subcommittee.
- If the retrospective review denial is upheld by the Appeals Subcommittee, the Subcommittee Chair completes and signs the notice. The notice will provide the reason for the determination of the denial.
- The ABHA UM will also orally communicate the decision to the treating provider.

Outpatient Denials and Appeals

The process for outpatient denials and appeals is the same as for all other levels of care, as described above in Section 10.0. Special considerations are noted below.

County subcontractors to whom the responsibility for utilization management of such services has been delegated, are responsible for determining medical necessity. However, such a determination can only be made by the County Utilization Manager if he/she has the same or “higher” level of license as the provider being denied. It is not required that an MD make this determination. The order of “higher” to “lower” is as follows:

1. Physician
2. Psychologist
3. LCSW/LNP
4. LPC

If a County Utilization Manager’s credentials do not meet this standard and he/she cannot recommend an extension of outpatient treatment, the case is referred to a second clinician who has the same or “higher” license type as the provider to perform the review.

The County Utilization Manager completes all the steps described in Section 10.0 for notifying the member and the provider of the reason for the determination and of all subsequent rights. All Notice of Action (NOA) forms must also be sent within one business day to ABHA.

- Each county will keep a log of when they send a Denial of Authorization or a Notice of Action form.
- Each county will notify ABHA of all NOAs
- Each county will identify on each Notice of Action forms sent:
 - What led to Notice
 - Options made available to the member

- Proposed solutions
- Whether member requested further action
- Notification of all subsequent rights
- ABHA will monitor counties' issuance (or non-issuance) of NOA's. Corrective action plans will be required, if needed, to address any systemic problems or deficiencies observed. The action plan will be presented to the ABHA QMC for discussion and recommendation for approval.

Special Considerations:

If a member specifically requests to be refurbished to a panel provider and a county agency determines that the service should be provided and have an agency clinician can provide the service requested , it is within the agency's right to deny this request, but a Notice of Action letter must be written to the member.

1.0 TREATMENT AUTHORIZATION CORRESPONDENCE

When the request for treatment is approved for services provided by a panel provider, a letter identifying precertified services is generated by the County Utilization Manager on the day of the decision and mailed to the member and provider.

When the request for authorization of treatment is denied:

1. A letter is generated on the day of the denial decision and faxed to the member and provider/s for patients currently receiving outpatient treatment services. Patients in weekly outpatient treatment may be sent notification via mail. This letter identifies the services denied authorization and explains the appeals process. The letter also contains:
 - A patient-specific reason for the denial
 - A statement informing the claimant of his/her right to the next level of appeals with clear instructions that describes how to request an appeal through the County, ABHA or the appeals process available through AMH

13.0 TIMELINESS STANDARDS

13.1 Inpatient Treatment

Accountable Behavioral Health Alliance supports the following national standards for timely patient evaluation, which apply to any patient who is admitted to any acute inpatient psychiatric treatment facility.

Within 24 Hours of Admission:

- History of present illness

- Previous mental health treatments
- Relevant family history and developmental history
- General medical (non-psychiatric) history, including previous treatments
- Current physical condition, determined by physical examination, neurological examination, and appropriate laboratory studies
- Mental status examination
- Initial diagnostic formulation
- Individual psychiatric evaluation
- Initial discharge plan

Within Two Days of Admission:

- Assessment of any factors that may complicate treatment, such as substance abuse, physical/sexual abuse, or other co-morbid psychiatric disorders
- Interdisciplinary treatment team meeting
- Detailed treatment plan and evidence of implementation
- Expected discharge plan summary

At Time of Discharge:

- Written formal discharge plan
- Discharge treatment team meeting
- Outpatient Mental Health Care arranged

It is expected that a specific aftercare plan will be developed prior to discharge and a designated county staff person will be responsible for assuring that the plan is followed.

APPENDIX 1

ABHA CLINICAL NECESSITY CRITERIA

INPATIENT

1. Member presents as a significant danger to self as evidenced by a suicidal risk factors, or member is at high risk for self destructive acts secondary to severe psychiatric symptoms (i.e. command hallucinations or persecutory delusions); **OR**
2. Member is at significant risk of committing violent, aggressive or impulsive acts that can best be explained as resulting from a severe emotional state or exacerbation of an existing psychiatric condition; **OR**
3. Member has acute onset of psychosis, severe thought disorganization or deterioration of a chronic psychotic condition so that the member is unmanageable and unable to cooperate in treatment in a less restrictive, less intensive setting; **OR**
4. Member needs psychiatric medication adjustment that cannot be managed in the community including monitored administration of medication; **OR**
5. Member presents severe functional impairment resulting from an acute psychiatric condition such that the member is unable to provide for basic self-care without 24-hour supervision; **OR**
6. Member meets the crisis respite admission criteria; **AND**

No respite bed is currently available; **OR**

The member is considered an elopement risk; **OR**

It is considered likely that the member will require restraint or seclusion; **OR**

The member's condition is such that proposed treatments require 24 hour nursing observation (i.e. tube feedings, ECT, IV therapy) which are not appropriate outside of a hospital setting and are not primarily for a substance abuse or medical condition.

SUB-ACUTE/CRISIS RESPITE

1. The member exhibits risk factors for self harm (e.g., frequent suicidal ideation, a recent gesture) such that safety cannot be reasonably assured outside of a structured overnight setting. The risk of self harm is secondary to psychiatric symptoms such as depression, command hallucinations or persecutory delusions; **OR**
2. The member is experiencing an increase in psychotic symptoms and the member cannot be managed in a less restrictive, structured environment; **OR**
4. The member is at risk of committing aggressive or impulsive acts resulting from emotional distress related to a psychiatric condition; **OR**
5. The member presents sufficient functional impairment resulting from a psychiatric condition such that the member is unable to provide for basic self-care without 24-hour supervision.

AND

It is anticipated that the member will benefit from the level of care available in the Sub-Acute/Crisis Respite facility.

The member is not suffering from a medical condition that requires inpatient evaluation or treatment.

The member has the potential of becoming an imminent risk to self or others as evidenced by recent or ongoing unpredictable dangerous behaviors; **OR**

Contracting for safety is not shown effective in current literature and if we are going EBP we should leave out **AND**

The member gives evidence, historically or verbally, that they will respond to redirection when it is available.

OUTPATIENT TREATMENT

INTRODUCTION: quick, easy access to outpatient treatment is to be encouraged.

Though all levels of care are to be managed, any patients seeking outpatient care for the treatment of a problem which is generating psychological distress should have an initial assessment session authorized without consideration of medical necessity.

Authorizations for outpatient treatment must consider time and cost as legitimate parameters of effectiveness. It is expected that specific, measurable treatment goals will be developed by the third session of treatment as well as criteria for discharge.

Positive criteria:

- The patient has a psychiatric disorder consistent with the diagnostic nomenclature of the DSM IV.²

AND

- Treatment is likely to result in either:
 - demonstrable improvement in the signs and symptoms of a psychiatric disorder

OR

- the prevention of demonstrable deterioration

AND

- The proposed treatment method and frequency is consistent with:
 - national standards of treatment and
 - Evidence Based Practice guidelines on treatment effectiveness for the specific psychiatric condition and diagnosis of the patient.

Generally excluded:

- The treatment of long-standing, pervasive, maladaptive traits and/or behavior patterns which are not associated with a current Axis I diagnosis.
- Treatment which has as its main goal: personal growth, greater happiness, personal fulfillment etc.
- Treatment which has not been effective in helping the client to achieve treatment plan goals.

² V-codes are acceptable as long as the covered member has a numbered diagnosis in addition to a V-code diagnosis.

- Treatment frequency of more than one session per week, unless the patient's psychiatric illness or condition requires greater intensity to be effective. Not all patients meet criteria for high risk casemangement but may need more contact (e.g. DBT clients)
- Psychological services that are primarily educational or geared to self-improvement; assertiveness training; communication skills, etc.

APPENDIX 2

ABHA

PSYCHOLOGICAL TESTING GUIDELINES

POLICY

Psychological testing is authorized by ABHA only to the extent that it facilitates behavioral health treatment. Testing is authorized when it is found to be medically appropriate to the clinical issue being addressed. Testing is provided only by licensed psychologists.

PURPOSE

To provide guidelines for evaluating requests for psychological testing, including services connected with procedure codes 96100 (Psychological Testing) and 96117 (Neuropsychological Testing). To provide a list of acceptable tests with time allowances for administration, scoring, interpretation, and report writing.

CLINICAL MODEL FOR UTILIZATION OF PSYCHOLOGICAL TESTING SERVICES

A. Overview

Clinical information is gathered through a variety of methods including observation, mental status examination, and history taking. When these techniques do not resolve important clinical issues, psychological tests also can play a useful role. Psychological tests systematically measure human behavior and provide "objective" evidence to assist in treatment. Nevertheless, test results are to be considered an adjunct to the clinician and not a replacement for professional judgment.

Testing techniques are varied. Some merely quantify clinical observations (e.g., checklists). Others use standardized testing procedures to assess attributes that need accurate measurement (e.g., intelligence, cognitive abilities). Still others are structured self-report measures that describe the patient's personality and psychopathology (e.g., MMPI). Finally, some psychological tests rely on less obvious measures of important traits using the projective technique (e.g., TAT and Rorschach). Psychological tests are administered, scored and interpreted by licensed psychologists.

B. Authorization Guidelines

Authorization of psychological testing depends upon three major factors: extent of services covered, medical appropriateness of testing, and appropriateness of the specific psychological tests.

Coverage exclusions

The assessment of certain clinical issues through testing is not a covered benefit. These include but are not limited to:

- a) testing to satisfy the demands of outside agencies (courts, state agencies, etc.).
- b) educational testing (e.g., for educational placement or school services or for diagnosing learning disabilities). Public schools are responsible for such assessment of children under IDEA.
- c) measures of functioning secondary to an established neurological diagnosis (e.g. dementia) as such a testing is covered under the medical benefit.
- d) forensic evaluations, including competency to stand trial, Workers Compensation, disability and personal injury evaluations.
- e) career or job-related testing such as job placement or career interests.
- f) to diagnose or evaluate the intelligence of those with Mental Retardation.
- g) research.

Medical appropriateness

Testing is appropriate only when the following criteria are met:

- There is a specific clinical question to be answered or issue to be resolved.
- The issue directly impacts the form and/or extent of treatment in a timely way.
- The question cannot or has not been answered through a comprehensive clinical evaluation (interview, etc.) or by referral to an appropriate medical specialist (e.g., psychiatrist, neurologist).
- There are valid test instruments available that can directly address the clinical issue.
- The basic adequacy of the patient's functioning (occupational, interpersonal, self-care) is in jeopardy.
- Other than checklists, psychological testing may be performed only by licensed psychologists.

ABHA policy is to deny authorization for testing solely for:

- a) routine evaluations.
- b) establishing a baseline for future assessment.
- c) screening (e.g., for nursing homes).
- d) confirmation of diagnosis.
- e) to obtain data purely for increased understanding of the member's intrapsychic conflicts.
- f) differential diagnosis. Diagnoses are ultimately made by clinicians and not by tests. Most diagnostic questions can be answered by further observation, evaluation and/or consultation. For testing to be authorized, the clinician must demonstrate that other

assessment approaches are inadequate to resolve the diagnostic question at hand, and that discerning a particular diagnosis will have a practical impact on treatment.

Appropriateness of psychological tests

For psychological tests to be authorized the following should be considered:

- Each test must have acceptable reliability and demonstrated validity for the specific clinical issue being addressed. Before testing can be considered appropriate, the effect of potential erroneous results (e.g., unnecessary testing, worry, and unfounded reassurance) must be taken into account.
- Each test must be appropriate for the setting and member (age, gender, and culture).
- Use of the test is the standard of practice in the psychological community.
- The most cost-effective and time-effective tests are to be utilized.
- .

C. Specific Clinical Issues

In addition to the factors noted above, there are additional considerations for specific clinical issues.

Attention Deficit Disorder (with or without hyperactivity)

- Testing would only be appropriate if the proper use of interview and observational checklists have been inconclusive. Even then, only limited assessment of attention would be authorized.
- Testing to resolve concerns about inattention as symptomatic of learning disabilities or level of intelligence is not covered, but may be available through the school system or the Developmental Disabilities Services Division.
- Neuropsychological batteries are unnecessary unless there is reason to believe that a genuine neurological disorder is present. Assessment of neurological disorders is available through the member's medical plan.

Dementia

- Dementia is diagnosed by a physician, typically either a primary care physician or a neurologist. Therefore, members suspected of having dementia must be evaluated by a physician. If, after that evaluation, the physician believes neuropsychological testing would be appropriate, the testing may be authorized under the medical benefit.
- Likewise, assessment of daily functioning, prognosis and level of care may be considered a medical benefit issue.
- Testing may be authorized for members with dementia who also have a psychiatric diagnosis or when there is differential diagnosis issue (e.g., Depression vs. Dementia).

Intelligence, Achievement and Cognitive functioning

- Assessment of cognitive abilities in general (memory, concentration, learning ability, abstract reasoning, perceptual motor functioning, etc.) will be authorized only if the results would have a direct impact on mental health treatment and alternative evaluation methods (interviews with relatives and coworkers, observation, etc.) are not sufficient.
- Testing is not covered for addressing concerns related to learning disabilities, school achievement or level of intelligence. Such assessments may be available through the school system under IDEA, or through the Developmental Disabilities Service Division.

Personality

- Assessment of normal range personality is not authorized because it does not have a direct impact on the form or extent of treatment.
- Assessment for personality disorder is also rarely authorized because personality change is not the goal of problem focused, goal-directed treatment.

Suicide risk

- Risk of suicide is best evaluated clinically. In rare cases, use of checklists may be authorized. General psychological testing (e.g., MMPI) is not necessary for this issue.

Interpersonal / marital relationships

- Clinical evaluation and observation are the most valuable techniques for assessing this issue. Testing will only be authorized if it can be demonstrated that treatment of the individual's covered mental health diagnosis will be effected.

PROCEDURE

1. The psychologist requesting psychological testing authorization submits the ABHA "Request for Authorization of Psychological Testing" to the County Mental Health office. The form may be completed following a clinical interview or following consultation with the referring professional.
2. An Inpatient Sub-Acute/Crisis Respite Program may request authorization for psychological test through the ABHA Utilization Manger review process.
3. The county reviews the testing request within two business days and authorizes time for testing according to the following factors:
 - a) Consideration of Sections A through C above.

- b) Time requirements according to the “Time Allowances for Psychological Tests” (attachment). The allowances include time for administration, scoring, interpretation, and report writing.
4. The County Utilization Management staff notifies the practitioner of the approval status of the testing request via telephone. The submitted "Request for Authorization of Psychological Testing" is retained as part of the member's clinical record.
5. Claims for testing services should be submitted with the names of all tests used and the total amount of time being billed for each service code.

APPENDIX 3

ICTS REFERRAL, DETERMINATION, and TRANSITION³

Summary Of State ICTS Rules and Contract Requirements⁴,

(Inclusive of Language developed cooperatively by ABHA and County Mental Health as appropriate)

LEVELS OF CARE DETERMINATION:

A determination must be made as to whether a child or adolescent is eligible and will benefit from ICTS. Once the eligibility has been established, decisions as to the services provided will be made based on the individual strengths and needs of the child and family as reflected in the Service Coordination Plan, developed by the Child and Family Team. The intensity, frequency, and blend of supports and services are based on the mental health needs of the child and their family. Children with the most acute mental health needs will be prioritized for the ICTS.

ICTS Referral and Determination:

The County Children's Mental Health screening, referral and assessment process shall be clearly communicated to family members, guardians, and community partners, and shall encourage mental health referrals from multiple sources. The process shall include:

1. Referrals from multiple sources to County Mental Health.
2. A face to face screening to assert that there is a mental health diagnosis.
3. Orientation of the child and family to the services and supports of the local systems of care.
4. Administering of the CASII If clinically indicated and there is evidence that the severity of issues would cause the client to score at level 4 – 6 on the CASII
5. A decision made with the family as to whether the child would benefit from ICTS if the client scores as a Level 4 – 6 on the CASII
6. A Referral for ICTS Services is completed. The Referral contains:
 - CASII Data Form
 - A mental health assessment completed within 60 days
 - Evidence that the client has a DSM IV Diagnosis covered by OHP
7. An ICTS determination will be made based on:
 - The clients score on the CASII;
 - A mental health diagnosis covered by OHP;

³ As noted below, for the purpose of meeting the requirements of the State Contract, the ABHA "Transition" requirements meet the criteria listed in the ICTS discharge.

⁴ Sources: MHO Agreement and OAR 309-032-1245, OAR 309-032-1260 and OAR 309-032-1285

- Additional prioritizing factors
8. ICTS determinations will be made within **3 working days** of completed ICTS referral. The family will be participants in the ICTS determination and will be provided information and support in making decisions regarding treatment and support options.

Prioritizing children for ICTS:

When an area Care Coordinator determines that a client meets criteria for ICTS and would benefit from services, they shall prioritize children with the most acute presentation based on the following:

- CASII score
- MH assessment within 60 days of eligibility finding
- DSM IV diagnosis covered by OHP
- Additional factors which may be considered for planning and prioritizing services include but are not limited to:
 1. Exceeding usual and customary services in outpatient settings
 2. Multiple agency involvement
 3. Multiple out-of-home placement
 4. Significant risk for out-of-home placement
 5. Frequent or imminent admission to acute inpatient psychiatric hospitalizations or other intensive treatment services
 6. Caregiver stress
 7. School disruption due to mental health symptoms elevating
 8. Significant risk of harm to self or others

Adding ICTS Services to Day Treatment or Psych Res services

Both Psychiatric Residential Treatment and Psychiatric Day Treatment provide services individualized to meet the needs of ABHA clients and their families. While the Oregon Administrative Rules are clear as to the staffing requirements for Intensive Treatment Services, modalities of treatment are not specified. ABHA and our partner counties recognize that there are expectations of services that should be provided as part of the “package” of services provided to our clients and their families while participating in these agencies. We are also aware, that in order to meet the intensive needs of our clients, there are times when additional services should be authorized. It is the intent of this section of the UM plan to be clear as to the expectations of services that should be provided as part of Psychiatric Residential and Psychiatric Day Treatment and what services can be authorized in addition to these “packaged” services.

1. Services provided by Psychiatric Residential Treatment Services:

- a. Psychiatric Assessment
 - b. Pharmacologic management
 - c. Milieu Therapy: daily goals, daily supervision, problem solving issues and situations and practicing skills
 - d. Case Management and attendance at Wraparound Meetings
 - e. Group therapy
 - f. Individual therapy
 - g. Family Therapy
 - h. Special education services
 - i. Discharge planning
2. Services provided by Psychiatric Day Treatment Services:
- a. Psychiatric Assessment
 - b. Milieu Therapy: daily goals, daily supervision, problem solving issues and situations and practicing skills
 - c. Case Management and attendance at Wraparound Meetings
 - d. Group therapy
 - e. Individual therapy:
 - f. Family Therapy – Can occur in the facility or in the home depending on the agencies clinical model
 - g. Special education services
 - h. Linkage to clients “home school” and transition services
3. Services that can be authorized in addition to Psychiatric Residential Treatment and Psychiatric Day Treatment:
- a. Screening to determine appropriateness of Day Treatment
 - b. Pharmacologic management (only for Day Treatment clients)
 - c. Skill building occurring in the home
 - d. Family therapy when occurring as an adjunct to family therapy traditionally provided

ADMISSION and TRANSITION:

Admission policy:

Children shall be admitted into the ICTS based on the criteria identified in the ICTS Referral and Determination process, (discussed in Section 8.0 of this document.) Prioritization will be given to children with the highest CASII scores, with DSM IV diagnosis covered by OHP and have additional factors significant to consideration, (discussed in Section 8.0 of this document).

Transition policy:

(For the purpose of meeting the requirements of the State Contract, the ABHA Transition requirements meet the criteria for ICTS Discharge listed in the ICTS OAR)

Each client must have the criteria to transition to a lower level of care documented in their Service Coordination Plan. The criteria will include written diagnostic, behavioral, and functional indicators the child and family will meet to transition out of ICTS services as documented in a child's Service Coordination Plan. (OAR 309-032-1240) The Care Coordinator, in partnership with the client, family and Child and Family Team will determine when the client is ready to transition and recommend a time line for transition.

Criteria for transition includes:

1. Client has met the goals of their Service Coordination Plan; and
2. Client, clients family/guardians and Child and family Team agree that client is ready to transition to a lower level of care; or
3. Client and/or guardian refuse further ICTS services;
4. Client is no longer eligible for ICTS services.

Transition summaries are to include: (OAR 309-032-1240)

1. Review of service coordination planning
2. Type and duration of services, supports and level of care utilized
3. Concerns that arose during the treatment and planning process
4. Significant child and family accomplishments
5. Recommendations about and planning to coordinate access to ongoing services and supports that would benefit the child and family as well as any other transition planning that will ensure continuity of care.

SYSTEM STRUCTURE AND FUNCTIONS:

ICTS Services:

ABHA shall provide cost efficient, comprehensive and individualized care to children and their families. Children who are determined to be eligible for ICTS will receive care coordination and access services within the Integrated Service Array, (ISA) as is deemed medically appropriate.

ABHA and our county partners shall ensure:

1. A Child and Family Team is identified and organized jointly with the family;
2. A Child and Family Team meeting is convened and an initial Service Coordination Plan, including any necessary crisis prevention and intervention planning, is developed no later than 14 calendar days from the date the provider receives an authorized request for ICTS services;
3. The Service Coordination Plan is completed within 30 calendar days from the date the provider receives an authorized request for ICTS services. The plan is reviewed and revised quarterly by the child and family team. It includes:

- A. A strengths and needs assessment that includes all relevant domains of the comprehensive mental health assessments
 - B. Short- and long-term goals related to identified needs across domains;
 - C. Planning that utilizes a combination of existing or modified formal services; newly created services; informal, formal and natural supports and community resources; and documentation of the individuals responsible for providing these services and supports;
 - D. A proactive safety/crisis plan that utilizes professional and natural supports to provide 24 hours, seven days per week flexible response and is reflective of strategies to avert potential crises without placement disruptions and provide appropriate interventions when crises occur;
 - E. ICTS discharge criteria as well as transition planning and coordination of the child's discharge from intensive community-based treatment and support services.
4. The child receives medically appropriate mental health services and supports that include evidence-based practices, at the appropriate level of care, as determined by the ongoing service coordination planning by the child and family team; and
 5. Services and supports are documented in the child's clinical record.

Community Care Coordination Committee, (policy recommendation):

Community Care Coordination Committees shall be developed and implemented on a community level to facilitate local planning and decision making. The Community Care Coordination Committee has a primary function of blending local cross system services and resources to meet the individual needs of children and their families. It provides:

- Service level consultation
- Identification of gaps in community services and supports
- A forum for problem solving to families, ICTS providers, child serving agencies, and child and family teams.
- Development and identification of funding for service/supports to fill gaps in service plans

The Community Care Coordination Committee shall have representation of the local system of care that includes:

- Consumer and family members,
- Child serving providers,
- Child and family advocates,
- Other local stakeholders representative of the system of care.

Children's Mental Health Advisory Council:

ABHA shall develop and implement a Children's Mental Health Advisory Council.

- The Council will advise ABHA and provide oversight of the local and regional policies for the ISA as well as ensure continuous quality improvement.

Appendix 4

Admission, Continued stay and Transition Requirements for Psychiatric Day Treatment

Admission Requirements:

1. Ambulatory resources available in the community do not meet the child's mental health treatment needs as determined by the established Child and Family/Wraparound Team. The team has identified a need best met in a day treatment setting and documentation is included regarding attempt/failure at a lower level of care.
2. Child has a problem in at least two of three following areas: school behaviors, home behaviors, and community behaviors. Behaviors might include: Temper tantrums, aggression, suspension from school, demands constant attention at home or school, unable to function adequately at home or school, withdrawal.
3. Child would benefit from the intensive focus of the program and from a multi disciplinary approach to treatment and education.
4. Day Treatment services can reasonably be expected to meet the child's needs so that the treatment will be successful. Success in this context means that the child can return to their home school (with outpatient mental health support as needed) in a transition plan designed by the Child and Family/Wraparound Team.
5. Client's referral packet includes:
 - Indication that client meets Level IV criteria via the CASII, (not yet necessary for children under 6 years).
 - Educational Records which may include: An Individualized Education Plan, Individualize Family Support Plan, 504 Plan, Personal Education Plan (PEP), and/or other assessment as required by the Department of Education.
 - A mental health assessment completed by a QMHP, which includes a completed five axis, DSM IV diagnosis covered by OHP.
6. Local County Mental Health's ICTS representative in partnership with the Community Care Coordination Committee pre-authorizes admission.
7. Client must be OHP eligible.

Continued Stay Criteria: *All of the following criteria are necessary for continuing Day Treatment:*

1. The child/adolescent's condition continues to meet admission criteria at this level of care.
2. The child/adolescent's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.

3. Child's behavior continues to be unmanageable at a lower level of care; i.e., child is often placed in a safe room, requires physical restraint, has outburst of destructive behavior and aggression, has had numerous holds, has temper tantrums, aggression, demands constant attention at home or school, unable to function adequately at home or school, is withdrawn etc. This behavior occurs either in the classroom, in the treatment environment, or in both settings.
4. The child/adolescent and family are actively participating in treatment.

Expectations of Treatment provided:

1. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning should include assessment of family or other support systems (social, educational/occupational and interpersonal) with involvement unless contraindicated. Expected positive outcome of all relevant treatment is documented.
2. There is documented active transition planning from the beginning of treatment.
3. There is a documented active attempt at coordination of care with relevant providers when appropriate.
4. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
5. Progress in relation to specific symptoms/impairments or adjustments in the treatment plan to address lack of progress are clearly evident and can be described in objective terms, even while goals of treatment have not yet been achieved.
6. Care is rendered in a clinically appropriate manner and focused on child/adolescent's behavioral and functional outcomes as described in the transition plan.
7. . When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.

Transition Criteria: *Any of the following criteria are sufficient for transition from Day Treatment:*

1. The child/adolescent's documented treatment plan goals and objectives have been substantially met and/or the individual no longer meets admission criteria, or meets criteria for a less or more intensive level of care.

2. Behavioral symptoms secondary to the psychiatric diagnosis have decreased to a level where there is no immediate risk of out-of-school placement.
3. The child/adolescent appears able to remain stable with a less intense level of services including routine outpatient care, physician-prescribed medications as needed, community-based support, and educational programming as needed.
4. The child/adolescent exhibits severe disruptive or dangerous behaviors (e.g., suicide/homicide attempt, drug/alcohol addiction, and symptoms of psychosis) that require stabilization at a more intensive level of care.
5. The child/adolescent, family, guardian, and/or custodian are competent but non-participatory in treatment or in following the program rules and regulations. Non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues.
6. Consent for treatment is withdrawn, and it is determined that the child/adolescent or parent/legal guardian has the capacity to make an informed decision and the child/adolescent does not meet criteria for a more intensive level of care.
7. The child/adolescent is not making progress toward treatment goals and there is no reasonable expectation of progress in continued Day Treatment.
8. Child demonstrates an ability to attend public school on a part time basis.

Appendix 5

Requirements for Admission to Psychiatric Residential Level of Care

1. Primary DSM Axis I mental health diagnosis above the funded line on the Oregon Health Plan Prioritized List of Health Services. This diagnosis must be the focus of the treatment requested.
2. Behaviors considered responsive to treatment in a residential setting:
 - Active psychosis
 - Risk of harm (homicidal or suicidal ideation) when insufficient mental health services and supports exist in the community
 - Need for active psychiatric treatment under the direction of a child psychiatrist 24 hours/7 days a week.
3. Primary diagnoses not paired with residential treatment on the Oregon Health Plan Prioritized List of Health Services and therefore not covered for treatment in a residential setting
 - Attention Deficit Hyperactivity Disorder
 - Adjustment Disorder
 - Substance abuse
 - Developmental disability
4. Behaviors not considered responsive to or best practice to treat in a psychiatric residential setting:
 - Primary behavior associated with diagnoses of Reactive Attachment Disorder, Oppositional Defiant Disorder or Conduct Disorder with symptoms not directly related to a psychotic disorder.
 - Primary behavior includes:
 - Bullying others
 - Physical aggression
 - Sexual offending behavior
 - Property destruction
 - Fire setting
 - Truancy
 - Running away
 - Pattern of defiant behavior
 - Indiscriminate sociability (excessive familiarity with strangers)
5. Level of Need Determination Screening process, including administration of the Child and Adolescent Service Intensity Instrument, results in a determination that psychiatric residential treatment is appropriate.

6. Documentation of attempts at lower levels of treatment and community intervention OR the child's mental health treatment needs cannot be adequately met in a less restrictive setting.
7. Child and Family Team agree on this intervention as being most appropriate and it is included in the service coordination plan.
8. Admission is not solely for placement or for the convenience of the family, the provider or other child-serving agencies.
9. Prior to admission there is an identified discharge plan, including a community plan
10. Psychiatric assessment has occurred within 60 days of potential placement date

Referral and Determination:

Determination of a client's need for a Psychiatric Residential level of care will be made through a recommendation by the Child and Family Team/Wraparound Team, Care Coordinator, and Care Coordination Committee. Referrals to Psych Res will include information described above, a signed Release of Information Form and a CONS form signed by the County Care Coordination Committee. ABHA UM will verify that documentation is complete and criteria is met. Authorization occurs following Certification of Need Process inclusive of signature by ABHA Psychiatrist.