

**Accountable Behavioral Health Alliance  
Utilization Management Plan**

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**1.0 Preamble**

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.

This Utilization Management Plan is the broader ABHA policy document that guides Utilization Management decisions and processes.

The Utilization Management Manual, a supporting document of this UM Plan, is a more detailed document that can be found on-line at, [http://www.abhabho.org/Utilization%20Management/ABHA\\_UM.htm](http://www.abhabho.org/Utilization%20Management/ABHA_UM.htm) and provides more information and instruction such as, utilization management processes, information needed to conduct Utilization Management, instruction regarding the OHP prioritized list, and contact information. The Manual is intended to be used by providers needing more information on how to conduct UM.

**2.0 Utilization Management Program Authority and Scope**

Activities of the Utilization Management (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 covered behavioral health services. Its scope is comprehensive and includes, but is not limited to, the following:

- Inpatient care, (Acute and Sub acute care)
- Respite care
- Intensive outpatient programs
- Outpatient treatment
- Alternative treatment settings
- Psychological testing

- Emergency care
- Psychiatric Residential Treatment
- Psychiatric Day Treatment

It is noted that the scope of benefits offered is subject to limitations and exclusions specified in the Oregon Health Plan of benefits. ABHA applies the same utilization management program to treatment delivered both in-network and out-of-network.

To fulfill its charge of ensuring necessity, appropriateness and efficiency of ABHA services, the Quality Assurance Committee is responsible for overseeing the UM Program including both the evaluation of patterns of care and monitoring outcomes of corrective actions.

### **3.0 Definitions**

- 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.

- 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 that 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.

- **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 HIPAA 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, most particularly, 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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 comply with HIPAA privacy standards, as well as all related standards developed by the State of Oregon and its regulating agencies.

- **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 Management**

**Wikipedia defines utilization management** as “the evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan. Typically it includes new activities or decisions based upon the analysis of a case. Utilization management describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or patient. Utilization management is forward looking and intends to manage health care cases efficiently and cost effectively before and during health care administration.

The term “utilization review” generally refers to the activities involved in determining level and intensity 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.

The terms “utilization management” and “utilization review” overlap considerably and in the managed care industry, they tend to be used interchangeably. So, for the purpose of the ABHA UM Plan, the term “utilization review” will be used only to describe a case level set of activities, not the overall program of to manage care in the context of limited resources.

#### **4.0 Primary Levels of Care**

- **In-patient 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 illness covered by the OHP prioritized list.

- **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 Respite or Psychiatric Residential 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.

- **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.

- **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.

- **Integrated Service Array (ISA)**

ISA means a range of service components that are coordinated, comprehensive, culturally competent and include intensive and individualized home and community-based service for children and adolescents with severe mental or emotional disorder whose needs have not been adequately addressed in traditional settings. The ISA integrates Psychiatric Residential and Psychiatric Day Treatment and community-based care provided in a way to ensure children and adolescents are served in the most natural environment possible and that the use of institutional care is minimized. The intensity, frequency and blend of these services are based on the behavioral health needs of the clients.

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

ICTS services is the definition given in the Oregon Administrative Rules for a specialized set of in-home and community-based supports and behavioral health treatment services available to children and adolescents within the Integrated Service Array, (ISA). These services are developed through recommendations of the Child and Family Team, (Wraparound Team) and delivered in the most normative, least restrictive setting. Family and community involvement and coordination are essential. Requirements for admission and approval for ICTS are provided later in this document.

- **Outpatient Care**

Outpatient care includes assessment and treatment that is provided within the community (non-facility) in the least restrictive and least invasive manner possible. Populations served include children, families, young adults in transition, adults, individuals with severe and persistent mental illness, and seniors. Services may include, but are not limited to, assessment, individual and family therapy, group therapy, skills training, Psychiatric assessments, medication management services, outreach services, preventative services, consultation services, wrap around services, and case management. These services may be provided by a Qualified Mental Health Professional, who may be a Psychologists, Clinical Social Worker, or Professional Counselor or a Qualified Mental Health Associate who is an individual with a bachelors degree and at least three years experience working with the population they serve. Services may be provided in a community Behavioral health setting or by independent practitioners.

## **5.0 Purpose and Principles**

The purpose of the UM Program for outpatient, ISA/ICTS, Psychiatric Residential, Psychiatric Day Treatment, Sub acute 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 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
- services are provided in the least restrictive setting and in the least invasive manner.
- services are cost effective

## **6.0 Procedures**

OHP Member with Special Health Care needs are assessed in order to identify any ongoing special conditions that require a course of behavioral health treatment or care management.

The Program utilizes explicit (written) criteria to evaluate the necessity, appropriateness, and efficiency of behavioral health services. 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.

Procedures for conducting first and second level reviews for behavioral 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
  - All denials of care are reviewed by peer professionals
- Preauthorization: ABHA or subcontractors will perform utilization review functions for those behavioral health services requiring prior authorization. Inpatient, sub-acute, Psychiatric Residential, respite, Psychiatric Day Treatment, ISA/ICTS and outpatient treatment require prior authorization from ABHA or County Behavioral health Programs.

### **Inpatient, (Acute and Sub acute Care)**

#### **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 behavioral 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 required to be admitted to an acute care facility in a true clinical emergency, ABHA does require preauthorization by the member's local County

Behavioral health Clinic crisis team, which can be contacted directly through the county or through the ABHA Crisis Line at 1-888-232-7192. If the Member resides or is in need of treatment while outside of the ABHA region Mental Health assessments may be completed by the most accessible crisis clinician.

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 or most accessible County Crisis Team. During business hours the ABHA Utilization Manager needs to be contacted by the county crisis clinician for preauthorization. After hours or on the weekend ABHA UM's are notified via secure email, voice mail or fax of an admit and follow-up the next business day. A face sheet and Psychiatric Assessment are required for all admissions within one business day. 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.

### **Inpatient Retrospective Review**

Retrospective reviews are only conducted when the members' clinical presentation did not allow for preauthorization or the Member needed care out of the area and the facility was not aware of the need for preauthorization. When one or more of these criteria are met ABHA conducts retrospective reviews of inpatient care to evaluate care which has already been delivered but not preauthorized. The purpose of this type of review is to determine if such services were medically necessary 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 8.0. A final determination is issued on all prepayment reviews within 30 days of receipt of all necessary clinical materials. (see ABHA Grievance and Appeal Policy for details).

### **Psychiatric Residential**

Determination of a clients need for a Psychiatric Residential level of care will be made through a recommendation by the Child and Family Team/Wraparound Team, and Care Coordinator. Referrals to Psych Res will include information as to Diagnosis and behavioral concerns, a mental health assessment that has been updated in the last 60 days, a copy of the most recent Plan of Care, and a CONS form signed by the Child and Family team. ABHA UM will verify that documentation is complete and criteria are met. Authorization occurs following Certification of Need Process inclusive of signature by ABHA Psychiatrist.

The ABHA Child and Family System of Care Manager:

- Reviews the clinical data reported by the Care Coordinator
- Verifies and substantiates that the client meets Admission Requirements as identified in the Medical Necessity Criteria listed later in this document.
- Participates in the Certification of Need, (CONS process), with ABHA Medical Director
- Authorizes Psychiatric Residential Services
- Works with County Behavioral health to determine that discharge planning begins from the date that the client is admitted and continues through clients therapeutic stay in Psychiatric Residential.
- Completes on-going Utilization Reviews while the client is Psychiatric Residential Care. Continued authorization is based on:
  - Continued risk of harm to self or others if returned to the community
  - Client continues to require active psychiatric treatment under the direction of a child psychiatrist 24hours/7 days a week
  - Client is benefitting from current level of treatment
  - Behavioral health needs cannot be met in less restrictive environment

### **Psychiatric Day Treatment**

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

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

### **ICTS Services**

- County Mental Health Care Coordinator meets with family to develop a relationship and begin identifying family strengths, needs and goals. Services recommended are documented in the clients Service Coordination Plan or Individualized Service and Support Plan, (ISSP). Authorizations by County Behavioral health occur based on these plans.

### **Transition/Discharge policy for ISA/ICTS:**

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 ISA services as documented in a child's Service Coordination Plan. 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/discharge 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;
3. Client and/or guardian refuse further ISA services;
4. Client has moved out of catchment area;
5. There is a lack of follow through or involvement in team process by the child's family/guardian;

Client is no longer eligible for ISA services

### **Outpatient Services**

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.

In order to be eligible for outpatient behavioral health benefits following an initial assessment, the member must be diagnosed by an eligible behavioral 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. 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. Services are required to be offered in the timeliest manner consistent with the presenting problem.

Counties are responsible for the ongoing review to determine medical necessity of continued services.

- It is expected that specific, measurable treatment goals will be developed as well as criteria for discharge.

### **Access to Outpatient and Crisis Intervention (emergent and urgent)**

Behavioral 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 behavioral health services that are medically appropriate, but not covered by the Oregon Health Plan.

### **Psychological Testing:**

Psychological and in specialized cases neuropsychological testing is authorized by ABHA only to the extent that it is necessary for the evaluation of the appropriateness of behavioral health treatment. Testing is authorized by County Behavioral health when it is found to be medically appropriate to the clinical issue being addressed. Testing is provided only by licensed psychologists or psychology interns who are supervised by a licensed psychologist.

1. The professional requesting psychological testing authorization submits the ABHA "Request for Authorization of Psychological Testing" to the County Behavioral 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 and authorizes time for testing according to the following factors:
  - a) Considerations defined in medical necessity criteria.
  - b) Time required to conduct the tests that are authorized- 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.

### **7.0 Medical Necessity Criteria**

#### **Acute INPATIENT**

1. Member presents as a significant danger to self as evidenced by person is at imminent risk to self or others or unable to meet their basic needs due to a major mental illness , 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 medical condition.

### **SUB-ACUTE**

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**
3. The member is at risk of committing aggressive or impulsive acts resulting from emotional distress related to a psychiatric condition; **OR**
4. 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.
5. Member needs Psychiatric medication adjustment that cannot be managed in the community including monitored administration of medication.

### **AND**

It is anticipated that the member will benefit from the level of care available in the Sub-Acute facility. The member has the potential of becoming an imminent risk to self or others as evidenced by recent or ongoing unpredictable dangerous behaviors.

### **Psychiatric Residential**

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

Continued stay criteria:

- Continued risk of harm to self or others if returned to the community
- Client continues to require active psychiatric treatment under the direction of a child psychiatrist 24hours/7 days a week
- Client is benefitting from current level of treatment
- Mental health needs cannot be met in less restrictive environment

**Psychiatric Day Treatment Referral, Determination and Transition:**

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 behavioral 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, or ECSII
  - 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 ISA 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.

**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.

### **ISA/ICTS Referral and Determination**

Referrals for a Level of Service Intensity Determination Screening are accepted from multiple sources including families or legal guardians, school personnel, allied agencies, community partners, or physical or behavioral health providers. Referrals may be initiated by telephone or in writing to that person designated by County Mental Health.

The process for referral shall include:

1. An Authorization to Release Information form signed by the parent or legal guardian.
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 and agreement by the family that they are interested and invested in having central involvement in the process.
4. Administering of the CASII, (Child and Adolescent Service Intensity Instrument), or ECSII, (Early Childhood Service Intensity Instrument - for children 5 and younger) will occur 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 or ECSII.
5. A decision made with the family as to whether the child would benefit from ISA/ICTS if the client scores as a Level 4 – 6 on the CASII or ECSII, (Exceptions can be made for clients who score less than a level 4 on the CASII or ECSII but have factors which indicate that the ICTS process will be helpful and County Behavioral health has sufficient capacity and resources available).
6. A Referral for ISA/ICTS Services is completed. The Referral contains:
  - CASII or ECSII Data Form
  - A mental health assessment completed within 60 days
  - Evidence that the client has a DSM IV Diagnosis covered by OHP
7. An ISA determination will be made based on:
  - The clients score on the CASII or ECSII;

- A mental health diagnosis covered by OHP
  - The family/guardians agreement to participate in the process
  - Additional prioritizing factors
8. ISA/ICTS determinations will be made with in **3 working days** of completed ISA referral. The family will be participants in the ISA/ICTS determination and will be provided information and support in making decisions regarding treatment and support options.
9. County Behavioral health shall prioritize children with the with the most serious mental health needs for ISA/ICTS taking into consideration prioritization factors including:
- exceeding usual and customary services in an outpatient Setting;
  - multiple agency involvement;
  - history of one or more out-of-home placements;
  - significant risk of out-of-home placement;
  - frequent or imminent admission to acute inpatient psychiatric hospitalizations or other intensive treatment services;
  - caregiver stress;
  - school disruption due to mental health symptomatology;
  - elevating or significant risk of harm to self or others; or
  - for children birth to 5:
    - history of abuse or neglect;
    - conditions interfering with parenting, such as poverty, substance abuse, mental health problems, and domestic violence, and
    - significant relationship disturbance between parent(s) and child.

## **Outpatient**

### Positive criteria:

The patient has a psychiatric disorder consistent with the diagnostic nomenclature of the DSM IV.<sup>1</sup>

#### **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**

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<sup>1</sup> V-codes are acceptable as long as the covered member has a numbered diagnosis in addition to a V-code diagnosis.

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.

Criteria which generally excludes client participation in outpatient services:

- 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.
- 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 case management 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.

### **Psychological testing:**

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.

### **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.

## **8.0 Appeals**

### **APPEALS:**

An appeal is an ABHA Member, member representative, or provider's request for review of a Notice of Action for any Service Authorization request in which the service has been terminated, suspended or reduced, or a request for service authorization or request for claim payment is denied. If the Appeal is not resolved in favor of the member, this includes notification of the member or member's representative of the right to request an Administrative Hearing by AMH to review of the Notice of Appeal Resolution.

1. ABHA members or duly appointed member's representative have the right to appeal a Notice of Action.
2. Appeals to ABHA must be made orally or in writing within a reasonable time frame that can be no later than 45 calendar days from the date the Notice of Action was mailed to the member or member's representative. Oral appeals must be followed

with a written appeal unless the member or member's representative requests an expedited appeal process. ABHA will provide the member or member's representative any reasonable assistance in completing forms and taking other procedural steps related to filing and resolution of an appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity.

3. ABHA will provide the member or member's representative an opportunity to present evidence for an appeal in person as well as in writing; ABHA will inform the member or member's representative of the limited time available for presentation of evidence for an expedited process. The member or member's representative will be given the opportunity before and during the appeals process to examine their own clinical records and other documents and records considered during the appeals process.
4. ABHA will ensure that staff responsible to review and render a decision for an appeal were not otherwise 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.
5. OHP members, member's representatives, or providers have the right to request a 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 member, that is, upholds the action, ABHA may recover from the member the cost of the services furnished to the member while the appeal was pending.
6. Continuation of benefits pending Administrative Hearing: If, at the member, member's representatives, or provider's request, ABHA continues or reinstates the member's benefits while the appeal is pending and the Notice of appeal Resolution is adverse to the member, the benefits must be continued pending Administrative Hearing pursuant to OAR 410-141-0260 through 410-141-0266.
7. If the member or member's representative asks for an Administrative Hearing made to AMH, the hearing request will be immediately transmitted to AMH's Hearing Unit. Upon notification by AMH after receipt of a hearing request, ABHA must review it through the appeal procedures if an appeal has not been previously conducted on the action.

#### **NOTICES:**

A Notice of Action is defined as any actual action or intention to take any action, including, denials or limiting prior authorizations of a requested covered service(s) in an amount, duration, or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service.

1. ABHA does not delegate the appeal procedure related to the termination, suspension, reduction, or denial of service. All such appeals go directly to ABHA; there is no County level appeal process.
2. ABHA and 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, reduced, or a request for service authorization will be denied without the member's consent within 10 days

- before effective date of action unless there is documentation that the member had previously agreed to the change as a part of the course of treatment, or;
- ABHA may mail the Notice no later than the day of the action in the following circumstances:
    - (i) ABHA receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;
    - (ii) The member has been admitted to an institution where he or she is ineligible for covered services;
    - (iii) The member's whereabouts are unknown and the post office returns the Notice directed to him or her indicating no forwarding address;
    - (iv) ABHA establishes the fact that another state, territory, or commonwealth has accepted the member for Medicaid services;
    - (v) There is a change in the level of medical care that is prescribed by the member's Provider;
    - (vi) The date of action will occur in less than 10 calendar days, in accordance with 42 CFR 483.12(a)(5), related to discharges or transfers and long-term care facilities;
    - (vii) There is factual information confirming the death of the member;
    - (viii) There is an adverse determination made with regard to the preadmission screening requirements for Nursing Facility admissions; or
    - (ix) The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the Nursing Facility for 30 days (applies only to adverse actions for Nursing Facility transfers).
    - (x) ABHA may shorten the period of advance notice to 5 calendar days before the date of the Action facts indicate that an action should be taken because of probable fraud on the part of the member. Whenever possible, these facts should be verified through secondary sources.
  - For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested, ABHA will provide Notice of Action as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service, with the following exceptions:
    - (i) ABHA may have a possible extension of up to 14 additional calendar days if the member, member's representative, or the provider requests the extension; or if ABHA justifies (to AMH upon request) a need for additional information and how the extension is in the member's interest;
    - (ii) If ABHA extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. ABHA will issue and carry out its prior authorization

determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

- 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 of Action shall include:
    - A statement of the action, the effective date of the action, and the reasons for the action
    - The member or member's representative right to file an appeal
    - The member or member's representative right to request an Administrative Hearing with DHS, information on how to request an Administrative Hearing, or an expedited appeal
    - The member or member's representative right to request continuation of benefits until a decision is made and 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 staff member responsible for assisting the member or member representative to file an appeal or provide additional information related to the Notice
    - 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 Partner 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 Partner agencies will reinstate services if any action to deny, terminate, suspend or reduce, services was made without providing the required notice, or if the notice is not provided in the timeframe outlined 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.
  6. If a member or provider requests, or ABHA determines, that following the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, ABHA will make an expedited service authorization decision and provide Notice as expeditiously as the member's behavioral health condition requires and no later than 3 working days after receipt of the request for service. ABHA may extend the 3 working days time period by up to 14 calendar days if the member requests an extension, or if ABHA justifies a need for additional information and how the extension is in the member's interest.

#### **RESOLUTION OF APPEALS:**

1. All appeals received by ABHA will be reviewed immediately upon receipt and will be resolved, if possible, within 16 calendar days of receipt. (OAR 410-141-0264). ABHA will provide a written notice of appeal resolution, including the outcome and the date of resolution, to the ABHA member or member's representative within the

specified timeframe. ABHA may extend this timeframe by up to 14 days if the member or member's representative requests and 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 behavioral health condition of the member is such that following the standard timeframes for appeal resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the member or member's representative can request an expedited appeal process. If an expedited appeal is requested and meets the above criteria, the ABHA Utilization Manager presents an immediate report to the ABHA Executive Director who will determine if the behavioral health condition at issue meets the criteria for an expedited appeal. For all expedited appeals, ABHA will provide the member or member's representative a Notice of Appeal Resolution 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 provided written notice within 2 calendar days.
4. An ABHA member or member representative may request that service affected by any notice of action 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's representative. If the Notice of Appeal Resolution rules against the member, the member can be held financially responsible for all service delivered after the date of the Notice of Action.

#### **DHS ADMINISTRATIVE HEARINGS:**

1. At any time, ABHA members or member's 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's representatives to request a hearing within 45 days of the date of the Notice of Action or Notice of Appeal Resolution. If the hearing issue involves a Notice of Action and the member or member's representative indicates the desire to have services continued while the hearing issue is resolved, the member or member's 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. The member or member's 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's 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's 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

### **Procedure**

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 of decisions based on the ABHA criteria and medical expertise of the reviewer. If the first-level review cannot determine medical necessity of a requested service, 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 second level review or 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 consultation will be offered by the ABHA UM to the treating provider MD.
  - If an authorization cannot be supported and an **Intended Notice of Action is to 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 intent to issue a Notice of Action, (if not already done by the ABHA Physician advisor or designee) will inform the provider when the NOA is to be issued, and inform the treating provider of the **expedited appeal process** on behalf of the OHP member.



- **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 be 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 behavioral 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 will provide written notice of the disposition that includes outcome and date of the Appeal resolution. If the decision is not in the member's favor, the notice must include member's right to request an Administrative Hearing and the process to request a hearing, the member's right to request continuation of services pending a hearing, the process to request continuation of services, and notification that the OHP Member may be held responsible for the cost of continued services if the hearing is in favor of ABHA.
- **There are no other levels of appeal within ABHA.** The member has the right to request an Administrative Hearing with the DHS and will be notified of such with the 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 Appeal Resolution to the treating provider.
- 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 provider 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.
  - ABHA shall ensure that no member of the Appeals Subcommittee 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 behavioral 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 requesting services. It is not required that an MD make all service request determinations. The order of “higher” to “lower” licensure 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 form 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 NOAs. 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.