

# ACCOUNTABLE BEHAVIORAL HEALTH ALLIANCE

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



# UTILIZATION MANAGEMENT MANUAL

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## **1.0 Principles and Objectives**

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 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.

## **2.0 Responsibilities 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.

## **3.0 Outpatient Utilization Management Philosophy**

Timely access to behavioral health services has been correlated with positive outcomes. 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.

Authorization of outpatient Behavioral Health services should be based on the Evidence Based Practice literature and the consideration of various models of psychotherapeutic change.

Regular review of a client's progress in treatment should be conducted to insure that continued service are medically necessary and that the client is receiving an array, intensity, and duration of care which is effective and appropriate.

The Utilization Management process reflects core tenets of managed care:

- 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.) UM decisions should consider time and cost as legitimate parameters of effectiveness.
- Specific goals for change should be based on the desired behavioral or observable intended outcome of services.
- The development of Individual Support and Service Plans (ISSP) must be based Evidence Based Practices and informed by consideration of ABHA's Practice Guidelines.

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

### 3.1 Outpatient Utilization Process

In order to be eligible for outpatient mental health benefits following an initial assessment, the member must be diagnosed by an eligible 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 (see appendix 2, OHP prioritized list); and must have a condition that meets ABHA's medical necessity criteria for outpatient services (see appendix 3). **The initial authorization should be for a specific amount of time and type of services, consistent with the individuals presenting problem, diagnosis, and best practices.**

In order to be eligible for chemical dependency treatment, the Member should meet admission criteria for treatment following the most current version of the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders*.

Following an initial assessment, which could be conducted by either a Panel Provider or the County Subcontractor, the County Utilization Manager determines if the need for services can be met internally or requires an authorization for outpatient services to a Panel Provider. To complete an authorization for services, the Utilization Manager 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

When authorizing services for a Panel Provider 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.

When a Members condition changes necessitating a modification of the intensity, frequency, or duration of treatment a new authorization for treatment or a modification of an existing authorization must be made. 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.

Providers will contact their County Utilization Manager immediately if the need for a new, extended, or modified outpatient authorization for services requires an 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.

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 client's progress in treatment and may request, at any time, copies of progress notes or other components of the provider's clinical record.

After-hour emergency services can be provided without authorization. Any follow up treatment that may be needed after the crisis needs to be preauthorized. Claims for payment of services not authorized may be denied.

### **Timeline for County Review of Request for Authorizations**

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

### **3.2 Initial Access to Chemical Dependency Services**

*ABHA counties manage Chemical Dependency services in Deschutes, Crook and Jefferson counties only.*

In Crook and Jefferson Counties, the Utilization Management Process for Chemical Dependency services is the same as the process for Mental Health services. Members access services directly through the local health department and the utilization manager authorizes treatment for medically appropriate services to be provided internally or through a Panel Provider.

In Benton and Lincoln counties, the local Physical Health Plan governs the Chemical Dependency process. Members may contact the County Health Department directly to access services. After an initial assessment, the provider obtains authorization from the physical health plan.

In Deschutes County, please see below for the utilization management process.

### **Chemical Dependency Process in Deschutes County**

- A. To request authorization the provider shall complete the “CDO Service Authorization Request Form”. Provider shall complete all required data fields including the date of first service, the level of care, and the types and frequency of Covered Services requested. Authorization requests not completed with the required data fields may be denied and returned to Provider. Authorization request must be received by Deschutes County Utilization Manager via fax (541) 322-7565 within 10 business days from date Contractor provided the first Covered Service to the ABHA member. Provider may call the Utilization Manager at 541-322-7500 to discuss issues of cause and assistance in determining DMAP member’s eligibility.
- B. To request reauthorization Provider shall complete the “CDO Service Authorization Request Form”. Reauthorization requests must be submitted by the Provider to the Deschutes County Utilization Manager via fax 541-322-7565 prior to, or by the date that reauthorization is due. When a Reauthorization request is due on a weekend or holiday the Reauthorization request must be received by the Deschutes County Utilization Manager, the next business day. The Deschutes County Utilization Manager will close open authorizations on the date the request for reauthorization is due unless Provider submits request for reauthorization.
- C. If Provider provides after-hour emergency services to the ABHA Member, which was not authorized by the Deschutes County Utilization Manager, the Provider shall call the Deschutes County Utilization Manager at 541-332-7500 on the following business day to request authorization.

### **4.0 Inpatient (Acute and Sub acute Care) Utilization Management Process**

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. During business hours the ABHA Utilization Manager needs to be contacted by the county crisis clinician for preauthorization. For adult Members whose county of origin is Benton or Lincoln County, Todd Noble should be contacted at 541-257-2216. For adult Members whose county of origin is Deschutes, Crook, or Jefferson, Randy Richmond should be contacted at 541-602-1663. For all children and adolescents, Karen Weiner should be contacted at 541-753-8291.

After hours or on the weekend ABHA UM’s are notified via voice mail of an admit and follow-up the next 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.

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 or most

accessible 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.

#### **4.1 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 behavioral health treatment for inpatient, sub-acute/respite admissions. Prospective review activities may be completed on site or telephonically.

#### **4.2 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 10.0. 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).

#### **4.3 Inpatient Continued Stay Review**

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.

#### **4.4 Inpatient Discharge Planning**

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.

#### **5.0 ISA/ICTS Utilization Management Process**

ABHA's Children and Family System of Care Manager provides the major support to local county mental health in the development of their system of care policies, practices, and provides utilization management for Members requiring Psychiatric residential, sub acute, and acute care.

ABHA County Mental Health programs are responsible for developing the integrated service array working with County partners and providing the ISA determination process, care coordination and necessary supports. Care Coordinators meet 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. ABHA has adopted Wraparound as the clinical guideline for providing care coordination and developing the Child and Family Team.

#### **5.1 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-Certification of Need form signed by the Child and Family team. ABHA Children and Family System of Care Manager 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

## **5.2 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.

## **5.3 Transition/Discharge procedure 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;
6. Client is no longer eligible for ISA services

## **6.0 Denials and Appeals**

When a Members request for services are denied, reduced, or discontinued and the Member is not in agreement with the reduction in services a Notice of Action must be sent to the Member, detailing the process to appeal the denial or reduction in services. Please see the attached ABHA Grievance policy for more details on how to issue a Notice of Action.

When a provider disagrees with an authorization denial the guidelines in the UM Plan are to be followed. Please see the attached UM Plan.