

## Utilization Management Procedures

Utilization Management is necessary to assess the need for treatment and to authorize or deny the appropriate treatment options for BHI Members. Utilization Management of Intensive Services determines the appropriateness of admissions, continued need for treatment and which treatment setting is most appropriate to meet clinical needs of the patient.

### Preauthorization

All services provided to BHI Medicaid enrolled Members require preauthorization by BHI or the Mental Health Centers (MHC's) in order for the Provider to be reimbursed for services rendered. *Failure to obtain preauthorization except in cases of hospital emergencies will jeopardize payment by Behavioral HealthCare, Inc.* It is the network provider's responsibility to ensure that preauthorization has been obtained, and the network provider cannot bill the Member for services that are not reimbursed (denied) by BHI because of failure to obtain prior authorization.

In the event of a hospital emergency, assessment of the Member must be arranged by network provider within twenty-four (24) hours of the emergency intervention. If the situation meets BHI's utilization review criteria for emergency services, then BHI will retroactively authorize such emergency services.

### Emergency Services

BHI expects network providers to provide a twenty-four (24) hour on-call service to patients. This can be a shared on-call emergency service.

Members in crisis are expected to call their therapist. A telephone response by the network provider, or clinician on-call, is expected within 15 minutes. If a Level of Care Assessment is needed, the clinician is expected to call BHI to make these arrangements.

BHI is responsible for the following:

- Providing twenty-four (24) hour crisis service for Medicaid Members
- Arranging for licensed clinicians to provide Level of Care Assessment twenty-four (24) hours per day, seven days per week.

## **Level of Care Assessment**

Any changes in a Member's level of care require preauthorization by BHI or the MHC's. Anytime a network provider believes a Member requires a different level of care, the network provider needs to contact BHI/MHC's utilization team.

In the event that a network provider is of the opinion that a Member needs to be psychiatrically hospitalized, the network provider must call BHI/MHC's Emergency Services Team with the clinical information, along with the Member's phone number and physical location. They will arrange for a Level of Care Assessment, and give feedback to the Member and network provider.

It is imperative that the network provider contact BHI/MHC regarding a Level of Care Assessment (and NOT have the Member call for a Level of Care Assessment), for the following reasons:

- The network provider can provide BHI/MHC with clinical background information to be utilized in the Level of Care Assessment.
- If the Member does not show for the Level of Care Assessment, then BHI/MHC would know to follow-up with the patient, network provider, police, and family.

Prior to contacting BHI/MHC for referring a Member for a Level of Care Assessment, it is expected that the network provider will have had contact with the patient, either in person or on the telephone, and has assessed the Member adequately enough to believe that the patient meets criteria for a higher level of care.

## **Continued Authorizations**

In the event that a Member's clinical needs exceed the initial authorization, the network provider can request authorization for additional treatment sessions. Authorization of additional sessions must be obtained prior to provision of such treatment; otherwise, reimbursement for treatment will be jeopardized.

- Network providers must submit a written treatment plan and call the appropriate MHC or BHI (720-490-4400) prior to the last session for review to determine medical necessity for more sessions.
- The utilization management review process will address relevant clinical issues.
- If further care is requested and determined to be clinically indicated subsequent authorization will be made.
- If the treatment plan does not meet clinical criteria, the utilization review will address the relevant issues with the provider and refer the case for review.

## **Provider Service Agreement Procedures**

It is important to note that your contractual arrangement with BHI is the Provider Services Agreement (PSA). The (PSA) indicates that covered services must be medically necessary, appropriate, and delivered in an appropriate, timely, and cost effective manner.

In terms of Utilization Management and Covered Services it is important to note the range of clinical diagnoses that are covered. For a list of covered diagnosis, please see Section XII.

One other important reminder regarding Utilization Management procedures has to do with prior authorization. Per the Provider Services Agreement (PSA) contract with BHI, it is the network provider's sole responsibility for obtaining preauthorization for services rendered not the Medicaid Member (or representative of the Member or BHI). Regarding concurrent review, the network provider has contractually agreed that if the number of treatment sessions provided to a Medicaid Member exceeds the number authorized under BHI's utilization management policies as Medically Necessary, BHI shall not be required to pay nor shall the network provider be entitled to bill, charge, collect a deposit from, or have any recourse against any Medicaid Member (or person acting on behalf of such Member) for Covered Services provided pursuant to the Provider Services Agreement.

## **Specialized Services**

All specialized services require preauthorization by BHI. These services require authorization separate from and in addition to any other authorization received from BHI. These services include, but are not limited to:

- Psychological Testing
- Neuropsychological Testing
- Electroconvulsive Therapy (ECT)

## **Utilization Management Procedures for Inpatient Admissions**

Pre-determined clinical criteria are used to evaluate each case in order to determine which treatment setting will best meet the clinical needs of the Member. The application of these criteria during the review of each case provides a consistent protocol to judge medical necessity. BHI Utilization Management Criteria follow this document.

Use of BHI contracted hospitals must be preauthorized by a designated BHI Emergency Services or Access Team Agent. Failure to obtain preauthorization may result in denial of reimbursement to the provider. The initial authorization is usually for a period of 72 hours.

Once admission occurs, BHI will continue to be involved with the case. This involvement may assume many forms, including but not limited to:

- Collaboration with the attending physician;
- Attendance at treatment planning meetings;
- Review of the patient's medical record;

Length of stay may be extended as a result of concurrent reviews if the Member's condition continues to meet medical necessity criteria. BHI utilization managers meet weekly with emergency services and clinical care coordinators for clinical updates.

Case management decisions and recommendations are based on principles of sound clinical practice with attention to quality of care. Because of this collaborative style, the need for conflict or adversarial decision-making is minimized, the focus thereby remaining on the care of the Member. The function of the Hospital Management Team and the CMHC hospital liaisons in these cases is to facilitate the smooth transition of patients to the least restrictive setting.

In the event the patient no longer meets medical necessity criteria for continued stay, further days will be denied and the provider may appeal the denial according to BHI's appeal procedures. Refer to Section VII.

### **General Medical Records Requirements**

The State of Colorado requires the completion of the Colorado Clinical Assessment Record (CCAR). Additionally, BHI has medical record requirements for Members receiving services at any level of intensity.

1. A CCAR Form must be completed at admission, discharge and once annually if the Member is in treatment for 12 months or longer. The CCAR must be submitted to BHI/MHC within five working days of completion. Failure to complete & submit this form will result in a denial of claims.
2. Notification of an Action must be given to Members who are not in agreement with a plan to reduce or discontinue a level of care. A copy of the letter should be retained in the Member's medical record. (See Sample Clinical Forms, Section X, for a sample Notice of Action Letter). The facility/provider must contact BHI Utilization Management immediately to initiate the clinical review process, if the Member, guardian or parent of a minor disagrees with the decision to reduce or discontinue level of care.

3. Inpatient Denial – Notice of Action Letter  
Colorado Mental Health Services requires that written notification be given to the Member, guardian, or parent of a minor when the Member, parent or guardian requests inpatient hospitalization that is deemed to be not medically necessary and refuses alternative treatment services offered by the clinician who has completed the mental health evaluation. (See Appendix E for the Division of Insurance regulation). All Members enrolled in managed health care programs have an opportunity to request an Independent External Review of an adverse service determination. Refer to Appendix A.
4. EPSDT (Early and Periodic, Screening, Diagnosis and Treatment) Colorado Mental Health Services requires coordination of EPSDT services between the Primary Care Physician (PCP) and the mental health provider. BHI providers are required to document the following: The PCP has been contacted to determine:
  - A. That the EPSDT has been completed;
  - B. That the provider has requested the completion of EPSDT by the PCP if the screening has not been completed;
  - C. That the Medicaid enrollment broker has been called if the Member has no PCP.
5. Missed Appointment  
Providers are expected to contact Members who unexpectedly miss an appointment within 24 hours of the missed appointment. The urgency of the contact is determined by the provider's assessment of risk potential related to the missed appointment. Actions are to be documented in the Member's medical record.
6. Medical Records and Treatment Plan
  - A. All state required documentation must be contained in the Member's medical record. Additionally, all Member medical records must contain a comprehensive psychosocial assessment, measurable treatment goals, signed progress notes and disposition/discharge plan. Medical and psychological treatment documentation and progress notes must be current, and treatment plans must be updated regularly.
  - B. The provider initiating treatment must document an initial treatment plan that describes the specific target problems or symptoms and strengths, as well as the diagnosis, planned interventions at the level of care proposed and discharge plan.
  - C. Records require indication if other clinicians are providing care, documentation of any communication, and an integrated treatment plan.
  - D. The treatment plan must be signed by the Member, parent or legal guardian.

- E. All elements of the medical record are listed on the audit tool. (See sample clinical forms, Section X.)

### **Authorization When Level of Care Changes**

- Authorization of care does not extend from one level of care to another. BHI/MHC utilization management staff must be notified when a Member is discharged from any level of care.
- Authorization for treatment at a new level will be based on the current treatment plan and continuity-of-care concerns.
- A new authorization will be required with any change in the level of care.
- Any unused portions of prior-to-admission outpatient authorizations are null and void once an inpatient/partial hospital/alternative level of care case is opened.

### **Psychiatric Evaluation in an Inpatient Medical Unit**

Psychiatric evaluations performed in an inpatient medical unit require preauthorization by a utilization reviewer. If evaluation is for transfer to Inpatient Psychiatric Unit, the BHI Access Team must be contacted to perform the evaluation.

### **Electroconvulsive Therapy**

All inpatient and outpatient ECT requires preauthorization. ECT is authorized telephonically with a utilization reviewer and routinely reviewed by the attending BHI Medical Director who may wish to review the case with the attending psychiatrist. Written information regarding current Member functioning and results of prior treatment approaches may be required.

### **Out-of-Area Care**

BHI is responsible for all mental health care provided for Adams, Douglas, and Arapahoe counties for Colorado Medicaid Mental Health Capitation and Managed Care Program Participants. This includes care that is provided outside of Colorado. All out-of-area and care provided outside of a service area but still in Colorado must meet the same criteria and follow the same policies and procedures as described in this handbook for in-area care. All out-of-area care, except emergency care, must be preauthorized. Out-of-area providers must obtain preauthorization from BHI.

## **Medical Care**

- BHI is responsible only for psychiatric authorization/management and reimbursement. Authorization for any medical care rendered in conjunction with DSM-IV conditions must be obtained through the Member's medical plan.
- If the Member's medical plan is rendered through a Health Maintenance Organization (HMO), you must consult the Member's Primary Care Physician before ordering/rendering any medical care/test.
- Every effort should be made to obtain the Member's consent to release pertinent information to the PCP and the PCP should then be informed, particularly of prescribed psychiatric medications.
- Pertinent medical information, particularly medication management, should be coordinated with the Member's PCP.
- Early & Periodic Screening, Diagnosis & Treatment (EPSDT) program must be coordinated with Member's (age 1-21) PCP by obtaining results of screens, referring Members who need screens to their PCP and considering results of the screens in service planning.