

# Behavioral Healthcare, Inc.

## Utilization Management

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### Principles of the BHI UM Program

BHI maintains a comprehensive Utilization Management Program which is guided by the following goals/principles:

- 1) All BHI consumers consistently receive the appropriate type and amount of all medically necessary covered services, the most effective and least restrictive possible in supporting recovery.
- 2) BHI's utilization management functions operate in a way so as to maximize the ability to provide flexible, individualized, timely treatment while working within all regulatory and contractual requirements.
- 3) Ongoing evaluation of resource utilization occurs throughout the BHI system through which areas of over and underutilization, barriers to appropriate service usage, gaps in the continuum of care, and other opportunities for improvement are identified and effectively addressed.

### UM Program Structure

THE BHI UM Department consists of the Director of Utilization Management, the UM Manager and the Authorization Coordinator. The Director of Utilization Management is supervised by the BHI Medical Director and the Chief Executive Officer. BHI's UM functions are conducted under the direction of the BHI Department of Utilization Management and include activities performed by BHI UM staff, the BHI Medical Director, and entities that perform delegated UM functions including Arapahoe Douglas Mental Health Network, Aurora Mental Health Center, Community Reach Center, and InNet, Inc.

The BHI Utilization Management Program involves collaboration with and delegation to InNet and BHI's three core mental health center providers (MHCs). BHI and its delegates conduct UM activities in compliance with all federal and state regulations and in accordance with all Medicaid Capitation contractual requirements. Compensation to these organizations, their employees and physicians related to UM activities is not structured so as to provide incentives for the denial, limitation, or discontinuation of medically necessary services to any enrollee.

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**Activities of the BHI Department of Utilization Management**

The primary activities of the BHI Dept of UM include:

- Establish and ensure compliance with UM related standards and policy for BHI system;
- Facilitate collaboration between all aspects of the BHI UM system;
- Identify and work to improve those systemic issues that adversely impact ideal resource utilization through the collection and meaningful analysis of quantitative and qualitative utilization data;
- Ongoing analysis and trending of utilization data by levels of care, including identification and monitoring of over and under-utilization as defined by the BHI Utilization Management Committee;
- Conduct delegation oversight for all delegated UM functions;
- Provide ongoing technical assistance to delegates regarding UM policies, procedures and regulations;
- Make authorization decisions, monitor benefit limits and provide all required notification regarding out-of-area Mental Health Center services, specialty provider services, psychological testing and retroactive inpatient hospitalization authorizations;
- Provide care coordination and benefits monitoring for those consumers in out-of-area mental health and specialty provider services;
- Participate in MHC hospital reviews;
- Participate in Interagency Difficult Case reviews as appropriate;
- Conduct annual UM Program Evaluation;
- Oversee the claims processing and review, ensure state required standards are met with regards to processing timelines, provider appeals, etc.;
- Issue Action Notices regarding discontinuation of inpatient hospital care;
- Coordinate appeals of Actions in collaboration with the BHI Office of Consumer and Family Affairs; Maintain and report data on actions and appeals to internal bodies and the state;
- Ensure consistency in authorization decision-making and application of UM and Medical Necessity Criteria throughout the BHI system;
- Coordinate second opinions and specialty consultations;
- In conjunction with the BHI Department of Quality improvement, report, analyze and trend key UM performance indicators through the quarterly report card.

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**Delegated Utilization Management Activities**

**InNet, Inc.**

BHI has delegated to InNet the management of inpatient hospital services for BHI consumers of all ages to ensure that Medicaid covered persons are appropriately assessed, placed, treated and discharged. This includes the reauthorization of inpatient services and communicating with inpatient providers regarding authorization decisions within appropriate timelines. Reauthorization decisions are made in conjunction with mental health center physicians and BHI who collaborate with hospital providers on treatment decisions through InNet hospital liaisons and inpatient Clinical Care Coordinators. InNet’s other UM activities include:

- Monitoring inpatient benefit limits; informing BHI and consumers when an individual has utilized 35 days of his/her 45 day limit;
- Ensuring care coordination for persons in inpatient care related to benefits limits. Participating in discharge planning for all enrollees regardless of whether benefit limits have been reached;
- Supplying necessary information to InNet IS Department to maintain daily hospital census;
- Notifying BHI when a consumer’s condition no longer requires an inpatient level care and assisting with required Action procedures and notifications.
- Notifying BHI of quality of care concerns including but not limited to the professional conduct and competence of inpatient health care providers that could adversely affect the health and welfare of BHI consumers.
- Review of all critical incident and seclusion and restraint reports of hospitalized BHI Medicaid consumers.

**Community Mental Health Centers**

BHI’s Mental Health Centers maintain individual UM programs that play a large role in the utilization management of a broad array of BHI services. In addition to responsibility for making authorization decisions as outlined in the table in the following section, the BHI MHCs perform the following functions related to UM:

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- Report utilization and access data for BHI analysis and required state reporting;
- Conduct weekly hospital review meetings that include participation by MHC staff, BHI and InNet;
- Monitor and ensure internal compliance with all BHI policy and federal and state regulations related to UM functions including: 1) consistent application of BHI utilization management and medical necessity criteria by MHC staff in all UM decisions made by the MHC 2) the appropriate documentation by MHC staff of medical necessity 3) making authorization decisions in accordance with Medicaid established UM decision timelines 4) ensuring authorizing individuals have necessary training and education;
- Monitor outpatient individual therapy benefit limits for those services that are authorized by the mental health center. Work with consumers and providers to ensure continuity of care for those individuals at risk of reaching their benefit limit;
- Participate in Appeal Review panels as requested by BHI;
- Provide Authorization and Action Notification related to authorization decisions made by the MHC to consumers and providers as required;
- Arrange for second opinions and specialty consultations;

**Authorization and Action Processes**

It is BHI’s goal to maintain authorization processes that minimize the steps a consumer and/or provider must take in order to receive authorization for services. This goal is rooted in the understanding that minimizing administrative barriers to accessing care supports consumer recovery. The entity/individual responsible for specific types of authorization decisions is outlined below. Authorizing individuals are responsible for documenting medical necessity and informing consumers and providers of authorization decisions as required. BHI and MHC UM staff are available no less than eight hours per working day and are accessible to providers and consumers to respond to all UM related questions. All individuals authorizing services are licensed in an appropriate mental health related field. Pre-authorization is required for all services through BHI with the exception of emergency and post stabilization services, and consumer-run alternative services, such as Drop-in Center, Clubhouse and Peer Specialist services.

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<b>Service Type</b>	<b>Initial auth-responsible party</b>	<b>Ongoing auth-responsible party</b>	<b>Retrospective authorization-responsible party</b>	<b>Action-responsible party</b>
Inpatient Hospitalization	MHC Emergency Services Staff	InNet Liaison in consultation with MHC/BHI staff	BHI UM Manager	BHI Medical Director
Out of Area Mental Health Center Services	BHI UM Manager	BHI UM Manager	BHI UM Manager	BHI Medical Director
Specialty Clinic Services	BHI UM Manager	BHI UM Manager	BHI UM Manager	BHI Medical Director
ECT	MHC or BHI Medical Director	MHC or BHI Medical Director	MHC or BHI Medical Director	MHC or BHI Medical Director
BHI MHC Services	MHC UM Staff	MHC UM Staff	MHC UM Staff	MHC Medical Director
Contracted Outpatient Services (non-specialty or out of area MHC)	MHC UM Staff	MHC UM Staff	MHC UM Staff	MHC Medical Director
Contracted Residential, Subacute, Day Treatment, Respite and Wrap-around	MHC UM Staff	MHC UM Staff	MHC UM Staff	MHC Medical Director

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<b>Service Type</b>	<b>Initial auth-responsible party</b>	<b>Ongoing auth-responsible party</b>	<b>Retrospective authorization-responsible party</b>	<b>Action-responsible party</b>
Services				
Specialty Consultation	BHI or MHC UM Staff	BHI or MHC UM Staff	BHI or MHC UM Staff	MHC or BHI Medical Director

Preauthorization procedures vary by service. Pre-authorization for any and all services may be initiated by contacting a member of the BHI Utilization Management Department or a Utilization Management staff person from the mental health center responsible for the geographic area where the enrollee's Medicaid originates. The individual contacted will then forward the request to the appropriate person as identified above (includes in bound calls). Authorization decisions take into account the following administrative and clinical factors:

- 1) Determination that the individual for whom services are requested is a BHI Medicaid enrollee for the relevant date(s) of service
- 2) Determination that the service request is covered under the Medicaid Capitation contract. In the case that the service request includes a non-covered new technology or a new application of existing technology, the service request is reviewed through BHI's clinical technology review process according to BHI policy.
- 3) Confirmation of benefit availability
- 4) Special regulatory circumstances such as EPSDT or SB 230
- 5) Determination of medical necessity as defined by BHI policy and Medicaid regulations. Medical necessity is determined through the evaluation of a number of factors, including:
  - a. Consumer and family/guardian identification of preferences and needs for recovery

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- b. Ongoing consultation with the provider throughout the episode of care to determine medical necessity according to changes in the consumer’s condition and treatment needs;
  - c. Consultation with the member, family and/or person with legal custody
  - d. Treatment history
  - e. Clinical Practice Guidelines as applicable.
  - f. Any identified unique or special needs of the consumer. This could include cultural considerations, communications needs, and special clinical circumstances that may necessitate a unique approach to treatment.
  - g. BHI Utilization Management Criteria-BHI Utilization Management Criteria serves as the basis for all clinical authorization decisions made by BHI and its contractors.
- 6) Presence of necessary supporting documentation. Authorization decisions are based on a thorough review of complete and current clinical documentation. If documentation is not complete UM staff will follow up with a verbal request for missing clinical information. For outpatient services this includes a CCAR, Initial Assessment, Individualized Service Plan and admission form, progress notes, specialty evaluations or consultations, or equivalent information. For inpatient services this includes a Census Tracking and Authorization form, inpatient psychiatric and medical evaluations, assessments, progress notes, specialty evaluations or consultations and other inpatient services;
- 7) Ability to credential and/or contract with requested provider, if not already included in BHI provider network. Single case agreements are offered to out-of –network providers upon verification of unrestricted professional license and absence of Medicare and Medicaid sanctions.
- 8) The Utilization Management Criteria are applied based on individual need and takes into account the local delivery system.

All services are authorized in sufficient amount, duration or scope to achieve identified treatment objectives. All authorization decisions are made in compliance with regulatory and contractual required timelines and documentation standards [see BHI Policies re: Notice of Action and Authorization Timelines]. Required services will not be arbitrarily denied or reduced in amount, duration or scope because of diagnosis, type of illness, or condition of the consumer. All

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authorization decisions are based solely on the appropriateness of the care for the member. BHI does not offer incentives of any kind for individuals or entities to deny limit or discontinue medically necessary services to any member.

**Services to consumers with co-occurring developmental disability and mental illness**

In collaboration with the other Colorado Behavioral Health Organizations (BHOs), BHI has developed practice standards that delineate the responsibility for the evaluation and treatment of Medicaid recipients with developmental disabilities and mental illness. BHI provides training on implementation and monitoring of services to this population. Adherence to criteria will be monitored through formal delegation oversight, beginning in FY 08.

BHI Utilization Management criteria and protocols do not supplant provider judgment in making decisions related to individual service needs. Any provider may request that BHI make an exception to restrictions or protocols in order to obtain medically necessary services for an enrollee by contacting the BHI Director of Utilization Management. All requests will be reviewed by the BHI Medical Director or designee. A determination will be issued as expeditiously as is required by the enrollee’s medical condition, not to exceed 10 working days. BHI will arrange for specialty consultation as needed in making the determination.

**Utilization Program Monitoring and Evaluation**

The BHI Utilization Management program conducts ongoing evaluation and oversight activities that help monitor the appropriateness and effectiveness of the UM Program, ensure consistency of UM decision making, and identify and address areas for improvement including over and underutilization and barriers to accessing services.

These activities include:

**1) Delegation Oversight-**

The BHI Director of Utilization Management is a member of the BHI Delegation Oversight Committee and monitors all UM functions delegated to external entities through a formal annual delegation oversight process. If the event that a delegate is not in full compliance with a UM delegation requirement, a Corrective Action Plan is submitted by the delegate. Once

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approved and enacted, further monitoring by the delegation committee of the plan is conducted. In the event that a delegate is unable to appropriately perform delegated UM functions, these functions are withdrawn from the delegate. BHI Utilization Management staff provides ongoing technical assistance and training as needed related to UM functions to delegates.

**2) Ensuring Consistency in Authorization Decision-Making**

BHI and its delegates ensure consistency of authorization decision making through a number of mechanisms, including but not limited to:

- Periodic auditing of authorizations to determine compliance with documentation requirements, appropriate application of Utilization Management and medical necessity criteria and standards of practice, when applicable;
- Dissemination of and training on BHI Utilization Management and Medical Necessity Criteria;
- Inter-reviewer reliability auditing to ensure consistency in authorization processes. These audits may focus on any type of authorization decision and may be implemented as a consistent aspect of an entities UM program or as a tool to further evaluate a potential problem;
- Participation in hospital review meetings. Conducted weekly at each mental health center, these meetings include participation by mental health center prescribers, mental health Center Emergency Services personnel, other relevant mental health center staff, InNet Hospital Liaisons, and BHI Utilization Management Staff. Participation in these meetings by BHI UM personnel allows for a monitoring of compliance with medical necessity criteria and comparison of decision-making processes related to inpatient care across the BHI system. Additionally, details regarding individual consumers are discussed, allowing a case by case identification of access issues, barriers to discharge from higher levels of care, identification of provider specific UM issues, and potential gaps in the BHI service continuum.

**3) Data Reporting, Trending and Analysis**

BHI Utilization Management data sources include:

- InCare Authorization and Claims system. This system provides current and retrospective data regarding inpatient and external outpatient services. The system provides standardized or custom utilization reports on inpatient admissions including lengths of stay, diagnosis, provider, assigned mental

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health center, program, age, discharge to, admission from, and inpatient benefit remaining. InCare also provides information on volume and claims paid and denied for all external services including emergency department visits, residential, and outpatient providers.

- InNET data warehouse. The data warehouse compiles both InCare external as well as mental health center internal service utilization data and related studies. A full array of variables can be queried to provide BHI with information on utilization including age, gender, ethnicity, diagnosis, outpatient program, outpatient service, provider, mental health center assignment, or geographic location.
- BHI grievance database
- BHI Action and Appeal Database.
- Inpatient and Individual Outpatient Benefit Limit Reports

The primary vehicle for aggregate data reporting and analysis is the BHI UM Report Card. The UM Report Card reports and trends key indicators of over and underutilization including:

- Penetration rates by age, ethnicity, and mental health center;
- Inpatient recidivism at 7 and 30 days;
- Inpatient length of stay by age group and mental health center; and
- Inpatient admits /1000 enrollees and inpatient days/1000 by age group and mental health center.
- Emergency department utilization and cost data by emergency facility, consumer age group and mental health center.

Any identified areas of over or underutilization or other UM related trends or recommendations resulting from Report Card review are explored through the BHI R&R and Provider Advisory Council where recommendations for further study or corrective action are made.

**4) Utilization Program Evaluation**

The BHI Quality Improvement Committee evaluates the UM program on a formal basis through the review of annual written reports regarding service utilization and access data, analysis of grievances, delegation oversight review outcomes, Action and Appeal data including denials overturned on appeal, over and under utilization data, claims data and any other pertinent information related to the Utilization Management Program. The Utilization Program Evaluation serves as a guide to the activities and improvement efforts of the Utilization Management

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Program for the following year. Ongoing improvement activities are monitored and evaluated by the Utilization Management Committee.