SAN MATEO COUNTY HEALTH SYSTEM
BEHAVIORAL HEALTH & RECOVERY SERVICES

DATE: June 25, 2018

BHRS POLICY:	18-03
SUBJECT:	Utilization Management Program
AUTHORITY:	Mental Health Parity and Addiction Equity Act of 2008; Final Medicaid/ CHIP Parity Rule; Delegation Agreements with the Health Plan of San Mateo; The State Department of Health Care Services, Medical Necessity Criteria for Specialty Mental Health Services, California Code of Regulations Title 9. Division 1—Department of Mental Health 1830.205
SUPERSEDES:	New Policy
ATTACHMENTS:	A: UM Decision Workflow for Call Center B: Affirmative Statement about Incentives

Related BHRS Policies at: http://smchealth.org/bhrs-documents

BHRS Policy 92-09: Adult and Older Adult Eligibility Criteria
BHRS Policy 96-12: Medical Necessity – Adults Receiving System of Care Services – Procedure for Reassessment
BHRS Policy 04-09: Authorization Standards – Managed Care
BHRS Policy 05-03: Child/Youth Eligibility Criteria

SCOPE:

The BHRS Utilization Management Program (UMP) applies to all Health Plan of San Mateo (HPSM) covered services in the Mild-to-Moderate Managed Care/Private Provider Network overseen and implemented by the BHRS Access Call Center. Providers receive an overview of the UMP in the "Managed Care Provider Orientation" packet which details all requirements and includes all required forms located at the public web site: http://www.smchealth.org/bhrs/contracts

PURPOSE:

The UMP monitors and ensures that service request decisions are based on clinical criteria and rationale; decision-making staff are licensed and in good standing; and that decisions are made consistently and communicated to the beneficiary and the provider within mandated timelines. The

UMP evaluates the quality and effectiveness of services provided, and verifies that clients' needs are triaged and result in referrals to the appropriate level of care (LOC). The UMP verifies that care is offered using evidence-based practices and applicable industry standards, and that audits performed have high levels of interrater reliability

POLICY:

THE UTILIZATION MANAGEMENT PROGRAM COMPONENTS:

A. Description of utilization management process for making determinations

B. Timeliness and notice of organizational determinations

C. Ensuring quality of utilization management program

D. Parity of services

A. DESCRIPTION OF THE UTILIZATION MANAGEMENT PROCESS FOR MAKING DETERMINATIONS

1) The UM Committee (UMC) reports to the BHRS Executive Committee. UMC members include: BHRS Medical Director, Deputy Medical Director, Compliance Officer, the Quality Management (QM) Manager, Call Center Manager, Call Center Psychologist, and other members as assigned.

2) The Medical Director is responsible to develop, implement, and oversee the UMP. The Medical Director is the liaison between the program and BHRS staff and regularly informs the BHRS Director of program results. The BHRS Medical Director and/or the Deputy Medical Director help develop UMP related policies and procedures. They or their designee provide professional opinions for denials and actions that require physician review.

3) The UMC assists with the development, implementation, and operation of the program, as needed.

   The UMC oversees and monitors the effectiveness of the UMP's decisional supports, guidelines, and rationale; and, when needed, recommends changes and improvements to decision-making processes. The UMC monitors data reporting for trend analysis and to detect over- and under-utilization of services. The UMC is responsible for the review and analysis of any technology or other methods used in the UMP.

   The UMP activities are described in the Annual UM Work Plan by the UMC, which reviews and adopts the work plan on an annual basis. The BHRS Executive Committee and Quality Improvement Committee (QIC) advise the UMC on goals and policies and receive updates on the activities of the UMC annually. The UMC meets no less than quarterly, provides a public copy of the agenda prior to the meeting, and ensures that accurate minutes and attendance are recorded, which are available upon request.

4) Annual Evaluation: The UMP is reviewed at least annually and recommendations for improvements are promptly implemented. The Medical Director or Deputy Medical Director and the Compliance Officer schedule the evaluation and present the completed report to the UMC. The UMC oversees the implementation of updates/improvements, and if needed, a plan of correction, which may be incorporated into the Annual UM Work Plan.

Criteria for Decision Making:

1) UM Criteria: For service requests, BHRS uses criteria required by the California Department of Health Care Services (DHCS) Medical Necessity Criteria for Mental Health Services, the Department of Managed Health Care, the Center for Medicare & Medicaid Services (CMS) National Coverage Determinations and Local Coverage Determinations (Medicare), American Society of Addictive Medicine (ASAM), and the Milliman Care Guidelines (MCG). Additional criteria come from BHRS policies listed on Page 1 and the ACCESS Call Center Desktop Procedures. Criteria are reviewed annually and updated when necessary.

2) Availability of Criteria: Criteria within statutes are available online at the DHCS, Medical Necessity Criteria for Specialty Mental Health Services (Full citation in Authority Page 1). The MCG are available electronically to decision-makers. The MCG is an Internet-based software and decision-making staff may obtain an access login if needed. Users may need training on the use of the MCG software program. In addition, beneficiaries/clients and providers may request a copy of the guidelines and criteria used in the decision-making process. Criteria required by statute shall be provided in their entirety. The MCG Service Request Summary documentation contains the care guidelines used in decisions and will be provided upon request. The request to access the criteria and guidelines shall be in writing.

3) Consistency in Applying Criteria: BHRS uses information from the DHCS and The Department of Managed Health Care. The QM Manager, Medical Director or designee, Call Center Manager and the Compliance Officer oversee and monitor interrater reliability.

   BHRS shall establish policies and procedures for interrater reliability audits, to be performed no less than annually. These audits evaluate the consistency with which clinicians in the UMP apply decision-making criteria and guidelines in decisions and implement improvements. Audit results are included in the Annual Evaluation Report to the UMC. Any noted deficiencies shall be addressed through a plan of correction that is monitored by the UMC and overseen by the Compliance Officer.

4) Qualifications of Staff Applying Criteria: Licensed clinical staff, supervised by licensed supervisors/managers, make UM decisions using clinical documentation and information. Decisions in the UMP are overseen by the Medical Director. ACCESS Call Center decisions are reviewed by a licensed clinical psychologist, licensed Unit Chief, and licensed program specialist. Individual and network-wide practice interventions and trainings help to ensure that BHRS providers provide high quality care using relevant information to make decisions, as indicated

below.

5) Affirmative Statement about Incentives: All BHRS staff who make organization determinations, including staff in the UMP, are required to sign a statement stating that no incentives were used to make UM decisions. The affirmative statement they must sign is Attachment B to this policy.

Clinical Information/Consults with Treating Providers to Make Determinations:

1) Relevant Information for Decisions: Service requests are based on clinical information and must be adequate to determine diagnosis, functional impairment, and the viability of proposed interventions. This information is usually provided as an assessment and treatment plan. If more information is needed, the provider shall be given the opportunity to provide additional documentation. If needed, the clinician making the UM decision may contact the provider to seek additional information or provide guidance in an effort to improve the quality of the work.

2) Warm Handoffs to Other Level of Care: BHRS takes referrals from Primary Care Physicians; an assessment by the PCP is not required. All beneficiaries are entitled to receive an assessment through the Managed Care network without prior authorization. If the beneficiary contacts the ACCESS Call Center, they will be referred to a network provider for an assessment and treatment plan. Both documents must be submitted to the ACCESS call Center before a UM decision is made.

3) Beneficiaries with significant mental health impairments and an uncertain diagnosis are referred for a further assessment by the Mental Health Plan (MHP) to determine if they qualify for Specialty Mental Health services. Those beneficiaries not meeting the criteria established for MHP services yet found to have a qualifying mental health diagnosis, are authorized to a network provider for Managed Care Plan (MCP) services. All beneficiaries and/or providers on a beneficiary's behalf who contact BHRS for services will either receive an authorization for the requested services, an offer for modified services with an explanation, or a denial with the reason for the denial. This is further explained in the section below entitled, "Denial Notices."

B. TIMELINESS AND NOTICE OF ORGANIZATIONAL DETERMINATIONS:

1) Standard (Routine) Pre-Service Determinations: For non-urgent pre-service decisions, BHRS makes decisions within 14 calendar days of receipt of the request.

2) Expedited (Urgent) Pre-Service Determinations: For expedited (urgent) pre-service decisions, BHRS makes decisions within 72 hours of receipt of the request.

3) Concurrent Review: For expedited (urgent) concurrent review, BHRS makes decisions within 24 hours of receipt of request.

4) Post-Service Determinations: For post-service determinations, BHRS makes decisions within 30 calendar days of the receipt of the request.

5) Extensions of Time for Organizational Determinations: Timeliness deadlines may only be extended in those instances in which insufficient information has been submitted with the service request, which staff will strive to work with the party requesting service to achieve sufficient information necessary to make a service determination, and if not, upon provision of both oral and written notice, may extend the time needed to make the determination consistent with regulatory and policy requirements. Extensions can also be requested by the party that made the service request.

    a. Standard or Routine Pre-Service Determinations: The deadlines may be extended up to an additional 14 calendar days.

    b. Expedited or Urgent Pre-Service Determinations: The deadlines may be extended up to an additional 14 calendar days from the date of the service request only to the extent that such an extension does not endanger the health of the beneficiary.

Notice of Organizational Determinations

1) Standard Pre-Service Determinations: For non-urgent pre-service decisions, BHRS provides written notification of decisions within 15 calendar days of receipt of the request.

2) Expedited Pre-Service Determinations: For urgent (expedited) pre-service decisions, BHRS provides verbal and written notification of decisions within 72 hours of receipt of the request.

3) Concurrent Review: For urgent (expedited) concurrent review, BHRS provides verbal and written notification of decisions within 24 hours of receipt of request.

4) Post-Service Determinations: For post-service determinations, BHRS provides written notification within 30 calendar days of the receipt of the request.

Denial Notices

1) Reason for Denial: BHRS shall provide the beneficiary and provider a written notice of denial (including partial denial) that contains the following information: 1) the specific reasons for the denial in easy to understand language; 2) a reference to the benefit provision, guideline, protocol, or other criterion for the denial; and 3) a statement that members can obtain a copy of the benefit provision, guideline, protocol, or other criterion for the denial, upon request.

2) Discuss Denial with Reviewer: BHRS gives providers the opportunity to discuss UM denial decisions with the Medical Director or Deputy Medical Director or other appropriate reviewer.

3) Denial Log: BHRS maintains a log of denials that documents the name of the beneficiary, the date of the request, request description, who made the request, whether it was standard or expedited, the date of the decision, the denial reason, the date of the verbal notification (if required), the date of the written notification, the name of the clinician processing the request, the name of the doctor reviewing the denial, and the date the doctor reviewed the denial. This

log shall be provided to HPSM on a semi-annual basis or upon request.

4) Notice of Appeals and Rights Process: Written notification of denials provided to beneficiaries and providers shall contain the following:

    a. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.

    b. An explanation of the appeal process, including the right to member representation and appeal time frames.

    c. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.

    d. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.

C. ENSURING QUALITY OF UTILIZATION MANAGEMENT PROGRAM

Interrater Reliability Audit Methods:

BHRS shall assure interrater reliability of clinical decisions made during the access to services intake processes in all locations where such decisions are made. The specifications will be in accordance with the National Committee for Quality Assurance and audits will be carried out by the Call Center Manager, Medical Director, QM Manager, and Compliance Officer.

a. Interrater reliability audits consist of case review and testing that assess the judgment of decision making based on criteria previously identified in The Criteria for Decision Making section.

b. The assessment will identify training needs, and assess compliance with regulations, consistency in the application of clinical rationale and guidelines, completeness of documentation and notifications, and adherence to mandated timelines.

c. Assessment of decision making by staff shall consist of two approaches:

    i. Peer Review: A minimum of ten cases per staff member being evaluated shall be selected for review no less than annually by a panel of peers assembled to conduct the reviews. These cases will be reviewed for the appropriateness of referrals, authorizations, retrospective reviews and concurrent reviews.

    ii. Testing: Interrater reliability tests occur at least annually for clinical staff that

make service request decisions. The reviews will include the analysis of case studies, including cases with only one appropriate clinical determination. Failure to reach the proper determination will result in remedial training.

d. Staff review test results that do not meet acceptable standards established by the UMC shall be referred for training. Training consists of scenarios with only one appropriate clinical decision and the staff person is taught how to reach this type of determination. Training shall be ongoing with relevant trainings at least quarterly, until the staff can successfully pass subsequent reviews and testing.

2) Audit Schedule: Annually the Compliance Officer, with the agreement of the UMC, shall establish a schedule for the Interrater Reliability Audit. This is in the UM Work Plan with the results included in the Annual Evaluation Report.

UM Under- and Over- Reporting

1) Monitoring: BHRS shall provide for the monitoring of over- and under- utilization activities of providers in the private provider network. Monitoring shall occur at decision making levels, financial levels, and administrative analysis levels.

a. Decision Making Level: Utilization review of services occurs as part of the review following the issuance of an authorization of services either at a previously selected review date or when additional authorizations are requested. Actual services provided and/or the number of services authorized are compared against care guideline recommended service levels and the statistical table of national averages to determine if the level of services provided or requested is consistent with those used by other providers treating similar conditions across the country.

b. Financial Level: Through the auditing of service claiming by fiscal staff and the utilization of monitoring software, billing anomalies are identified, investigated, and addressed.

c. Administrative Analysis Level: BHRS conducts ongoing and regular data analysis activities, which include the collection and analysis of utilization data that identifies high service utilizers and high cost activities. Beneficiaries are identified on a program basis and then individual data is collected and analyzed.

2) Reporting: BHRS will create reports that assess and detect potential over- and under-utilization of services and any barriers to access in the authorization or intake processes on a monthly and quarterly basis. The specific categories included in these reports shall be established in consultation with HPSM. An example is the “Industry Collaborative Effort” (ICE) UM Report, which includes actionable steps to be pursued upon review of the data.

Retrospective Review

1) BHRS shall provide for retrospective review of clinical information used in the determination of medical necessity and in the payment of claims using National Committee on Quality Assurance guidelines and audit tools.

2) BHRS QM staff members perform chart audits on an ongoing basis; all programs, including contracted services, are audited at least annually as described in BHRS Policy 17-02: Delegation Oversight & Audit Program.

3) Retrospective review of clinical information used in the determination of medical necessity at the Call Center is done by the Call Center Psychologist on an ongoing basis.

4) Retrospective review of clinical information used in the determination of pharmacy benefits is conducted by the Pharmacy Manager.

5) Review of guidelines used in the payment of claims shall be conducted by the Deputy Medical Director on an ongoing basis.

Utilization Management Work Plan

The UMC creates an annual UM Work Plan with goals and objectives based on clinical decision-making data, audit results, and audit activities with actionable steps. The plan includes findings and appropriate responses from the Annual Evaluation Report. The plan is modified based on regulatory and program changes, national trends, and emerging or best practices. The draft UM Work Plan is reviewed by the UMC prior to implementation. The results of the UM Work Plan shall be incorporated into the Annual Evaluation Report.

D. PARITY OF SERVICES

1) Access to Assessment without Prior Authorization: All beneficiaries are entitled to an assessment and referrals for services do not require the prior completion of an assessment. A beneficiary can seek an assessment from any network provider without authorization. BHRS will provide payment to network providers upon submission of the assessment and treatment plan documentation. Out of network providers will receive payment only when no in-network provider is available to provide the assessment.

2) Medical Necessity Not Met, Mental Health Condition Present: Beneficiaries are referred for MHP covered services when a significant mental health condition and medical necessity are present. When medical necessity does not meet criteria for severe mental illness but a less severe mental health condition is present, beneficiaries are authorized to MCP covered services in the provider network.

3) Parity Review by Categories of Service: Periodically, BHRS and HPSM shall review categories of service where prospective, concurrent, and/or retrospective review

activities are used for the application of clinical guidelines, clinical rationale, and interrater reliability for both medical/surgical and behavioral health services to assure that access to either is no more restrictive than the other.

The categories of service shall include inpatient, outpatient – office, outpatient – other, emergency care, SNF/Residential Treatment, and pharmacy.

Approved: *Signature on File*
Robert Cabaj, MD
BHRS Medical Director

Approved: *Signature on File*
David A. Young, PhD MPH
BHRS Director

Next Review Date by Compliance Officer Due July, 2019