

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

DATE: August 28, 2019

BHRS POLICY: 19-02

SUBJECT: Standard Pre-Service Organizational Determinations

AUTHORITY: Federal Medicaid Managed Care Regulations, Title 42, CFR Part 438; MHP Agreement with State of California; Delegation Agreements with the Health Plan of San Mateo

SUPERSEDES: New Policy

PURPOSE:

This policy explains procedures for issuing timely initial and continuing standard organizational benefit determinations for services that a client is entitled to receive. It also explains what happens when these are not completed on time and other related information.

SCOPE:

This policy complies with all applicable federal and state statutory, regulatory, and contract requirements and applies to Medicare, Medi-Cal, H-Line (Healthy Kids, Health Worx) and Access to Care for Everyone (ACE) pre-service authorization requests for all Health Plan of San Mateo (HPSM) covered services in the Mild-to-Moderate/Private Provider Network. This policy covers standard pre-service and continuing authorization requests. Standard means that the decision is made within 14 calendar days of the request.

Please see Policy 19-03: Expedited Pre-Service Organizational Determinations for the rules regarding expedited pre-service authorization requests.

DEFINITION OF ORGANIZATIONAL DETERMINATION:

An organizational determination is an evaluation and decision made in response to a request for BHRS services. This includes payment for urgently needed services and for services provided by non-contracted providers that are covered under Medicare or Medi-Cal.

RESPONSIBILITY AND AUTHORITY:

- The Medical Director or her or his designee is responsible for the overall Utilization Management Program.
- The ACCESS Call Center Clinical Services Manager manages the daily pre-service authorization

process.

- Clinical staff are responsible for reviewing pre-service authorization requests.
- Administrative assistants are responsible for the receipt, and entry of pre-service authorization requests into AVATAR.
- The Medical Director or her or his designee is responsible for all denials and modifications of pre-service requests based on medical necessity.

PARTIES TO AN ORGANIZATIONAL DETERMINATION:

A member, a member's provider, or a member's authorized representative may request an organizational determination for an initial or continuing pre-service authorization. A request will not be considered until all the appropriate documentation is provided.

- Provider Submitted Requests

Provider submitted requests for organizational determinations are submitted on Authorization Request Forms. This form is completed by providers to request services that require prior authorization by BHRS. The Authorization Request Form may serve as an initial assessment and plan for treatment.

Non-Contract providers must request authorization prior to providing any services using the Authorization Request Form.

Providers submit the form to BHRS via mail, Fax, or portal.

Prior authorization is not required for members who request an initial assessment and/or emergency inpatient services.

- Member Submitted Requests

Member requests for initial or continued pre-service authorization may be submitted verbally or in writing to BHRS.

After receiving a member's request for an initial or continuing pre-service authorization, ACCESS staff will request documentation from the member's provider to support the request.

Member authorized representatives may submit the requests in the same way as the member.

TIMELINES FOR STANDARD INITIAL AND CONTINUING PRE-SERVICE AUTHORIZATIONS:

BHRS will make an initial or continuing pre-service organizational determination on a standard authorization request as expeditiously as the member's health requires, but no later than fourteen (14) calendar days from receipt of the request.

BHRS may extend the time frame for up to fourteen (14) additional calendar days if:

- The member requests the extension; or
- BHRS can justify a need for additional information that would result in a decision in the clients favor. (for example, the receipt of additional medical/clinical information, or updated diagnosis from a provider). In this case, documentation showing how the extension is in the best interest of the member is needed.

If BHRS extends the time frame for making the initial or continuing pre-service organizational determination, it will provide the member and the provider with a written notice that includes:

- Reason for the extension, and
- Information about the member's right to file an expedited appeal if the member disagrees with BHRS's decision to extend the time frame.

If the extension is allowed, BHRS must provide a written notice of its organizational determination within twenty-eight (28) calendar days from receipt of the request for authorization.

If BHRS fails to provide the member with timely notice of an adverse organizational determination, the failure is considered an adverse benefits determination that may be appealed in accordance with Care Advantage or Medi-Cal appeals procedures, whichever is appropriate based on the client's coverage.

Processing Requests

All requests for organizational determinations are entered into AVATAR, capturing date and time of request. The informing documents used in the decision are scanned into the client's episode.

ACCESS Clinical Staff:

1. Reviews referral information. (Materials must be complete and clearly show the requester has coverage for BHRS services.)
2. Makes a medical necessity determination based on documentation available, approved criteria, and adopted care guidelines.
3. Determines appropriate authorization of services.

If additional information is needed to make an organizational determination, the clinician will request it.

If the clinician finds that the documentation does not meet medical necessity criteria the request is forwarded to the ACCESS Call Center Psychologist, who reviews the decision and prepares it for review by the Medical Director, or his or her designee, to make a final decision on whether to approve, modify or deny the request.

Requests that are Denied:

Standard Procedure: All denials will be prepared by the Psychologist and submitted for review by the Medical Director or her or his designee. The Call Center Psychologist is responsible to assure that all necessary documentation is available for review, that the review occurs timely, and that the results of the review are carried out. The Call Center Program Specialist or other designee shall carry out this responsibility in the absence of the Psychologist.

Requests that are denied can be appealed by the member or their designated representative, or by the provider acting on member's behalf. The right to appeal applies to all pre-service organizational determinations, but organizational determinations can also occur post-service, such as when payment is made on a claim submitted for reimbursement of a previously authorized service. Examples of post-service determinations that would be appealable include:

- (a) If not covered under Medicare and/or Medi-Cal, should have been furnished, arranged for, or reimbursed by BHRS.
- (b) BHRS declines to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by BHRS.
- (c) Reduction, or early discontinuation, of a previously authorized ongoing course of treatment.
- (d) Failure of BHRS to approve, furnish, arrange for, or provide payment for behavioral health care services in a timely manner; or failure to provide the member with a timely notice of an adverse benefits determination, such that a delay would adversely affect the health of the member.

MEMBER AND PROVIDER NOTIFICATION:

Members are notified in writing of BHRS's initial determination to modify, deny, or approve a pre-service request.

Notice of a decision to modify or deny a request for initial or continuing pre-service authorization must include the following information with approved Medicare and/or Medi-Cal language:

- The specific reason for the denial that considers the member's presenting medical condition, disabilities, and special language requirements, if any;
- Information regarding the member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the member's behalf;
- For initial and continuing pre-service authorization denials, a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;
- For post-service authorization denials, a description of the standard reconsideration process and time frames, and the rest of the appeals process; and
- The member's right to submit additional evidence in writing or in person.

Providers receive a written copy of each member notice via fax; if no fax is available, a copy is mailed to their address.

REVIEW OF DECISIONS:

The Utilization Management Program Policy (18-03) explains in detail how organizational determinations are reviewed regularly for consistency and appropriateness of care. Please see that policy for more detail.

To monitor for potential inappropriate utilization patterns, the Call Center Manager or designee will review:

- Quarterly utilization and quality reports, which review patterns and trends in outpatient service utilization;
- Prior authorizations for initiation and completion of treatment and services;

The Call Center Manager will present follow-up reports on utilization and trends to the Utilization Management Committee.

The Call Center Psychologist will review all or a sample of standard authorizations, all expedited authorizations, and all denials for quality purposes on a regular basis. The Psychologist will also conduct peer review and interrater reliability monitoring and testing of clinicians who are involved in completing authorizations on an annual basis.

Any quality concerns about the work of ACCESS Call Center Staff or submitting providers are noted and referred to the ACCESS Call Center Program Specialist, who's responsible for Quality and Provider Relations.

The Call Center Program Specialist will:

- address individual quality concerns with staff and providers as necessary;
- track overall trends in quality at the Call Center;
- develop measures, including policies and training, to address any concerns or trends;
- present overall trends and quality concerns to the Call Center Manager;
- provide programming and training at scheduled staff and provider meetings;
- record the date and type of training conducted and keep a roster of attendees.

APPROVED: _____ *Signature on File* _____
Scott Gruendl, MPA
BHRS Assistant Director/Compliance Officer

APPROVED: _____ *Signature on File* _____
Scott Gilman, MSA
BHRS Director

Next Review Date: July, 2020