



APS Healthcare

2011 Behavioral Health

Utilization Management

Program Description

I. PURPOSE

The APS Healthcare Behavioral Health Utilization Management (UM) program provides a systematic method to manage the utilization of services provided to enrollees by providers in the APS Network. Management of services is achieved through the ongoing monitoring and evaluation of medical necessity criteria and evaluation of the appropriateness of the level of care. The program is implemented in conjunction with the Quality Improvement program to identify and promote optimal clinical practices in all settings. This program description describes the scope, goals, structure and operations of the Behavioral Health UM program.

II. SCOPE

The Behavioral Health UM program consists of activities that promote the appropriate allocation of behavioral health resources for UM clients managed by staff in the APS Maryland office. Processes used within the context of UM include: prospective, concurrent, and retrospective review; non-certification and appeals; discharge planning and other care management activities. All levels of care are generally included in the UM of authorized behavioral health and substance abuse services to include: inpatient, partial hospitalization, intensive outpatient, residential treatment, and outpatient services. Along with monitoring the appropriate level and allocation of care, APS assesses Ambulatory Follow-Up (AFU) rates. Ambulatory Follow-Up activities serve to ensure that patients are provided with a timely outpatient appointment after they are discharged from the hospital. Ambulatory Follow-Up Coordinators provide support to members following discharge to ensure appointment compliance within seven days following discharge and assist with rescheduling of appointments on an as needed basis. Pharmaceutical management is not a service delegated to APS Healthcare when providing UM services.

APS maintains compliance with recognized UM accreditation standards through the Utilization Review Accreditation Commission (URAC). APS Healthcare also complies with State and Federal regulations and guidelines and may include the Department of Labor ERISA regulations.

III. PROGRAM GOALS

- A. To provide access to high quality, medically necessary behavioral health services in the most appropriate setting.
- B. To ensure effective and efficient utilization of health care services and benefits through appropriate allocation of resources and services.
- C. To document and evaluate patterns of resource utilization including under- utilization and over-utilization of services.
- D. To provide the Quality Improvement Department with data and support that identifies areas for improvement of UM services, establishes priorities, and supports implementation of recognized best practices for optimum outcomes.
- E. To ensure health care services are coordinated based on medical necessity criteria (MNC) as well as to ensure services are timely and effective.
- F. To facilitate and coordinate health care services for enrollees.
- G. To ensure patients with both psychiatric and medical illnesses receive appropriate treatment that integrates body-mind therapeutic concepts.

IV. PROGRAM STRUCTURE

APS Healthcare's Behavioral Health UM operations and UM specific policies guide all work processes and decisions.

A. Description and Responsibilities of Program Staff

The Behavioral Health UM and Customer Service Department staff carry out their responsibilities as defined by the scope of practice of their individual professional discipline(s) and assigned job description. The following delineates the oversight structure of the UM Program.

1. Sr. Vice President Operations, North Region

The Sr. Vice President must have completed a masters and/or doctoral degree in a related behavioral health field with seven (7) years experience in related services. The Sr. Vice President is responsible for oversight of all behavioral health management functions. The Sr. Vice President reports to the National Operations Executive.

2. Executive Director/Medical Director, Behavioral Health

- a. The Executive Director must have, at a minimum, a bachelor's degree in a related behavioral health field and seven (7) years management experience. A master's degree or a doctorate with clinical licensure is preferred. The Executive Director serves as the APS chief administrative officer for behavioral health UM services. The Executive Director is responsible for oversight of all behavioral health UM functions. The Executive Director reports to the Senior Vice President.
- b. The Medical Director is an actively licensed, Board Certified psychiatrist responsible for the supervision and oversight of clinical care as well as the ongoing clinical training and education of the behavioral health clinical staff. The Medical Director also provides oversight for non-certifications and appeals review, Physician Advisor (PA) availability, medical necessity criteria and quality program outcomes. The Medical Director can review and render determinations involving non-certification of benefits based on failure to meet the APS Medical Necessity criteria and/or other appropriate clinical criteria applicable to the clinical needs of the enrollee. The Medical Director chairs all Utilization Management Committee (UMC) meetings. The Medical Director also guides, leads, and assesses the overall clinical knowledge of the UM staff. The Medical Director will ensure that the clinical staff receives regular didactic training and practical clinical consultation. Finally, the Medical Director also serves as a liaison to the medical community on all issues designed to improve the quality of services provided to enrollees by APS providers.

3. Corporate Chief Medical Officer

The Corporate Chief Medical Officer is responsible for the oversight and implementation of the Quality Improvement program for APS Healthcare. The Corporate Medical Officer reports to the President and Chief Operating Officer of APS Healthcare.

4. Behavioral Health Clinical Director

The Behavioral Health Clinical Director is a licensed masters or doctoral level clinician who has at least 5 years of management experience and a minimum of 8 years of experience in behavioral health. The Clinical Director provides leadership and management of the clinical program activities by participating in ongoing program development, policy application, and maintenance of critical relationships with clients and contracted providers. The Clinical Director manages department clinical activities including fiscal, staffing, coaching and planning. The Clinical Director approves requests for clinical services that are consistent with the APS Medical Necessity criteria and/or other appropriate clinical criteria applicable to the clinical needs of the enrollee. The Director may only non-certify administrative related requests for service based upon benefit and/or contractual limitations/specifications. All clinical non-certifications must be based on a determination by a licensed, board certified psychiatrist (or clinical psychologist for psychological testing reviews). The Clinical Director also assists in implementation and coordination of quality improvement activities and initiatives. The Behavioral Health Clinical Director reports to the Executive Director, Behavioral Health.

5. Behavioral Health Clinical Manager

The Behavioral Health Clinical Manager is a licensed masters or doctoral level clinician who has more than 5 years of experience in behavioral health and is responsible for directly supervising the clinical care managers who perform the Behavioral Health UM tasks. The Clinical Manager is also responsible for developing and maintaining policies and procedures for his/her assigned areas. The Clinical Manager approves requests for clinical services that are consistent with the APS Medical Necessity criteria and/or other appropriate clinical criteria applicable to the clinical needs of the enrollee. The Clinical Manager may only non-certify administrative related requests for service based upon benefit and/or contractual limitations/specifications. All clinical non-certifications must be based on a determination by a licensed, board certified psychiatrist (or clinical psychologist for psychological testing reviews). The Clinical Manager also assists in implementation and coordination of quality improvement activities and initiatives. The Behavioral Health Clinical Manager reports to the Behavioral Health Clinical Director.

6. Behavioral Health Care Managers

Behavioral Health Care Managers are masters or doctoral level clinicians, and/or psychiatric registered nurses with active licenses. These clinical staff members conduct the UM review activities. Behavioral Health Care Managers monitor and coordinate care with participating practitioners, enrollees, and provider organizations utilizing APS Medical Necessity Criteria or other appropriate clinical criteria. Behavioral Health Care Managers may only non-certify administrative related requests for service based upon benefit and/or contractual limitations/specifications. All clinical non-certifications must be based on a determination by a licensed, board certified psychiatrist (or clinical psychologist for psychological testing reviews). There are 10 Behavioral Health Care Managers for APS' daytime clinical operations and two Behavioral Health Care Managers for the after hours service. The Behavioral Health Care Managers report to the Behavioral Health Clinical Manager and the Behavioral Health Clinical Director.

7. Ambulatory Follow-Up Coordinators

Ambulatory Follow-Up Coordinators reach out to enrollees post discharge from an inpatient admission and assist in coordination of aftercare appointments. These Coordinators also assist with appointment setting for enrollees who are not stepping down from a higher level of care but still require assistance in securing an outpatient appointment. An Ambulatory Follow-Up Coordinator must have, at a minimum, a high school diploma or GED, but a Bachelor's Degree in a Mental Health related field is preferred. This position also requires a minimum of three, but preferably five, years of customer service experience in a position that requires ownership of resolution of customer service issues. The Ambulatory Follow-Up Coordinators report to the Clinical Manager.

7. Customer Service Manager

The Customer Service Manager is responsible for oversight of the day to day operations of inbound and outbound calls for the behavioral health call center. The Manager also acts as a liaison between the Call Center staff and internal departments for resolution of credentialing, contracting, member eligibility and claims payment issues. Lastly, the Manager ensures policies and procedures are in place to meet all goals and performance guarantees. The Manager must have a minimum of 3-5 years of Call Center experience with a Bachelor's Degree or 5 years experience without a degree. The Customer Service Manager reports to the Executive Director.

8. Client Services Supervisor

The Client Services Supervisor supervises the call center activities including resolution of difficult issues, HR activities and handling of daily operations. The Supervisor also provides call support when needed and serves as a resource for more complex customer inquiries and escalated calls. The Supervisor must have a minimum of five years customer service experience in a call center with healthcare experience. The Client Services Supervisor reports to the Customer Service Manager.

9. Behavioral Health Member Referral Coordinators

Behavioral Health Member Referral Coordinators (MRCs) are non-clinical, administrative staff that act in a limited capacity within the Behavioral Health UM Program. These staff members quote benefits, assist with referrals and provide initial authorizations for routine outpatient care based on factors such as eligibility information, network status of the provider, number of units previously authorized, and plan benefits. These authorizations do not require clinical qualifications and are administratively prescribed. The MRCs report to the Customer Service Manager.

10. Psychiatric Physician Advisors (PAs)

APS utilizes physician advisors who are board certified, actively licensed psychiatrists to Perform initial clinical reviews and appeals in accordance with APS policies and procedures. With the exception of psychological testing requests (which may utilize the services of a clinical psychologist reviewer), APS physician advisors review and render determinations involving non-certification of benefits based on failure to meet the APS Medical Necessity criteria and/or other appropriate clinical criteria applicable to the clinical needs of the enrollee. APS physician advisors also provide clinical determinations for expedited and standard appeals. The physician advisors may provide case consultation to both care managers and treating clinicians. In addition, APS physician advisors monitor and notify care managers of any quality of care and/or patient safety issues. The activities and responsibilities of the physician advisor may also be performed by the APS Medical Director.

11. Behavioral Health Quality Improvement Manager

The Behavioral Health Quality Improvement Manager oversees the day to day operations of the Quality Improvement Department as well as the Appeals and Complaints Department. The Quality Improvement Manager manages the development, implementation and ongoing monitoring of the local QI program and activities for the service center. The Manager ensures the local Quality Improvement program operates in accordance with corporate policies, accreditation standards and QI processes. The Quality Improvement Manager also ensures compliance with all performance guarantees related to Appeals and Complaints administration and monitors compliance with URAC/ERISA/DOL and contract regulations specific to non-certifications and/or appeals of health care determinations. The Behavioral Health Quality Improvement Manager reports to the Executive Director.

12. Behavioral Health Quality Improvement Supervisor

The Behavioral Health Quality Improvement Supervisor supervises day-to-day operations of the Quality Improvement Department as well as the Appeals and Complaints Department. The Quality Improvement Supervisor must have a minimum of a bachelor's degree and 4-6 years of healthcare quality improvement or utilization management experience. The Quality Improvement Supervisor ensures the local program and procedures support company goals for service, quality and cost effectiveness as well as compliance with contract, federal and state requirements. The Quality Improvement Supervisor also supervises the daily operations of the Appeals and Complaints staff. The Behavioral Health Quality Improvement Supervisor reports to the Behavioral Health Quality Improvement Manager.

13. Appeals Staff

APS manages clinical and administrative appeals in the APS Maryland office. Appeals coordinators are responsible for organizing documents and information submitted by enrollees and providers who request an appeal of the initial non-certification decision. Appeal coordinators research the facts associated with the non-certification and, when necessary, request additional information in order to provide complete information to the appropriate reviewer or committee. Once a decision has been rendered, the appeals coordinators prepare and send a determination letter with the name and professional experience of the individual making the decision and the rationale for the decision. The Appeals Staff report directly to the Quality Improvement Supervisor.

B. Committee Structure

1. Corporate Quality Improvement Committee (CQIC)

Reports to: APS Healthcare Board of Directors

Meeting Frequency: At least quarterly

Membership:

- Corporate Chief Medical Officer (Chair)
- VP Quality Improvement
- Corporate Directors, Quality Improvement
- Regional Managers, Quality Improvement
- Field Staff – URAC accredited locations
 - Medical Directors
 - Quality Improvement Staff
 - Operations Staff
 - Clinical Operations Staff

Roles and Function of Committee:

- Annually review, revise and approve the Behavioral Health Utilization Management Program Description, Work Plan, and Evaluation.
- Annually review and approve the APS Medical Necessity and Level of Care Determination Criteria and other clinical criteria.
- Provide oversight of and support for Behavioral Health UM quality improvement activities.
- Monitor allocation of resources needed to achieve quality improvement goals.

2. Managed Behavioral Health Quality Improvement Committee (MBHQIC)

Reports to: Corporate Quality Improvement Committee

Meeting Frequency: At least quarterly

Membership:

- Medical Director/Executive Director, Behavioral Health (Chair)
- Manager, Behavioral Health Quality Improvement
- Director, Facets Operations
- Director, Provider Operations
- Director, Clinical
- Manager, Customer Service
- Manager, Claims
- Supervisor, Behavioral Health Quality Improvement

Roles and Functions of Committee:

- Annually review, revise and approve the MBH UM Program Description, Work Plan and Program Evaluation.
- Provide input and make recommendations regarding the behavioral health UM policies and procedures.
- Identify opportunities to improve behavioral health UM processes, and support or direct the implementation of quality improvement activities.
- Regularly review and monitor data related to key UM indicators such as over and under-utilization and accessibility and availability of services.
- Annually review and approve inter-rater reliability measurements for all levels of behavioral health care reviewers (care managers and physician advisors).
- Reviews and monitors the two active QIPs

3. Utilization Management Committee (UMC)

Reports to: MBHQIC

Meeting Frequency: At least quarterly

Membership:

- Executive Director/Medical Director, Behavioral Health
- Director, Clinical
- Manager, Behavioral Health Quality Improvement
- Supervisor, Behavioral Health Quality Improvement

The Utilization Management Committee is a multidisciplinary team of behavioral health specialists and has primary responsibility for providing oversight of APS UM functions and services. The committee identifies goals and objectives for the UM program and develops an annual UM program description, work plan and program evaluation.

The UM committee members review the prior year's work plan to determine what goals and objectives were met and which should be evaluated for continuation in the UM plan under development. UM committee members identify program areas in concert with URAC and accreditation organizations. The UM work plan is written by an interdisciplinary team led by the Medical Director and is reviewed and refined in regularly scheduled UM committee meetings. Once complete, the UM work plan is presented to UMC, then sent to QIC and ultimately reviewed and approved by the CQIC.

Roles and Functions of Committee:

- Develop, review and approve the UM Program Description, UM Work Plan and Annual UM Program Evaluation.
- Provide input and recommendations regarding UM policies and procedures.
- Identify opportunities to improve behavioral health UM processes and support implementation of quality improvement activities.
- Regularly review and monitor data related to key UM indicators.
- Annually review and approve inter-rater reliability measurements for all levels of behavioral health care reviewers (care managers and physician advisors).
- Provide input and create opportunities to integrate new developments that address the needs of individuals suffering from both a medical and psychiatric illness and/or other psychiatric disorders.

4. Provider Advisory Group

The Provider Advisory Group (PAG) provides for structured input from external clinical providers who assist in the development and implementation of the APS Behavioral Health Quality Improvement program and activities. The APS PAG members are drawn from a variety of APS' networks where APS has behavioral health business. Providers participate via teleconference.

Meeting Frequency: At least annually

Membership: Providers with medical and behavioral health specialties from the following disciplines:

- Executive Director/Medical Director, Behavioral Health
- Providers: Psychiatrist
- Providers: Psychologist
- Providers: Masters level

Roles and Functions of Committee:

- Support the development of appropriate Clinical Practice Guidelines.
- Review best practice literature related to the use of new technology and make recommendations on how best to integrate its use in the UM Process.
- Review APS policies and procedures and make recommendations incorporating provider community suggestions.
- Review and recommend for adoption/approval the APS Medical Necessity and Level of Care Determination Criteria.
- Assist in development of provider education and communication materials, processes and tools.
- Serve as consultants to APS representing provider views and concerns.

V. BEHAVIORAL HEALTH UM CRITERIA

A. Organizational Method for Development, Review, Update and Modification of Criteria

The Medical Director, Behavioral Health, under the direction of the Corporate Chief Medical Officer, is responsible for the development, selection, approval, and update of behavioral health medical necessity review criteria. Draft criteria are reviewed by the Provider Advisory Group (PAG) and forwarded to the CQIC for final approval and implementation. Clinical criteria are reviewed at least annually and modified as needed. Criteria currently in use for prospective and concurrent reviews are the 2010 APS Medical Necessity and Level of Care Determination Criteria and the ASAM Patient Placement Criteria, 2nd Edition, Revised. For retrospective reviews, the criteria used are those that were in effect at the time of service. At times, this may be a prior version rather than the current clinical criteria mentioned above.

The current approved APS Medical Necessity and Level of Care Determination Criteria is made available to participating providers through the APS Healthcare website. Providers are notified about the availability and revision of behavioral health clinical criteria through direct mailings, provider newsletters and the website.

B. Review of Consistency of Behavioral Health UM Decision Making

Inter-rater reliability testing is administered semi-annually for care managers and physician advisors. Results of the testing are used to identify areas of variation among decision makers or types of decisions. The results of the testing also help to identify opportunities for improvement as well as future training needs.

Clinical documentation audits of care manager records are also done on a monthly basis by the clinical managers. APS has set a benchmark standard of four documentation audits per month for care managers who have been employed at APS for less than three months and two audits per month for existing care managers. APS has a benchmark standard of scoring at least 90% on each documentation audit. Any care manager with a documentation audit score less than 90% will have four documentation audits the following month. These audits assist the clinical managers in identifying training needs and to ensure consistency in documentation quality.

VI. UM METHODS AND PROCESSES

A. Organizational Process for Making Determinations of Medical Necessity and Benefits Coverage for Inpatient and Outpatient Services

The purpose of the UM review is to determine enrollee eligibility, benefit coverage, and/or establish the presence or absence of medical necessity so that a decision can be made regarding the request for services. Services may include requests for all levels of behavioral health care and requests for services from enrollees and behavioral health providers. The UM process provides a clear and timely response to enrollees and providers regarding requests for authorization of services.

Behavioral Health Member Referral Coordinators and/or Care Managers may authorize initial outpatient behavioral health care without clinical review, consistent with current policies and procedures. Pre-certification is deemed necessary for all elective and non-emergent admissions and procedures rendered by a hospital providing behavioral health services when consistent with health plan benefit requirements and current policies and procedures. Behavioral health care rendered by providers not participating in APS networks may also require pre-approval depending on health plan benefit requirements. Pre-certification, however, is not required for Emergency Department services including initial assessments and/or stabilization of emergency behavioral health conditions.

Pre-certification requests are initiated either telephonically, by fax or by other electronic means as appropriate. Participating providers, as consistent with health plan benefit requirements, are responsible for contacting APS to request in-network prospective review authorization.

After a request for pre-certification is received for residential, inpatient, partial hospitalization or intensive outpatient services, the clinical information is gathered by a behavioral health care manager. The care manager may seek the assistance of the behavioral health medical director and/or a psychiatric physician advisor in determining the clinical appropriateness of the authorization request. Care is authorized either by a behavioral health care manager, behavioral health medical director and/or psychiatric physician advisor.

Clinical non-certifications are only rendered by a licensed board certified psychiatric physician. The APS Medical Necessity and Level of Care Determination Criteria is utilized for psychiatric medical necessity determinations during the pre-certification process.

APS Behavioral Health utilizes the ASAM Patient Placement Criteria, 2nd Edition, Revised for the review of chemical dependency/abuse treatment services in all areas which do not mandate other specific criteria documents.

B. Concurrent Review

The purpose of the concurrent review function is to ensure that an enrollee who is already receiving inpatient, partial hospitalization, intensive outpatient, residential, home-based and on-site treatment services and/or outpatient behavioral health care services receives the correct intensity of services for his or her condition. APS behavioral health clinical staff conducts concurrent review activities telephonically or electronically in conjunction with utilization review staff at the facility. Case review is typically done prior to the expiration of the current certification or prior to the enrollee's anticipated discharge date to determine need for continued stay. It is the responsibility of the facility or the attending physician to notify the designated APS care manager and provide all necessary information in a timely manner so a decision can be made regarding authorization of the current course of treatment services.

Care managers request and review current clinical information from the facility or provider. In the event that the information provided is not consistent with the APS Medical Necessity and Level of Care Determination Criteria and/or other appropriate criteria sets, or if the complexity of the case indicates, a review is requested from the Medical Director or a Physician Advisor.

Discharge planning is another aspect of the concurrent review process. Discharge planning begins immediately upon admission to the facility and is monitored by the APS care manager. During the discharge planning process, behavioral health care managers educate enrollees, significant others and care givers (if appropriate releases are signed) about benefit administration, community resources and alternative care options, as indicated. APS works with the providers and enrollees discharged from an inpatient unit to ensure the enrollee has a follow up appointment within seven calendar days of discharge.

C. Retrospective Review

The purpose of a retrospective review is to determine the eligibility and medical necessity of behavioral health care services that were rendered without prior approval or authorization by APS. A care manager may authorize behavioral health care services retrospectively. Clinical non-certification decisions are only rendered by an APS Medical Director or Physician Advisor.

D. Intensive Case Management (ICM)

Intensive Case Management (ICM) is a program which involves the process of identification, planning, monitoring, and mobilization of resources to facilitate effective outcomes for high risk enrollees. The details of this service, where offered, are contract specific.

The goals of ICM are to:

- Minimize the reliance on facility-based care
- Decrease need for repeated crisis management
- Focus on maintenance and stabilization in outpatient care
- Establish a customized comprehensive plan that, over the longer term, will increase functioning in areas such as self-care, work/school, and family/ interpersonal; and
- Decrease symptomatology and risk factors.

Elements for ICM identification may include:

- Multiple inpatient treatment episodes.
- Discharge from inpatient Mental Health or Substance Abuse (MH/SA) treatment *and* no outpatient follow-up within 30 days.
- MH/SA readmission to inpatient within 30 days following discharge from inpatient.
- Multiple Emergency Department visits for MH/SA treatment within 60 days.
- Other complex conditions (e.g., co-occurring physical and behavioral health disorders without significant stabilization).
- High risk of self-injury, decompensation or death.

ICM activities may be conducted by a behavioral health care manager in consultation/coordination with other members of the UM team. ICM activities may include, but are not limited to:

- Research and review of current and past clinical information.
- Education of the enrollee/family concerning the role of the Behavioral Health Care Manager in the ICM process and assistance that may be provided upon request/identification of need.
- Identification of and evaluation of barriers to care and treatment resources considering the enrollee's specific linguistic, cultural, geographic, economic and other needs.
- Identification and coordination with all behavioral health and/or physical health care providers involved with the enrollee to ensure increased coordination and continuity of care activities.
- Linkage with community based resources to increase the likelihood of positive treatment outcomes.

E. Information and Responsible Parties Involved In Behavioral Health UM Decisions

The following tables identify the process, relevant data, and responsible parties involved in making UM decisions for behavioral health services. The information listed below, if appropriate and relevant to the enrollee's case, may be used by the responsible party in rendering a UM decision.

| UM Process | Data | Type of Decision | Responsible Party |
|-----------------------------|---|--|---|
| Prospective Review | | DECISIONS REQUIRING ONLY BENEFIT DETERMINATION: | |
| ➤ Routine Outpatient | <ul style="list-style-type: none"> Eligibility information Number of units previously authorized Network status of provider Plan benefits Behavioral health records from outpatient providers | <ul style="list-style-type: none"> Authorizations Non-certifications | <ul style="list-style-type: none"> Member Referral Coordinators, Care Managers, Behavioral Health Medical Director, Psychiatric Physician Advisors |
| | | MEDICAL NECESSITY DECISIONS: | |
| ➤ Urgent | <ul style="list-style-type: none"> Previous units authorized information Behavioral health records from inpatient and outpatient providers Information from conversations with treating providers Results of tests and evaluations Information from conversations with specialty consultants Benefits statements/Certificate of Coverage Network composition and availability of services APS Medical Necessity criteria and/or other appropriate clinical criteria | <ul style="list-style-type: none"> Authorizations | <ul style="list-style-type: none"> Care Managers, Behavioral Health Medical Director, Psychiatric Physician Advisors and Doctoral level Clinical Psychologists for psychological testing services provided by a non-physician practitioner |
| | | <ul style="list-style-type: none"> Non-certifications | <ul style="list-style-type: none"> Medical Director, Psychiatric Physician Advisors and Doctoral level Clinical Psychologists for psychological testing services provided by a non-physician practitioner |
| | | BENEFITS DECISIONS: | |
| | | <ul style="list-style-type: none"> Authorizations Non-certifications | <ul style="list-style-type: none"> Care Managers, Behavioral Health Medical Director, Psychiatric Physician Advisors and Doctoral level Clinical Psychologists for psychological testing services provided by a non-physician practitioner |
| CONCURRENT REVIEW | | MEDICAL NECESSITY DECISIONS: | |
| ➤ Routine/Urgent | <ul style="list-style-type: none"> Information from conversations with treating providers Results of tests and evaluations Information from conversations with specialty consultants Benefits statements/Certificate of Coverage Information about enrollee's home situation and availability of support services APS Medical Necessity criteria and/or other appropriate clinical criteria Provider contracts | <ul style="list-style-type: none"> Authorizations | <ul style="list-style-type: none"> Care Managers, Behavioral Health Medical Director, Psychiatric Physician Advisors and Doctoral level Clinical Psychologists for psychological testing services provided by a non-physician practitioner |
| | | <ul style="list-style-type: none"> Non-certifications | <ul style="list-style-type: none"> Medical Director, Psychiatric Physician Advisors and Doctoral level Clinical Psychologists for psychological testing services provided by a non-physician practitioner |
| | | BENEFITS DECISIONS: | |
| | | <ul style="list-style-type: none"> Authorizations Non-certifications | <ul style="list-style-type: none"> Care Managers, Behavioral Health Medical Director, Psychiatric Physician Advisors and Doctoral level Clinical Psychologists for psychological testing services provided by a non-physician practitioner |

| UM Process | Data | Type of Decision | Responsible Party |
|-----------------------------|---|--|---|
| RETROSPECTIVE REVIEW | | MEDICAL NECESSITY DECISIONS: | |
| | <ul style="list-style-type: none"> Behavioral health records from inpatient and outpatient providers Information from conversations with treating providers Results of tests and evaluations Information from conversations with specialty consultants Information from conversations with enrollee/significant others Benefits statements/Certificate of Coverage Claims forms APS Medical Necessity criteria and/or other appropriate clinical criteria Network composition and availability of services Provider contracts | <ul style="list-style-type: none"> Authorizations | <ul style="list-style-type: none"> Care Managers, Behavioral Health Medical Director, Psychiatric Physician Advisors and Doctoral level Clinical Psychologists for psychological testing services provided by a non-physician practitioner |
| | | <ul style="list-style-type: none"> Non-certifications | <ul style="list-style-type: none"> Medical Director, Psychiatric Physician Advisors and Doctoral level Clinical Psychologists for psychological testing services provided by a non-physician practitioner |
| | | BENEFITS DECISIONS: | |
| | | <ul style="list-style-type: none"> Authorizations Non-certifications | <ul style="list-style-type: none"> Care Managers, Behavioral Health Medical Director, Psychiatric Physician Advisors and Doctoral level Clinical Psychologists for psychological testing services provided by a non-physician practitioner |
| EMERGENT CARE | | | |
| | <ul style="list-style-type: none"> APS does not require prior authorization for behavioral health services rendered in an emergency department. APS does not review for medical necessity on behavioral health emergency services, but may review to determine contractual responsibility (medical vs. behavioral benefits) for costs. APS pays for services necessary to stabilize an emergent behavioral health condition. | N/A | N/A |

For all medical necessity non-certifications, a psychiatric physician advisor is available to providers to conduct a peer to peer discussion of the case. For psychological testing cases, a doctoral level clinical psychologist is also available to conduct a peer to peer discussion of the case with a non-physician practitioner.

F. UM Process Timeframes

TIMELINESS AND NOTIFICATION OF UM DECISION

| Review Process | Standards |
|--|---|
| <p>Prospective Review Process</p> <p>References:</p> <p>URAC Health UM Standards, Version 6.0</p> <p>URAC HUM – 17</p> <p>UM.002</p> <p>UM-DL.019</p> | <p><u>Urgent Care Reviews:</u></p> <ul style="list-style-type: none"> • The authorization determination is to be made and notice provided to Enrollee or Authorized Representative within 72 hours of APS initially receiving the request for review. This timeframe includes written notification to the member and/or provider. • If a request is non-certified, the enrollee, authorized representative and/or the requesting provider are informed in writing how to initiate an appeal. The requesting provider is also informed verbally regarding the non-certification and is asked to notify the participant immediately of the non-certification. <p><u>Non-Urgent Reviews:</u></p> <ul style="list-style-type: none"> • The authorization determination is to be made and notice provided to Enrollee or Authorized Representative within 15 days of APS initially receiving the request for review. This timeframe includes written notification to the member and/or provider. • This period may be extended one time by the MBH unit for up to 15 calendar days: • Provided that the MBH unit determines that an extension is necessary because of matters beyond control of the MBH unit; and <ul style="list-style-type: none"> ○ The member is notified prior to the expiration of the initial 15 calendar day period of the circumstances requiring the extension and the date when the MBH unit expects to make a decision; and ○ If the member fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the member must be given at least 45 calendar days from the receipt of the notice to respond to the MBH unit request for more information. • If a request is non-certified, the enrollee, authorized representative and/or treating provider are notified verbally, if possible, in addition to the written determination. The written determination includes information about how to initiate an appeal. |
| <p>Concurrent Review Process</p> <p>References:</p> <p>URAC Health UM Standards, Version 6.0</p> <p>URAC HUM – 19</p> <p>UM.002</p> <p>UM-DL.019</p> | <p><u>Urgent and Non-Urgent Reviews:</u></p> <ul style="list-style-type: none"> • For reductions or terminations in a previously approved course of treatment, the determination is issued early enough to allow the member to request a review and receive a decision before the reduction or termination occurs; and • For requests to extend a current course of treatment, the determination is issued within: <ul style="list-style-type: none"> ○ 24 hours of the request for a utilization management determination, if it is a case involving urgent care and the request for the extension was received at least 24 hours before the expiration of the currently certified period or treatments; or ○ 72 hours of the request for a utilization management determination, if it is a case involving urgent care and the request for the extension was received less than 24 hours before the expiration of the currently certified period or treatments • If a request is non-certified, the enrollee, authorized representative and/or treating provider are notified verbally, if possible, in addition to the written determination. The written determination includes information about how to initiate an appeal. |
| <p>Retrospective Review Process</p> <p>References:</p> <p>URAC Health UM Standards, Version 6.0</p> <p>URAC HUM – 18</p> <p>UM.002</p> <p>UM-DL.019</p> | <ul style="list-style-type: none"> • All retrospective reviews are considered to be non-urgent. • For retrospective review, a determination is issued: <ul style="list-style-type: none"> ▪ Within 30 days of the receipt of request for a utilization management decision; and ▪ This period may be extended one time by the MBH unit for up to 15 calendar days: <ul style="list-style-type: none"> ○ Provided that the MBH unit determines that an extension is necessary because of matters beyond control of the MBH unit; and ○ The member is notified prior to the expiration of the initial 30 calendar day period of the circumstances requiring the extension and the date when the MBH unit expects to make a decision; and ○ If the member fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the member must be given at least 45 calendar days from the receipt of the notice to respond to the MBH unit request for more information. • If the request is non-certified, the enrollee, authorized representative and/or treating provider are notified in writing. The written determination includes information about how to initiate an appeal. |

G. Triage and Referral Process for Behavioral Health Services

Enrollees are instructed by the health plan or their employer to contact APS through their contract's APS toll free number. Each APS toll free number has an emergency option on the phone tree that is answered by a live person immediately for triage.

Non-emergency enrollee calls are routed to an administrative staff person (unless otherwise required by contract) who verifies enrollee demographics and behavioral health benefits. A standardized screening checklist is used to differentiate calls that do not require clinical judgment from those that potentially do. If the screening checklist identifies the potential need for clinical assessment, the caller is transferred to a Care Manager.

Urgent calls identified through the screening checklist are connected to a Care Manager for clinical care and risk assessment. When the triage process is completed, the Care Manager facilitates, on behalf of the enrollee, a clinically appropriate referral.

VII. UM DECISION APPEAL PROCESS

In the event an enrollee, enrollee's representative, or provider disagrees with a non-certification, an appeal process is available for reconsideration of the request for services or payment for services. Enrollees and providers are notified of how to initiate the appeal process and steps in the appeal process at the time of the non-certification notification. The following is a summary of the steps in the appeal process. Details regarding the procedures are contained in these policies:

- UM.004 Clinical Appeals
- UM-DL.019 Utilization Management and Appeal Management Timeframes

(Note: State specific appeals policies and client requirements supersede the general policy to assure regulatory compliance.)

A. First Level Appeal

1. If an enrollee, enrollee's representative or provider chooses to appeal an initial non-certification of a UM decision, the appellant notifies the Behavioral Health UM Department of an expedited appeal request or else informs the Appeals Department of a standard appeal request. An expedited appeal can be requested at any time while an enrollee remains in the same higher level of care that was non-certified. Expedited appeals are not an option for non-urgent care but an appellant can request a standard appeal in such cases. Expedited and standard appeal requests are accepted telephonically, electronically or in writing. Upon receiving a request for an expedited appeal, the APS care manager will forward the request to the behavioral health medical director and/or a psychiatric physician advisor with appropriate expertise to evaluate the case and who was not involved in the initial non-certification decision. Upon receiving a request for a standard appeal, the Appeals Coordinator sends an acknowledgement letter confirming receipt of the appeal request. The Appeals Coordinator receives the request for standard appeal, logs the information provided and begins researching the appeal. All information used in making the initial non-certification, additional information submitted by the appellant and any additional information is gathered and reviewed. The file is forwarded to a behavioral health medical director and/or psychiatric physician advisor with appropriate expertise to evaluate the case and who was not involved in the initial non-certification decision.

2. The Medical Director and/or psychiatric physician advisor evaluates the request, conducts additional research (such as contacting the treating provider if necessary), consults the APS Medical Necessity and Level of Care Determination Criteria; ASAM Patient Placement Criteria, 2nd Edition, Revised and/or other appropriate criteria set, and renders a decision.
3. The Medical Director's and/or physician advisor's determination is forwarded to the Appeals Coordinator for processing and notification to the enrollee, and/or provider as applicable. Notification of the first level appeal decision contains information on how to file a second level appeal. Expedited appeal determination notifications are provided by phone, or by electronic means and written correspondence. Standard appeal notifications may be provided by electronic and/or written means.

B. Second Level Appeal

1. If the enrollee, enrollee's representative or provider chooses to appeal the first level appeal decision, they may do so by forwarding a request for second level appeal to the Appeals Coordinator. The Appeals Coordinator provides confirmation by letter of the receipt of the appeal request.
2. Upon receipt of a request for second level appeal, the Appeals Coordinator logs the case into the appeals log and gathers past data and any additional information forwarded by the appellant for consideration in the appeal.
3. The process of a second level appeal is dependent upon the contractual agreement APS has with the enrollee's plan. The second level appeal review process will involve a psychiatric physician advisor who was not involved in the initial non-certification or the first level appeal.
4. The psychiatric physician advisor evaluates the request, conducts additional research (such as contacting the treating provider if necessary), consults the APS Medical Necessity and Level of Care Determination Criteria, ASAM Patient Placement Criteria, 2nd Edition, Revised and/or other appropriate criteria set and renders a decision.
5. After consideration of all case information, the decision is communicated to the appellant via letter within the timeframes listed in section D.

C. External Independent Review Process

The External Independent Review Process is managed per individual client instructions and State specific appeals policies.

D. Appeal Timeframes

Timeframes for expedited and standard appeals are contained in the table below:

TIME FRAMES FOR APPEALS

| | |
|--|--|
| Expedited Appeal Process References: URAC HUM – 33 UM.004 UM-DL.019 | <ul style="list-style-type: none">• Available only for urgent Level I Appeals• Review completed and verbal notification provided within 72 hours of request• Written notification issued within 3 calendar days following verbal notification |
| Standard Appeal Process References: URAC HUM - 34 UM.004 UM-DL.019 | <ul style="list-style-type: none">• Available for urgent or non-urgent Level I and Level II Appeals• Review completed and written notification issued within 15 calendar days of receipt of the request for a pre-service appeal• Review completed and written notification issued within 30 calendar days of receipt of the request for a post-service appeal |
| External Independent Review Process | <ul style="list-style-type: none">• The External Independent Review Process is managed per individual client instructions and State specific appeals policies. |

VIII. EVALUATION OF NEW TECHNOLOGIES AND NEW APPLICATIONS OF EXISTING TECHNOLOGIES

A. Identifying New Technologies and New Applications of Existing Technologies

1. New technologies and new applications of existing technologies are those for which there is no external approval reference point.
2. The Clinical Advisory Panel (CAP) is responsible for maintaining currency with the new technologies available in the healthcare arena and new applications of existing technologies. This includes, but is not limited to, identifying, researching, evaluating and seeking approval of new technologies that are appropriate for use by APS enrollees. Recommendations for review of new technologies or new applications of existing technologies may also be made by operating unit staff, client organizations, network providers, or enrollees.
3. If a Medical Director, client organization, provider, enrollee or another APS staff identifies a new technology or new application of existing technology, the local site Medical Director verifies that the new technology meets the above definition of new technology and is not excluded by relevant contracts, and presents the need for review to the CAP.
4. If the CAP determines that the technology meets the criteria for a new technology or a new application of an existing technology, an ad hoc technology review group is convened consisting of up to 3 CAP members and other professionals as necessary, who have expertise in the technology.

B. Research and Evaluation of New Technology or New Application of Existing Technology

1. The ad hoc technology review group meets to research the new technology or new application of an existing technology. This research may include, but is not limited to, a review of:
 - Nationally accepted literature data bases, (e.g. Medline Data Base);
 - Government publications;
 - Published scientific evidence (Peer reviewed and double blind studies utilizing nationally accepted statistical techniques are given more weight);
 - Published practice parameters or guidelines documenting accepted uses;
 - FDA and/or other government regulatory body approvals, as required, and
 - When appropriate, the process for obtaining input from specialists with expertise in the technology under evaluation includes: 1) The Medical Director will identify the specialist using his/her knowledge of current research through literature review or personal experience; 2) an evaluation/opinion of the technology's efficacy is solicited from the specialist; 3) documentation of the specialist's opinion is forwarded to the ad hoc committee.

2. The ad hoc technology review group reviews all data and makes a determination regarding the use/non-use of the new technology or new application of existing technology. The determination is based upon the following four decision-making criteria:
 - Adequate peer reviewed literature supports a net positive health outcome;
 - The positive outcome is attainable outside the investigational setting;
 - The technology is as beneficial as existing non-investigational alternatives; and
 - FDA or other governmental regulatory approvals are secured, as required.
3. If the ad hoc committee decision is to approve the new technology or new application of existing technology, the ad hoc committee also recommends medical necessity criteria. The proposed criteria are reviewed by the CAP for approval.
4. If the ad hoc committee decision is non-approval of the new technology or new application of an existing technology, and the provider or enrollee appeals this decision, a new ad-hoc committee is formed. This appeal ad-hoc committee will consist of at least 2 members of the CAP who did not participate in the original decision and other professionals as necessary who have expertise in the technology.

C. Approval Process

1. The final recommendation for use/non-use of the new technology or new application of existing technology is presented to the CAP and documented in the CAP minutes.
2. If the recommendation is for non-use of the technology, the Corporate Chief Medical Officer communicates this decision to the local Medical Director who requested the review and the process is complete.
3. If the CAP approves the recommendation for use of the new technology or the new application of an existing technology, the Corporate Chief Medical Officer, or designee, presents the CAP recommendation at the next scheduled CQIC meeting for approval.
4. The CQIC reviews the recommendation and ensures that the established criteria and procedures for new technology review have been followed. The CQIC then makes the final decision regarding the approval/non-certification. In some circumstances the final approval of new technologies is not completely under APS' control, as in those circumstances when the health plan has the final approval of whether a procedure or medication will be covered by the enrollee's benefit package. In those instances, recommendations for approval of new technologies are communicated to client organizations for inclusion in the benefit packages/drug formulary. When the CQIC has made the final decision, the decision becomes applicable to all divisions.
5. The Corporate Chief Medical Officer notifies each of the local Medical Directors of the final decision and posts the result on APS central for future reference.
6. The Corporate Chief Medical Officer or designee (local MD) then presents the recommendations to the client organizations, as necessary.

D. Implementation of New Technologies

1. Once approved by the CQIC and by client organizations, when necessary, the local Medical Director and/or local management staff are responsible for the education of the provider network, enrollees, and APS staff of the approval of new technologies or new applications of existing technologies.
2. The Corporate Chief Medical Officer ensures that the approved new technologies or new applications of existing technologies are integrated into relevant APS clinical medical necessity criteria sets and Clinical Practice Guidelines, as indicated.

E. Informing Enrollees of New Technology Review Process

APS informs enrollees of its process for reviewing new technologies and new applications of existing technologies. It may use any of the following methods:

- Enrollee newsletter
- Enrollee brochures
- Targeted mailings
- APS web site

IX. ENSURING APPROPRIATE UTILIZATION

Under or over utilization of behavioral health care services may result in poor quality care to enrollees. To ensure that enrollees receive the appropriate level of services, APS implements a program to monitor service sites and improve the level of services received by enrollees. The variation in use of services is monitored by the MBHQIC.

UM data used to measure each product line may include the following:

- Average Length of Stay of inpatient utilization data.
- Average Length of treatment for outpatient services by product.

When potential under and/or over utilization is identified, the following steps may be taken to determine if there are, in fact, instances of actual under and over treatment:

1. The number and type of enrollee complaints related to high volume facilities or outpatient providers associated with under/over utilization of care will be reviewed.
2. If indicated based on average length of treatment, a sample review of medical records for facilities or outpatient providers will be conducted to identify any instances of under or over treatment.
3. APS will review the results of medical record reviews, utilization and/or readmission patterns, and any complaints received related to care delivery to determine if potential under or over utilization can be validated. If it is validated, the facilities or providers responsible will be targeted for educational outreach. This outreach will comprise the primary intervention to correct under or over treatment utilization.

X. UM PROCESSES USED FOR BEHAVIORAL HEALTH SERVICES

A. Structure and Accountability

UM structure, processes and criteria employed for management of behavioral health services are outlined in this behavioral health UM program description. Accountability for the management of behavioral health UM processes is the responsibility of the Executive Director/Medical Director, Behavioral Health Division. APS does not delegate any aspect of the UM program.

B. Ensuring Appropriate Use of Behavioral Health Services

On an annual basis, under and overuse of behavioral health services is assessed. Variation in the use of behavioral health services is assessed through a variety of measures. If variation is noted, quality improvement analyses are conducted to determine the source of the variation. Interventions are implemented to address the sources of variation, and a reassessment is conducted in the next program year.

XI. ENROLLEE AND PROVIDER SATISFACTION WITH BEHAVIORAL HEALTH UM PROCESSES

Satisfaction with behavioral health UM program is assessed for enrollees and practitioners.

A. Enrollee Satisfaction

On an annual basis, a survey is conducted to determine enrollee satisfaction with behavioral health UM processes. Results are evaluated and reported to the UMC, the MBHQIC, and the CQIC. Opportunities for improvement are identified and acted upon as appropriate.

B. Provider Satisfaction

On an annual basis, a survey is conducted to determine provider satisfaction with the behavioral health UM processes. Results are evaluated and reported to the UMC, the MBHQIC, and the CQIC. Opportunities for improvement are identified and acted upon as appropriate.

XII. ROLE OF THE BEHAVIORAL HEALTH UM PROGRAM IN THE QUALITY IMPROVEMENT PROGRAM

A. Organizational process for collecting UM data

The behavioral health UM program provides the Quality Improvement program with data related to monitoring and improving care and service rendered to enrollees. The Behavioral Health UM Department and Quality Improvement Department work together to monitor the care and service provided to enrollees. Through this partnership, APS staff is able to identify opportunities for improvement, intervene to improve care and services and conduct re-measurement activities to determine whether objectives are achieved.

B. Organizational use of this data for Quality Improvement activities

Results of the behavioral health UM program are used to identify quality of care concerns among providers. Key quality indicators are established in the Quality Improvement program to monitor behavioral health UM processes. These results provide a basis for prioritizing quality improvement initiatives.

XIII. DELEGATION

APS Healthcare does not delegate behavioral health UM functions.

XIV. CONFIDENTIALITY AND CONFLICT OF INTEREST

Enrollee and practitioner information is confidential. APS staff, committee members and any other persons who act for or on behalf of APS are required to accept and conform to designated confidentiality policies and procedures.

No person may participate in the review, evaluation or disposition of any behavioral health UM case discussion in which s/he has been professionally or personally involved, or where their judgment might otherwise be compromised. All staff who make behavioral health UM decisions are required to sign confidentiality and Utilization Management statements attesting:

- Their decisions are based only on appropriateness of care and benefit coverage;
- They understand that APS does not reward staff or participating providers for issuing non-certifications of coverage or medical care; and
- There are no financial incentives for behavioral health care UM decisions.

XV. BEHAVIORAL HEALTH UM PROGRAM EVALUATION

A. Frequency of UM Program Evaluation

A formal evaluation of the program occurs annually.

B. Responsibility for UM Program Evaluation

The UM Program Evaluation is conducted by the Behavioral Health UM Department staff. Any or all of the following data sources are incorporated in the annual evaluations:

- Under and over utilization monitoring results and activities.
- Enrollee and Provider satisfaction with the UM process.
- Compliance with UM decision-making timeframes.
- Compliance with non-certification and appeal resolution timeframes.
- Consistency of UM decisions and decision-makers.
- Complaints regarding the UM process.
- Appeal category analysis.
- Medical Necessity Review Criteria.
- New Technology Recommendations.

Evaluation results are reported to the UMC, MBHQIC and the CQIC. Results of the evaluation are used to guide the development and refinement of the Behavioral Health UM Program Description and Work Plan.

XVI. UM PROGRAM APPROVALS

This program description is approved by the following individuals and committees.



1/21/11

Lisa Hadley, MD, JD
Executive Director/Medical Director,
Managed Behavioral Health

| | | |
|----------------------------|-----------------|---------------|
| 1/21/11 | 1/21/11 | 1/19/11 |
| UM Committee Approval Date | Initiation Date | Revision Date |