

| Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual | |
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| Policy Name: Intake and Referral | Accessibility, Availability, Referral and Triage |
| Date: 8-93 Reviewed by QI Committee: 05-07, 05-08 Revised by QI Committee: 04-07, 05-08 | Page: 1 of 3 Policy Number: AR-2 |

Purpose: To provide an appropriate referral to a Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) psychiatrist, therapist, treatment program, agency, or hospital for eligible contracted health plan patients.

Policy:

1.0 Intake

- 1.1 An Intake Specialist who has training in customer service and healthcare completes a Pre-Review Screening using a standardized script (Reference Appendix D – Referral Script).
 - 1.1.1 Intake Specialists are non-licensed clinicians and therefore are only responsible for making non-clinical administrative judgments.
 - 1.1.2 Intake Specialists are under the supervision of the Director of Clinical Services, a licensed mental health professional with five years post-masters experience.
 - 1.1.3 All calls requiring clinical assessment and risk determination are warm transferred to a licensed clinician via the urgent queue for an Initial Review. The Intake Specialist remains on the line with the patient until the clinician answers.
- 1.2 The Intake Specialist will obtain the following information required to complete the referral for each patient:
 - 1.2.1 Name of patient and demographic information
 - 1.2.2 Source of referral, and any requests specified by source
 - 1.2.3 Presenting problem
 - 1.2.4 Structured clinical, including presence of suicidal or homicidal ideation and/or substance abuse concerns
 - 1.2.5 Prior treatment history including outpatient and inpatient
 - 1.2.6 Primary Care Physician name and phone number
 - 1.2.7 Medication usage (current only)
 - 1.2.8 Provider preferences
 - 1.2.9 Eligibility verification:
 - If CBHM/CHIPA has electronic connectivity with payer, Intake Specialist will logon to eligibility system and verify eligibility start date, benefit plan, # of sessions allowed per year, # of sessions used to date and copayment amount.
 - If CBHM/CHIPA does not have electronic connectivity with payer, Intake Specialist will call payer representative to verify eligibility start

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date, benefit plan, # of sessions allowed per year, # of sessions used to date and copayment amount.

1.2.10 Eligibility and benefit plan information including services per year, co-pay, certification number, subscriber name and identification number, and number of services authorized, if applicable.

1.3 If a patient indicates any of the following, s/he will be warm transferred to a licensed mental health clinician via the urgent queue for assessment and completion of Initial Review. The Intake Specialist remains on the line with the patient until the clinician answers:

- 1.3.1 Patient sounds distraught (is crying, extremely soft spoken, etc.)
- 1.3.2 Patient is disorganized or confused
- 1.3.3 Patient asks to speak to a counselor immediately
- 1.3.4 Patient indicates self harm or harm to others
- 1.3.5 Patient indicates problems with drugs or alcohol
- 1.3.6 Patient identifies possible domestic violence, sexual abuse, or other child/elder abuse
- 1.3.7 Patient requests immediate hospitalization and requests to speak to a counselor immediately
- 1.3.8 Patient identifies desire for CD treatment

2.0 Referral

- 2.1 After gathering the Pre-Review Screening information the Intake Specialist will search for appropriate providers based upon presenting problem and preferences (language spoken, gender, licensure, etc.)
- 2.2 Patients are warm transferred to nearest preferred practice location for scheduling. A generic authorization is created and faxed or mailed to practice location. If the preferred practice location does not have live warm-transfer capability, the Intake Specialist obtains member permission to call the POD on their behalf. The POD then calls the member within 48 hours with the assigned therapist and appointment information. A generic authorization is also created and sent to the practice location.
- 2.2 If a preferred practice location is not available up to five provider referrals will be given within a 30 mile or 30 minute radius of patient’s home zip code (or work zip code if patient prefers) and patient is instructed to call back with provider choice for authorization
- 2.3 Referrals include provider’s name, licensure, address, and phone number
- 2.4 Upon request, a written provider directory will be mailed or faxed to patient.
- 2.5 Patient is advised regarding benefit limitations and co-pay

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- 2.6 Patient is advised regarding Intake Specialist first name and the 24-hour services available
- 2.7 Upon notification from patient regarding provider choice, an authorization is faxed or mailed to provider within 24 hours and the patient is verbally advised regarding services authorized

URAC Standards

- UM 7 – Limitations in Use of Non-Clinical Staff
- UM 8 – Pre-Review Screening Staff Oversight
- UM 10 – Initial Clinical Reviewer Qualifications