

Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual	
Policy Name: Transition of Care	Utilization Management
Date: 11-97 Reviewed by QI Committee: 9-06, 7-07, 9-07, 9-08, 9-09 Revised by QI Committee: 9-06, 7-07, 9-07, 9-08, 9-09	Page: 1 of 3 Policy Number: UM-7

Purpose: To ensure quality consumer care, whenever a patient can no longer continue in treatment due to benefit exhaustion, eligibility ending, and/or provider terminating from panel, Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) will provide options for patient to transition to appropriate resources.

Policy:

1.0 Outpatient

1.1 Exhaustion of Benefits

- 1.1.1 Prior to the exhaustion of mental health benefits, CBHM/CHIPA will notify provider of sessions remaining either through a note added to the services notification or a telephone call. For accounts requiring pre-authorization, provider will be asked to call and speak to a CBHM/CHIPA Case Manager regarding their transition of care plan for the patient prior to final authorization and exhaustion of benefit.
- 1.1.2 CBHM/CHIPA Case Manager informs provider that he/she is responsible to inform patient of the following options:
 - 1.1.2.1 Patient may choose to develop a financial arrangement with provider to pay for services privately. In such cases, provider and patient must sign a written agreement.
 - 1.1.2.2 Provider may seek reimbursement through another health plan if the patient is eligible.
 - 1.1.2.3 Provider may refer the patient to community resources. If a provider needs assistance in identifying community resources, s/he may contact the CBHM/CHIPA Director of Care Management who will complete a resource search and report back the results.
- 1.1.3 At the time of benefit exhaustion, the patient and provider are mailed a written notification, which includes instructions for seeking assistance with community resource referrals as needed.
- 1.1.4 In the event that CBHM/CHIPA receives a request for authorization of sessions that exceeds the available benefit, per CBHM/CHIPA delegation agreements, an administrative denial letter, or request for the payer to issue an administrative denial, will be sent within 72 hours indicating that all sessions have been used and the available benefit has been exhausted. Reference CBHM/CHIPA Policy UM-6, Denial and Appeals.

1.2 Provider Termination

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1.2.1 At the time a provider resigns and/or his/her contractual agreement with CBHM/CHIPA is terminated, CBHM/CHIPA will identify all patients currently in treatment with provider.

1.2.2 CBHM/CHIPA notifies the member via telephone or mailed letter that the provider is no longer contracted with CBHM/CHIPA and offers alternative in-network referrals and/or referrals to community resources. CBHM/CHIPA does not disclose to the member the reason the provider is no longer contracted. CBHM/CHIPA documents patient's choice for ongoing care in the electronic medical record.

1.3 Member Ineligibility

1.3.1 At the time CBHM/CHIPA becomes aware that a member in active treatment has become ineligible with the health plan, all open authorizations are closed as of the date of ineligibility and the closed authorizations are mailed or faxed to the treating providers.

1.3.2 CBHM/CHIPA Case Manager informs provider that he/she is responsible to inform patient of the following options:

1.3.2.1 Patient may choose to develop a financial arrangement with provider to pay for services privately. In such cases, provider and patient must sign a written agreement.

1.3.2.2 Provider may seek reimbursement through another health plan if the patient is eligible.

1.3.2.3 Provider may refer the patient to community resources. If a provider needs assistance in identifying community resources, s/he may contact the CBHM/CHIPA Director of Care Management who will complete a resource search and report back the results.

1.3.3 The patient and provider are mailed a written notification, which includes instructions for seeking assistance with community resource referrals as needed.

1.3.4 In the event that CBHM/CHIPA receives a request for authorization of sessions after the member has become ineligible, per CBHM/CHIPA delegation agreements, an administrative denial letter, or request for the payer to issue an administrative denial, will be sent within 72 hours indicating that the member is no longer eligible for services under the health plan. Reference CBHM/CHIPA Policy UM-6, Denials and Appeals.

2.0 Inpatient/Alternative Levels of Care

2.1 CBHM/CHIPA UM Coordinator will advise facility via telephone that patient either has exhausted benefits or is no longer eligible with the health plan.

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- 2.2 Per CBHM/CHIPA delegation agreements, an administrative denial letter, or request for the payer to issue the denial, will be sent to the facility within 72 hours. Reference CBHM/CHIPA Policy UM-6, Denials and Appeals.
- 2.3 CBHM/CHIPA UM Coordinator will confer with facility staff regarding appropriate community referrals, conversion to private pay, or possible coverage through a secondary health plan.
- 2.4 A transition plan will be documented in the clinical notes by the UM Coordinator.