

Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual	
Policy Name: UM Review Process	Utilization Management
Date: 3-98 Reviewed by QI Committee: 04-07, 09-07 Revised by QI Committee: 04-07	Page: 1 of 7 Policy Number: UM-4

Purpose: The purpose of this guideline is to ensure that all utilization management decisions made by Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) are in accordance with State and Federal timeliness regulations.

Definitions:

Routine (Non-Urgent) Care: Any request for a utilization management determination which the application of the time periods for making determinations does not jeopardize the life or health of the patient.

Urgent/Emergent Care: Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations 1) could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or 2) in the opinion of a provider or prudent lay person with knowledge of the patient's condition, would subject the patient to severe consequences that cannot be adequately managed without the care or treatment that is the subject of this case.

Policy:

1.0 Clinical Information

- 1.1 CBHM/CHIPA relies on the minimal clinical information necessary to make a determination as outlined in Appendix E, Utilization Management Review Guidelines.
- 1.2 All patient specific clinical information obtained during Utilization Management is considered confidential in accordance with Policies RR-6, Confidentiality, and HP-8, Release of Personal Health Information.
 - 1.1.1 Clinical information is used solely for the purpose of utilization management, case management, quality management, discharge planning, and claims payment.
 - 1.1.2 Clinical information is shared only with those entities who have authority to receive such information and who need access in order to conduct utilization management and related processes.
- 1.3 CBHM/CHIPA bases prospective and concurrent review determinations solely on the clinical information obtained at the time of the review. For retrospective reviews the determination is based solely upon the information available at the time the services were provided.
- 1.4 CBHM/CHIPA does not routinely require providers or facilities to submit medical records as part of the review process. If and when records are requested, the request is limited to only those medical records, which pertain directly to the authorization request.
- 1.5 CBHM/CHIPA does not conduct on-site utilization management reviews.
- 1.6 Providers are not required to give diagnostic information by designated codes unless the diagnosis cannot be concluded from the narrative review.

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- 1.7 To eliminate duplication of information requests all demographic and clinical information is contained in a central electronic file, which can be accessed by all appropriate staff.
- 1.8 A provider or facility can request a retro-review determination and/or a determination can be pended for additional information. However, no review will be pended longer than forty-five calendar days without making a determination.
- 1.9 Reproduction Costs - CBHM/CHIPA, for review purposes other than an appeal or a legal request, will reimburse reasonable costs of medical record duplication, unless otherwise provided for by contract or law.

2.0 Pre-Authorization/Prospective Review*

- 2.1 Outpatient Services
 - 2.1.1 Prospective requests for routine outpatient services are reviewed and determination issued within five calendar days of receipt of requests. Prospective requests for urgent outpatient services are reviewed and determination issued within 24 hours of receipt of requests.
 - 2.1.1.1 Intake Specialists review routine requests using the Pre-Review Screening tool (Reference Appendix D). If medical necessity cannot be determined during a Pre-Review Screening, the Intake Specialist refers request to a licensed clinician for an Initial Review. Denials are not issued as a result of a Pre-Review Screening.
 - 2.1.1.2 Licensed clinicians complete Initial Reviews for routine requests forwarded from Intake Specialist, and for all urgent and/or emergent requests. If medical necessity cannot be determined during Initial Review, request is forwarded to Medical Director for Peer Review. Denials are not issued as a result of an Initial Review. Reference Policy UM-6, Denials and Appeals.
 - 2.1.2 Routine requests for outpatient services may be pended if additional information is needed, e.g., eligibility and benefit verification or provider preference. Providers and patients are notified in writing within five calendar days regarding the need for additional information. The pended requests are reviewed and determination issued within five calendar days of receipt of additional information. If the additional information is not obtained within forty-five calendar days, a determination is made and issued based upon the information available.
 - 2.1.3 Urgent requests for outpatient services may be pended up to 24 hours if additional information is needed. Providers and patients are immediately notified verbally and by fax or mail. If additional information is not received within 24 hours a determination is made based upon the information available. *Outpatient prospective and concurrent review does not apply to payers with an Open Access benefit or clinical model.

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2.1.4 If prospective requests are for services which are excluded from benefit coverage (Reference Policy UM-5, Excluded Services), they are forwarded immediately to the Director of Clinical Services who will review with the Medical Director. The requests will be reviewed and determination issued within five calendar days of receipt. If determination is recommendation for denial Policy UM-6, Denials and Appeals will be followed.

2.2 Inpatient/Alternative Level of Care Services

2.2.1 UM Coordinators complete Initial Reviews for all inpatient/alternative level of care services and determination is issued within 24 hours of receipt of request. All requests for inpatient/alternative level of care services are deemed to be urgent requests and treated accordingly. Reference 2.1.3 above.

2.2.2 If patient does not meet the clinical indicators for level of care requested, the UM Coordinator will review immediately with the Medical Director and determination issued within 24 hours of receipt. Determination will include recommendation for the appropriate level of care based upon clinical indicators. If the facility or patient disagrees with the treatment recommendation a Peer Review will be offered. Reference Policy UM-6, Denials and Appeals.

3.0 Outpatient Concurrent Review

3.1 Urgent Cases

3.1.1 Whenever a provider determines that an immediate modification or extension of an authorization is medically necessary s/he should call CBHM/CHIPA and provide information related to their request to a licensed clinician or fax a *Progress Report/Authorization Request (PAAR) or Payer Form* marked “Urgent”.

3.1.2 The urgent request will be reviewed and determination issued within 24 hours of receipt. Reference 2.1.3 above.

3.2 Routine Cases (Also Considered Prospective Reviews)

3.2.2 Providers must submit a legible and complete CBHM/CHIPA standardized *Progress Report/Authorization Request (PAAR) or Payer Form* when continuing care is indicated.

3.2.3 Office Assistant date stamps the request form with date received, creates a pending authorization, and verifies current eligibility.

3.2.4 Once eligibility has been verified, the Office Assistant reviews the request form using the Clinical Review Algorithms for Non-Clinical Staff (Reference Appendix H). Appropriate authorization is granted if the request passes the algorithms. If the request form does not pass the algorithms, it is forwarded to a licensed clinician for review. If additional clinical information is needed to determine medical necessity the provider

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and patient are notified in writing within five calendar days and determination is pended for forty-five calendar days. If the additional clinical information is not received within forty-five calendar days, a determination is made based upon the available clinical information.

3.2.5 All routine concurrent review requests are reviewed and determination issued within payer guidelines, not to exceed five calendar days.

4.0 Inpatient/Alternative Levels of Concurrent Review

- 4.1 UM Coordinator conducts concurrent review based upon the severity or complexity of the patient's case. Typically these reviews occur every two to three days for inpatient admissions, every three to five days for partial admissions, and every ten to fourteen days for intensive outpatient admissions. The current status of the case is compared with CBHM/CHIPA Guidelines and Clinical Indicators to determine the appropriate level of care.
- 4.2 UM Coordinator may request a psychiatrist-to-psychiatrist review by CBHM/CHIPA Medical Director at any time it is deemed necessary.
- 4.3 All concurrent reviews for certification of continued stay or for changes in level of care are completed and determination issued with 24 hours of receipt of request. At any time medical necessity cannot be determined and a recommendation for denial is made, the provider will be given the option of Peer Review. Reference Policy UM-6, Denials & Appeals.
- 4.4 Requests for Inpatient/Alternative Levels of Care certification for continued stay may be pended up to 24 hours if additional information is needed. Providers are immediately notified verbally and providers and patients are also given immediate notice by fax or mail. If additional information is not received within 24 hours, a determination is made based upon the information available.
- 4.5 At time of discharge the UM Coordinator arranges for appropriate after care with a CBHM/CHIPA provider. CBHM/CHIPA Policy UM-10, Urgent and Emergent Appointment Follow-up, is followed in assigning providers and following up on the patient's compliance with discharge appointments.

5.0 Retrospective Review

- 5.1 Outpatient Services
 - 5.1.2 Providers submit a Request for Retrospective Review indicating dates of service and clinical justification. Medical record documentation is requested for dates of service older than 90 calendar days or greater than five dates of service.
 - 5.1.3 The request is stamped with date of receipt.
 - 5.1.4 A CBHM/CHIPA clinician completes retrospective review and issues determination within 30 calendar days of receipt of request.
 - 5.1.5 If additional clinical information is required the provider and patient will be notified in writing within five calendar days. The retrospective review will be pended for forty-five calendar days after the request for additional clinical information. If the clinical information is not received by the

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forty-fifth calendar day, determination will be issued based upon available clinical.

5.1.6 If recommendation is for denial, Policy UM-6, Denials and Appeals, is followed.

5.2 Inpatient/Alternative Level of Care Services

5.2.2 Facility submits clinical chart for retrospective review.

5.2.3 The chart is stamped with date of receipt.

5.2.4 Medical Director or licensed clinician reviews the chart and issues a determination within 30 calendar days of receipt.

5.2.5 If the Medical Director requires additional clinical information the provider and patient will be notified in writing within five calendar days. The retrospective review will be pended for forty-five calendar days after the request for additional clinical information. If the clinical information is not received by the forty-fifth calendar day, determination will be issued based upon available clinical.

5.2.6 If recommendation is for denial, Policy UM-6, Denials and Appeals, is followed.

6.0 Notification of Authorization Determinations

CBHM/CHIPA provides both verbal and written notification of authorization. Verbal notification includes voice mail messages. Written notification can be by mail or facsimile. Notification is completed within one business day of determination.

6.1 Outpatient Services

6.1.1 Patients receive verbal notification of authorization at the time they initially seek services. This notification includes:

6.1.1.1 Authorization number to be used for future reference

6.1.1.2 Number of sessions authorized

6.1.1.3 Benefit limitations

6.1.2 Providers receive written notification of initial authorization by facsimile or mail. Notification is completed within one business day of determination. This written notification includes:

6.1.2.1 Authorization number to be used for future reference

6.1.2.2 Patient demographic information

6.1.2.3 Benefit information

6.1.2.4 Number and type of sessions authorized

6.1.3 Following a concurrent or retrospective review a written notification is sent to requesting provider by facsimile or mail within one business day.

6.1.4 Upon request notification letters are mailed to patients.

6.2 Inpatient/Alternative Level of Care Services

6.2.1 Within one business day of admission, patients, facilities, and providers are mailed an initial authorization letter, which describes review process for ongoing authorization.

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- 6.2.2 During concurrent review, requesting facilities and providers are verbally notified regarding additional services authorized, total services authorized, and next review date.
- 6.2.3 Within one business day of receiving discharge information, a final authorization letter describing all services authorized is mailed to patients, facilities, and providers.
- 6.2.4 Following retroactive review an authorization letter describing all services authorized is mailed to patients, facilities, and providers within one business day.

7.0 Notice of Non-Authorization (Denial) Determinations

Based upon the health plan delegation agreement CBHM/CHIPA will either make a denial determination and verbally notify patient and provider within 24 hours or will communicate a recommendation for denial to the health plan designee within 24 hours. When CBHM/CHIPA is making denial determination written confirmation of denial and appeal process will be mailed or faxed within one business day of denial determination. When CBHM/CHIPA is only making denial recommendations the Health Plan Designee who makes denial determination is responsible for providing written or verbal notification to patient, provider, and/or facility. All written denial communications will include

- 7.1 The principal reasons for the denial determination
- 7.2 A statement that the clinical rationale used in making the denial decision will be provided, in writing, upon request; and
- 7.3 Instructions for initiating an appeal and/or requesting the clinical rationale.

Reference Policy UM-6, Denials and Appeals.

8.0 Monitoring Timeliness of UM Decisions

- 8.1 Pre-Authorization
 - 8.1.1 Timeliness of pre-authorization is monitored through monthly reporting which compares date of request to date of determination.
 - 8.1.2 Results of the report are communicated in the monthly Utilization Management Meeting and corrective action initiated if target is not met.
- 8.2 Concurrent Review
 - 8.2.1 Timeliness of concurrent review is measured through a monthly report, which compares date of request to date of determination. The report includes number of requests received and percentage completed within five calendar days. The target to be met is 90% of requests reviewed and determination issued within five calendar days.

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- 8.2.2 Results of the report are communicated in the monthly Utilization Management Meeting and corrective action initiated if target is not met.
- 8.3 Inpatient/Alternative Level of Care Case Management
 - 8.3.1 UM Coordinators will document when a clinical review was done and the next date of review. All concurrent reviews will be completed and determination issued within 24 business hours of receipt. Target for compliance is 100%.
 - 8.3.2 Chart audits will be conducted quarterly to ensure that timeliness of reviews is met and documented. Results of the audit are communicated in the Utilization Management Meetings and corrective action initiated if target is not met.
- 8.4 Retrospective Review
 - 8.4.1 Office Assistant for Intensive Services documents receipt of request in chart as well as date of determination.
 - 8.4.2 A Retrospective Review Log is maintained to track number of days from receipt of request to ensure review and determination is completed within thirty calendar days. Target for compliance is 100%.
 - 8.4.3 The QI Assistant monitors the Retrospective Review Log monthly.

URAC Standards

- Core 22 – Consumer Communication Plan
- UM 9 – Pre-review Screening Non-Certifications
- UM 10 – Initial Clinical Reviewer Qualifications
- UM 11 – Initial Clinical Reviewer Resources
- UM 12 – Initial Clinical Reviewer Non-Certifications
- UM 13 – Peer Clinical Review Cases
- UM 17 – Prospective Review Timeliness
- UM 18 – Retrospective Review Timeliness
- UM 19 – Concurrent Review Timeliness
- UM 20 – Certification Decision Notice and Tracking
- UM 21 – Continued Certification Decision Requirements
- UM 22 – Written Notice of Non-Certification Decisions and Rationale
- UM 23 – Clinical Rationale for Non-Certification Requirements
- UM 25 – Frequency of Continued Reviews
- UM 26 – Scope of Review Information
- UM 27 – Prospective and Concurrent Review Determinations
- UM 28 – Retrospective Review Determinations
- UM 29 – Lack of Information Policy and Procedure