CHELAN-DOUGLAS RSN/PHP POLICY AND PROCEDURE MANUAL		Chapter:	2.1
Title:	MANAGED CARE SERVICES	Page:	1of 3
		Date Effective:	July, 1, 2002
Subject:	MEDICAL NECESSITY	Date Revised:	October 15. 2005
		Authorizing Signature: Formally Adopted	

AUTHORITY: RCW 71.24.025
DSHS Title XIX Contract and Federal Waiver
DSHS Access to Care (MHD Exhibit E)

PURPOSE: To have a process to determine the medical necessity of requested services.

POLICY: Establishment of Medical Necessity or **medically necessary** shall be as described by MHD as: "A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause of physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation, or where appropriate, no treatment at all.

PROCEDURE:

A. Services Which Require Prior Authorization:

1. Prior authorization is required for the following services:
   a. Elective/urgent hospital stays for mental health
   b. All outpatient treatment modalities

B. Protocols for Review for Each Level Of Care:

1. All CDRSN/PIHP clinical reviews are conducted telephonically or via completion of a treatment authorization request form. Treatment request forms as well as approval/denial forms may be completed either via facsimile or HIPPA compliant on-line technology.

2. Concurrent medical necessity reviews are a collaborative process based on level of care and discharge plans. The Care Manager will review Plans of Care/Authorization Request Forms for all inpatient and outpatient services. Care Managers gather only necessary and pertinent information to determine medical necessity for the requested service(s) which includes but is not limited to: danger to self or others, progress toward treatment goals, medication management, etc. The specific type of information collected during the review process is detailed (below) in the Level of Care Guidelines included in the UM Plan.

3. Concurrent review authorizations are completed by Utilization Care Managers prior to the exhaustion of the initial authorization Concurrent reviews of outpatient modalities and residential treatment, are conducted based on medical necessity, level of care, discharge plans (detailed below in the Level of Care Guidelines), the Triage Protocol and are documented in the computer system. Inpatient authorizations are based on established continued stay criteria as indicated by the severity and complexity of the patient's clinical presentation. Inpatient reviews are conducted upon admission, scheduled on the last authorized day, and reviewed on an "as needed" basis according to severity and patient progress. In addition, a set of clinical algorithms/flow charts have been specifically designed for the State of Washington which reflects both State and CMS eligibility and level of care criteria.

4. All utilization review activities, including approvals, denials, and appeals processes are completed in accordance with standards for appropriateness, clinical oversight, timeliness and notice provisions, as established by NCQA, URAC, and all applicable federal and state regulatory agencies.

5. In any instance when a Care Manager is not able to authorize requested care, the case is referred to a board-certified psychiatrist for review. The psychiatrist will either authorize the care or issue a denial, based on medical necessity criteria.

6. The <u>inpatient</u> hospitalization review guidelines include (please note that detailed information regarding admission and continued stay criteria are found in the CDRSN/PIHP Medical Necessity Criteria/Utilization Management Guidelines):

   a. The severity of the patient's admission status renders him/her unsafe for treatment at a less acute level of care.
   b. Current primary and secondary diagnosis
   c. The treatment provided must commence on admission and be commensurate with the necessity to utilize an acute facility (aggressive drug therapy, frequent dosage modification, ECT, etc.) and must proceed in a timely fashion.
   d. If child/adolescent, level of family involvement-family therapy should be involved at least 2 times per week.
   e. Discharge planning is to commence immediately following admission and be actively followed.
   f. The treating physician must see patient daily.
   g. Treatment must be appropriate to the patient's clinical presentation and aggressive enough to ensure rapid stabilization. Measures are to be promptly instituted to insure treatment compliance.

7. The <u>outpatient</u> level of care review guidelines include (please note that detailed information regarding admission and continued stay criteria are found in the CDRSN/PIHP Medical Necessity Criteria/Utilization Management Guidelines):

   a. Indicators continue to support need for treatment.
   b. Progress is likely to occur which will stabilize the patient and prevent hospital admission.
   c. The identified patient is generally motivated and participating actively in the therapy process.

Inter-rater Reliability for Medical Necessity Determinations

A. The RSN evaluates the consistency with which the UM staff clinical reviewers and physicians who certify services, utilize criteria/protocols and make UM decisions. Vignettes are utilized to facilitate consistent UM decision making, correct and consistent application of the criteria, and to identify and correct ambiguities in the criteria.

1. This evaluation is reviewed, approved, and corrective actions monitored annually by the Utilization Management Committee.
2. The audit tool assesses concurrence with decisions and confirms that the decision rationale is consistent with Mental Health Review Criteria. The auditors review for agreement with length of stay determinations as well as alternative treatment settings as recommended in the decision.

B. A minimum of two vignettes are selected for each care manager. The performance goal is 95% or better agreement. Each care manager failing to meet the stated goal will receive a corrective action plan that is designed to educate him/he in the area of the deficiency. Re-audits are required to confirm compliance with audit standards.

C. In addition to the annual audit, Utilization Management Specialists, Intake representatives and peer advisors are audited. All new hires are audited continuously during the new hire orientation period of up to 6 months. These audits are completed by the UM Compliance Director, UM Manager, Intake supervisor and Medical Director. The audit focuses on compliance with required data elements and timeliness standards as established by NCQA, URAC, appropriate regulatory agencies and internal policies regarding decision making and notification.

SEE ALSO: Glossary of Terms and Acronyms